REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

HEALTH WORKFORCE STUDY

(Item 11, 2000 Appropriations Act)

Joint Commission on Health Care
Old City Hall
1001 East Broad Street
Suite 115
Richmond, Virginia 23219
http://legis.state.va.us/jchc/jchchome.htm

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Preface

Item 11 of the 2000 Appropriations Act directs the Joint Commission on Health Care (JCHC) to continue its study of the various health workforce programs and initiatives related to improving access to care in underserved areas. Specifically, the Appropriations Act states that the Joint Commission's continuing work shall:

> (i) assess the impact of the programmatic and administrative changes enacted by the 2000 General Assembly on the various workforce programs;
>
> (ii) recommend any further improvements to the existing programs and identify additional cost-effective initiatives; and
>
> (iii) assess the need for and feasibility of establishing a pharmacist scholarship and loan repayment program for pharmacists who agree to practice in underserved areas of the Commonwealth.

A copy of Item 11 of the 2000 Appropriations Act is provided at Appendix A.

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

- The Virginia Department of Health (VDH) has taken steps to increase the number of underserved areas designated as health professional shortage areas (HPSAs) which will help increase the number of providers locating in these areas. However, provider recruitment and retention efforts are still hampered by limited staff at VDH. (Virginia assigns .5 FTE to recruitment; North Carolina devotes 5 FTE.)

- In FY 2000, only 8 providers were placed in underserved areas in Virginia.

- Budget language adopted by the 2000 General Assembly to consolidate the scholarship and loan repayment funds into one amount has provided needed flexibility to VDH in making awards. However, forfeited amounts revert to the general fund rather than staying within the respective scholarship/loan repayment program. Retaining these funds in the program would increase the number and amounts of the awards.

- Various pharmacy groups believe there is a national shortage of pharmacists. Some indicate the shortage is critical. Shortages are reported in urban as well as rural areas. The National Association of Chain Drug Stores estimates that their member stores have a continuing unmet need of 5,000 pharmacists. A 2000 survey by the American Society of Health Systems Pharmacists found that 70% of pharmacy directors report that there is a critical shortage of pharmacists.

- Several reasons are offered to explain the shortage of pharmacists: (i) expanding job opportunities; (ii) increasing number of prescriptions; (iii) increasing number of chain drug stores; (iv) increasing administrative demands on pharmacists; (v) greater number of pharmacy graduates wanting to work only part-time; and (vi) the number of pharmacy graduates not keeping up with demand. The Federal Health and Human Resources Administration is studying the national shortage of pharmacists.

- A preliminary analysis of where pharmacists practice in Virginia indicates that several rural counties have much higher population-pharmacist ratios than the state average. (Analysis was very limited due to available data; further study is needed to assess ratios throughout the Commonwealth.)

- A pharmacist scholarship and loan repayment program could help underserved areas. However, such a program may not fully address pharmacist supply issues. Scholarship/loan repayment programs typically are used to correct a maldistribution of an adequate number of providers. However, there is general agreement that there simply are too few pharmacists to meet demand. A scholarship and loan repayment program may only re-distribute an insufficient number of pharmacists.

- VCU/MCV typically graduates about 90 Pharm.D. students per year. The total number of pharmacy graduates in Virginia will increase by 95 per year beginning in 2004 when Hampton and Shenandoah University graduates enter the marketplace. However, many students are from out of state and may not practice in Virginia. Consideration should be given to increasing the class size at VCU/MCV.

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 33-34. Public comments were requested on a

draft of this report. A summary of the public comments is attached at Appendix B.

On behalf of the Joint Commission on Health Care and its staff, I would like to thank the Virginia Department of Health, the Department of Health Professions, the Virginia Board of Pharmacy, the Virginia Pharmacists Association, the VCU/MCV School of Pharmacy, the Hampton University School of Pharmacy, the Shenandoah University School of Pharmacy, and the other organizations and individuals who provided input and information during this study.

Patrick W. Finnerty
Executive Director

December, 2000

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Authority for Study/Organization of Report

Item 11 of the 2000 Appropriations Act directs the Joint Commission on Health Care (JCHC) to continue its study of the various health workforce programs and initiatives related to improving access to care in underserved areas. Specifically, the Appropriations Act states that the Joint Commission's continuing work shall:

- assess the impact of the programmatic and administrative changes enacted by the 2000 General Assembly on the various workforce programs;
- recommend any further improvements to the existing programs and identify additional cost-effective initiatives; and
- assess the need for and feasibility of establishing a pharmacist scholarship and loan repayment program for pharmacists who agree to practice in underserved areas of the Commonwealth.

The Appropriation Act directs the JCHC to conduct its continuing study in cooperation with the House Appropriations and Senate Finance Committees, and to consult with and involve the Virginia Department of Health and the affected workforce programs and initiatives in its review. A copy of Item 11 of the 2000 Appropriations Act is provided at Appendix A.

This Report Is Presented In Five Major Sections

This first section discusses the authority for the study and the organization of the report. Section II provides background information on previous JCHC studies of the Commonwealth's health workforce programs and the actions taken in recent years to improve the effectiveness of these programs. Section III assesses the impact of the programmatic and administrative changes enacted by the 2000 Session of the General Assembly, and identifies some further improvements in the area of health workforce recruitment and retention. The fourth section of the report discusses the need for and feasibility of establishing a pharmacist scholarship and loan repayment program as a means of encouraging pharmacists to practice in underserved areas of the Commonwealth. The fifth and final section presents a series of policy options the Joint Commission may wish to consider in addressing the Commonwealth's health workforce programs and the issue of a pharmacist scholarship and loan repayment program.

II.
Background: Recent JCHC Health Workforce Studies And Initiatives

The Commonwealth Has Established Several Programs To Improve Access To Care In Underserved Areas

Over the past several years, the Commonwealth has established a number of programs to train, recruit, and retain health care providers in underserved areas of the state. The primary goal of these efforts has been to improve access to quality care in areas of the Commonwealth where there have been too few providers to serve the population. Figure 1 identifies and briefly describes the primary health workforce programs supported by the Commonwealth.

Other Organizations Involved In Health Workforce Issues: In addition to the health workforce programs identified in Figure 1, there are also other private organizations actively involved in promoting access to primary care and recruiting providers to underserved areas. The Virginia Health Care Foundation is a private, non-profit foundation created by the General Assembly devoted to providing financial grants to support innovative programs that improve access to primary and preventive care for Virginia's uninsured citizens. 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 Community and Migrant Health Centers across the Commonwealth including recruitment of providers. The Free Clinics in Virginia provide training opportunities and clinical rotations for residents and other health professionals. The Rural Health Association advocates on behalf of rural areas regarding various issues, including access to primary care providers

Figure 1
Virginia's Health Workforce Programs And Initiatives

- ***Virginia Generalist Initiative:*** A collaborative effort of Virginia's three academic health centers to increase the supply of primary care providers available to serve the needs of Virginia

- ***Virginia Family Practice Residencies:*** Residency programs located across the Commonwealth which educate and provide clinical experience for family practice physicians

- ***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

- ***Office of Health Policy and Center for Primary Care And Rural Health:*** Located within the Virginia Department of Health, this office administers several health workforce programs and initiatives.
  - ***Recruitment/Retention:*** VDH coordinates efforts to recruit and retain providers in underserved areas
  - ***Scholarship/Loan Repayment:*** Several health professions scholarship/loan repayment programs help finance education of providers in return for a commitment to practice in an underserved area of the state.

Source: Joint Commission on Health Care Staff Analysis

This Is The Third In A Series Of Studies That The Joint Commission on Health Care Has Conducted Regarding Various Aspects Of The Commonwealth's Efforts To Recruit And Retain Health Care Providers In Underserved Areas

1998 JCHC Study: Item 12 of the 1998 Appropriations Act directed the Joint Commission on Health Care (JCHC) to study and develop a centralized planning and funding mechanism to ensure 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 JCHC study (published as 1999 House Document 49) examined each workforce program and offered several policy options for establishing a mechanism for coordinating the Commonwealth's efforts in

this regard. None of the policy options garnered widespread support among the interested parties. The JCHC decided to continue its review of these issues in 1999.

1999 JCHC Study: Item 12(B) of the 1999 Appropriations Act directed the JCHC to continue its review of the Commonwealth's health workforce programs and to recommend appropriate modifications to these initiatives along with recommended funding strategies. The JCHC's 1999 study (published as 2000 House Document 89):

- provided more detailed information regarding the activities of the various health workforce programs;
- assessed the Virginia Department of Health's effectiveness in recruiting and retaining providers in underserved areas;
- identified several alternative strategies for providing greater responsibility and accountability for coordinating Virginia's recruitment and retention efforts;
- analyzed in detail the operations, activities, and priorities of the Virginia Statewide AHEC program; and
- identified a number of potential actions to improve the effectiveness of Virginia's health workforce programs.

The 1999 health workforce study identified 18 policy options for consideration by the Joint Commission. Figure 2 identifies: (i) the various policy options included in the study, (ii) the policy options that the JCHC recommended to the General Assembly, and (iii) the actions taken by the 2000 General Assembly.

Figure 2
Actions Taken by the Joint Commission on Health Care and 2000 General Assembly on Policy Options Included in 1999 Health Workforce Study

Policy Option	JCHC Action	General Assembly Action
Legislation directing Virginia Department of Health (VDH) to designate health professional shortage areas	Recommended legislation *(HB 1076/SB 489)*	Passed both bills
Budget amendment directing VDH to review efficacy of provider database	Recommended budget language	Approved language
Legislation directing VDH to coordinate efforts to recruit and retain providers in underserved areas. Accompanying budget amendment for additional staff.	Recommended legislation *(HB 1076/SB 489)* Recommended budget amendment of $317,631 and 5 positions	Passed both bills Budget amendment was not approved
Legislation directing VDH to form public-private partnership to coordinate recruitment & retention efforts	Not Recommended *(recommended HB 1076/SB 489)*	N/A
Legislation reassigning responsibility for coordinating recruitment & retention to Statewide AHEC Board	Not Recommended *(recommended HB 1076/SB 489)*	N/A
Legislation directing VDH to contract with Va. Primary Care Assoc. to coordinate recruitment & retention efforts	Not Recommended *(recommended HB 1076/SB 489)*	N/A
Resolution directing JCHC to form a Subcommittee to recommend appropriate organizational structure for coordinating recruitment & retention programs	Not Recommended *(recommended HB 1076/SB 489)*	N/A
Legislation to include health professional shortage areas among underserved areas in which scholarship/loan repayment recipients can complete service requirement.	Recommended legislation *(HB 1011)*	Passed bill
Budget amendment to increase amount of physician loan repayment program	Recommended budget amendment of $100,000	Funding not approved
Budget amendment to reduce funding for medical scholarships and reallocate the funds to loan repayment	Not Recommended	N/A
Budget amendment (language) to consolidate all appropriations for provider incentives into one amount, and expand types of incentives	Recommended	Approved language

Figure 2
(cont'd)
Actions Taken by the Joint Commission on Health Care and 2000 General Assembly on Policy Options Included in 1999 Health Workforce Study

Legislation requiring Statewide AHEC Board to include information in annual report on how general fund (GF) dollars are spent	Recommended legislation *(HB 1202)*	Passed bill
Budget amendment (language) requiring local AHECs to spend state GF dollars only on provider recruitment & retention efforts	Not Recommended	N/A
Budget amendment to increase state support of AHECs	Recommended budget amendment of $300,000	$100,000 approved in each year for NVAHEC
Budget amendment (language) requiring AHECs to provide a certain percentage of local matching dollars to receive state GFs	Not Recommended	N/A
Budget amendment (language) to consolidate individual AHEC appropriations into one amount to be distributed by Statewide AHEC Board	Not Recommended	N/A
Budget amendment (language) directing JCHC to continue its study of workforce programs	Recommended language	Approved language

Source: Joint Commission on Health Care Staff Analysis

The 2000 JCHC Report Focuses On The Impact Of The Programmatic And Administrative Changes That Were Enacted By The 2000 General Assembly And The Feasibility Of A Pharmacist Scholarship And Loan Repayment Program

As evidenced in the preceding discussion of past JCHC studies of the Commonwealth's health workforce programs, a significant amount of analysis and review has been completed over the past two years. Rather than revisit the many issues that have been addressed in previous reports, this year's report focuses on the impact of the programmatic and administrative changes that resulted from last year's report and the actions taken by the 2000 General Assembly. The proceeding section discusses these issues.

III.
Impact Of Programmatic/Administrative Changes Enacted By 2000 General Assembly

Legislation Directing The Virginia Department of Health To Coordinate The Commonwealth's Health Workforce Recruitment And Retention Efforts Was The Most Significant Action Taken By The General Assembly

One of the key findings of the previous Joint Commission on Health Care (JCHC) health workforce studies was that no entity was responsible and accountable for achieving the primary objective of these programs, which is to increase the number of providers in underserved areas. As illustrated in Figure 2, the 2000 General Assembly approved several health workforce initiatives recommended by the JCHC. The most significant of these legislative actions was the passage of Senate Bill 489 and House Bill 1076. These companion bills addressed the central issue reviewed by the JCHC in its 1998 and 1999 studies: namely, which entity should have overall responsibility for coordinating the Commonwealth's health workforce programs.

SB 489/HB 1076 amended the *Code of Virginia* by adding Article 8, (*Health Workforce Recruitment and Retention*) in Chapter 4 of Title 32.1. Figure 3 identifies the key provisions of SB 489/HB 1076.

VDH Has Made Progress In Designating Health Professional Shortage Areas (HPSAs), Particularly Dental HPSAs

One of the key findings from last year's health workforce study and the JCHC's study on improving access to dental care was that designation of health professional shortage areas (HPSAs) had not been completed on many areas of the state. HPSA designations are crucial to recruiting health professionals to underserved areas because the National Health Service Corps (NHSC) loan repayment program provides significant financial aid to physicians, dentists, mental health workers, and other health professionals in return for agreeing to practice in a HPSA. In addition to the NHSC loan repayment program, communities that are designated as HPSAs also are eligible for other benefits. Underserved areas that are not designated as HPSAs lose these important benefits.

Figure 3

Key Provisions Of 2000 Senate Bill 489/House Bill 1076: Health Workforce Recruitment And Retention

§32.1-122.20: Provides that the Commissioner of Health shall direct the Commonwealth's activities and programs for recruiting and retaining health care providers for underserved populations and underserved areas throughout the Commonwealth. The Commissioner's duties include:

- *designating and updating as necessary those areas of the state which meet the criteria for primary care, dental, and mental health professional shortage areas (HPSAs);*
- *administering the scholarship and loan repayment programs;*
- *recruiting providers, residents and students in Virginia and other states for Virginia's underserved areas;*
- *publicizing the activities of the agency that are available to assist providers in establishing practices in underserved areas;*
- *coordinating the agency's workforce functions with state agencies and other public and private entities; and*
- *identifying and recommending to the Governor and General Assembly new programs, activities and other strategies for increasing the number of providers in underserved areas.*

§32.1-122.21: Requires the Commissioner of Health to establish a Health Workforce Advisory Committee to advise him on all aspects of health workforce activities. The Committee includes representatives of: academic health centers, Statewide AHEC Program, various health care organizations, and health professions students/residents

§32.1-122.22: Requires the Commissioner of Health to submit an annual report to the Governor and General Assembly on the agency's health workforce activities and accomplishments

Source: Joint Commission on Health Care staff analysis of SB 489/HB 1076

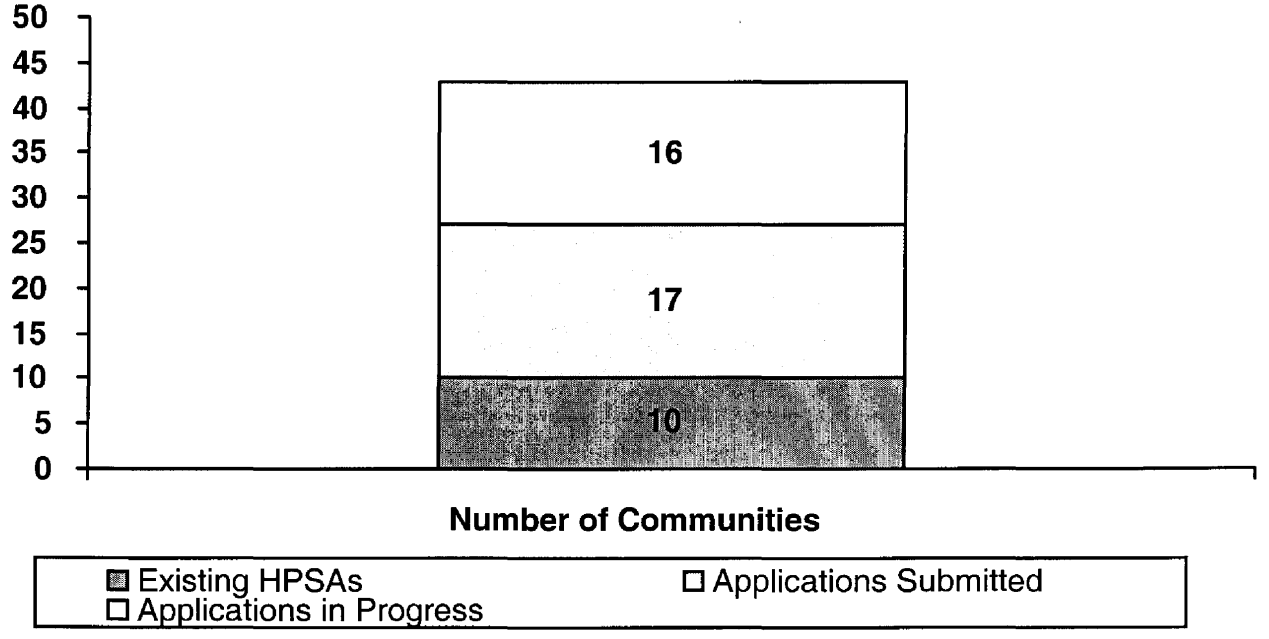
While most primary care HPSA designations have been obtained and updated by VDH staff, a few medical residents advised JCHC staff last year that they had to do complete much of the work involved in obtaining

the HPSA designation in a community in which they wanted to practice. However, the more troubling finding regarding HPSAs was that, despite the fact that 43 Virginia communities had been identified by VDH as dental shortage areas, only 10 of these communities had been designated as a dental HPSA. Accordingly, dentists who wanted to practice in a dental HPSA in order to have their loans repaid could choose from only 10 communities in Virginia. Obtaining dental HPSA designations for the other 33 communities is a critical step in recruiting dentists to these areas.

As seen in Figure 4, VDH has made substantial progress in seeking HPSA designations for many of Virginia's dental underserved areas. While only 10 communities had been designated as of last year's JCHC dental study, VDH reports that an additional 17 designations have been submitted for approval to the Division of Shortage Designations within the Federal Bureau of Primary Health Care. In addition, applications in 16 other Virginia communities are being processed at VDH.

Figure 4

Designation Of Dental HPSAs By VDH



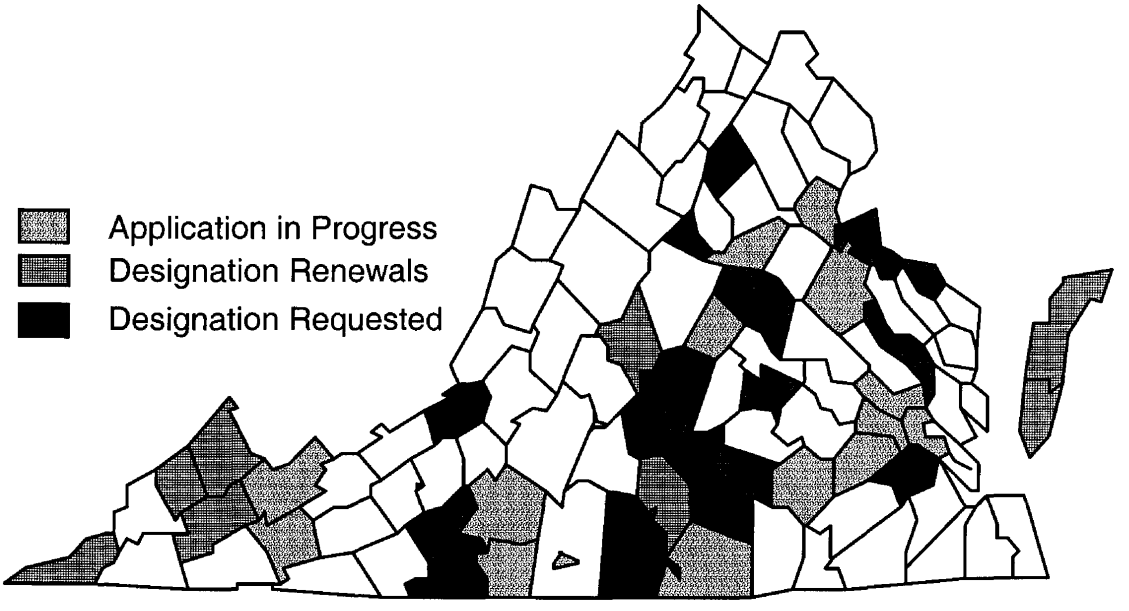
Source: Virginia Department of Health

Figure 5 illustrates the Virginia communities whose current dental HPSA designations are being renewed; those communities for which applications have been submitted for approval; and those communities whose applications currently are being processed by VDH. Assuming all of the communities whose new applications are being processed or already have been submitted eventually are approved, the number of dental HPSAs in Virginia will more than triple.

Primary Care HPSAs: VDH also reports that eight new primary care HPSAs were designated in fiscal year 2000: Page County, Richmond City (Homeless Population), Free Clinic of Central Virginia in Lynchburg, Newport News (census tracts 301-309 and 313), Mendota in Washington County, Konnarock in Washington County, Patrick County, and Northwest Roanoke. In addition, 12 renewal applications for primary care HPSAs were approved by the Bureau of Primary Health Care's Division of Shortage Designation.

Figure 5

Virginia Communities: Dental HPSA Designations



Source: Virginia Department of Health

Mental Health HPSAs: Mental health HPSAs are designated by areas of the state, rather than individual counties. VDH reports that data on eight areas of the state were collected and analyzed for mental health HPSA designation; six of the eight areas were determined to meet the designation criteria and were submitted to the Bureau of Primary Health Care's Division of Shortage Designation. Two of the six areas were approved and are now mental health HPSAs. These areas are: Planning District XII (the Counties of Pittsylvania, Henry, Patrick and Franklin, and the cities of Danville and Martinsville); and Northern Neck/Middle Peninsula (the Counties of Westmoreland, Northumberland, Lancaster, Richmond, Essex, Middlesex, Mathews, Gloucester, King and Queen, and King William).

Mental health HPSA designations in four areas are pending approval. These are areas are: LENOWISCO (Lee, Wise, and Scott Counties and the City of Norton); Crossroads (the counties of Charlotte, Prince Edward, Buckingham, Cumberland, Amelia, and Nottoway); Eastern Shore (the counties of Accomack and Northampton); and Mount Rogers (the Counties of Smyth, Wythe, Grayson, Carroll, and Bland, and the city of Galax).

The VDH Health Workforce Advisory Committee Is Being Formed; Annual Report Is Being Prepared

As previously noted, §32.1-122.21 of the *Code of Virginia* requires the State Health Commissioner to establish a Health Workforce Advisory Committee to advise the Commissioner on all aspects of the Department's health workforce activities. VDH staff report that while the committee has not yet been established, efforts are underway to form the committee. The committee is expected to be operational within the next few months.

As required in §32.1-122.22, VDH is preparing the first of its annual reports to the Governor and the General Assembly on the agency's health workforce activities and accomplishments.

Provider Recruitment And Retention Efforts Are Continuing, But Are Hampered By Limited Staffing

A key finding of last year's health workforce report was that there was little active recruiting of health care providers to the Commonwealth's underserved areas. JCHC staff interviews and focus group meetings with

medical residents revealed that very few were aware of VDH's recruitment efforts or the scholarship/loan repayment programs offered by the Commonwealth. It also was learned that VDH did not routinely recruit out-of-state residents or other health care providers.

One of the reasons identified in last year's report for the minimal level of active provider recruiting was the limited recruitment staff at VDH. For the past several years, only .5 of one FTE has been allocated to provider recruitment efforts. The person assigned to these duties has been a part-time employee. As of this report, there still is only .5 of one FTE recruiting providers to Virginia's underserved areas. By comparison, North Carolina assigns 5 FTEs to provider recruitment.

The limited amount of staff devoted to provider recruitment continues to hamper the effectiveness of VDH as evidenced by the fact that only eight providers were placed in an underserved area during the past fiscal year. In view of the fact that VDH estimates a total of approximately 100 physicians are needed to eliminate primary care HPSAs in the Commonwealth, placing only eight per year will not make any significant improvements, particularly if one assumes there will be some normal level of attrition, retirements, and other reasons for existing providers to discontinue practicing in these areas.

A budget amendment was introduced last year to provide $317,631 and 5 FTEs at VDH for provider recruitment and other workforce activities; however, neither the funding nor the positions were approved. Consideration should be given to submitting a budget amendment again during the 2001 Session to increase the number of staff specifically assigned to provider recruitment and retention efforts.

Budget Language Consolidating Scholarship And Loan Repayment Funding Into One Amount Will Allow A Larger Number Of Loan Repayment Awards To Be Made

Budget language recommended by the JCHC and approved by the 2000 Session of the General Assembly combined the GF amounts previously appropriated for scholarships and loan repayment into one amount so that VDH is not restricted to separate amounts for each type of financial assistance. The language provides more flexibility to VDH in the use of the funding and allows the agency to provide the student/resident the type of assistance that is desired. VDH staff report a large number of

loan repayment applications have been received, and that the new funding methodology will allow them to offer more in the way of loan repayment than would otherwise have been possible.

Consideration Should Be Given To Allowing Forfeited Scholarship And Loan Repayment Amounts To Be Retained In The Program Rather Than Reverting To The General Fund

Each of the scholarship and loan repayment programs include penalty provisions if the recipient does not complete the required service commitment in an underserved area. For several programs, recipients who do not complete the service requirement must pay back triple the amount of the award plus interest. VDH staff indicate that approximately $100,000 per year is paid back by medical students who do not fulfill their service obligation. Currently, this amount reverts to the general fund, and is not "recycled" through the program. One way of increasing the amount of funding available for scholarships and loan repayment would be to redirect forfeited amounts back into the respective program in which the forfeiture occurred.

IV.
Need For And Feasibility Of Establishing A Pharmacist Scholarship And Loan Repayment Program

The Commonwealth Has Established Scholarship And Loan Repayment Programs For Physicians, Dentists, And Nurses; Scholarship Programs Also Have Been Established For Nurse Practitioners, Physician Assistants, And Dental Hygienists

As discussed in the previous section, the Commonwealth has established scholarship and loan repayment programs for different types of health care providers, namely physicians, dentists and nurses. In addition, scholarship programs have been established for nurse practitioners, physician assistants and dental hygienists. These programs are codified in Title 32.1 of the *Code of Virginia.*

The financial assistance programs established for physicians, dentists, nurse practitioners, physician assistants, and dental hygienists are designed to attract health professionals into underserved areas where there are shortages of providers. The ultimate goal of these programs is to improve the availability and quality of health care in these areas.

Two financial assistance programs are available for nurses; one program offers scholarships to persons in education programs preparing them for licensure as a licensed practical nurse or a registered nurse. This program requires the recipient to perform a period of nursing service in the Commonwealth, but does not specify that the service must be in an underserved area. The other program is a scholarship and loan repayment program for registered nurses, licensed practical nurses and certified nurse aides. This second program requires the recipient to perform a period of nursing service in a long-term care facility in the Commonwealth.

Underserved Areas: For each of the scholarship and loan repayment programs that require the recipient to perform a period of service in an underserved area, the term "underserved area" includes those areas designated by the Board of Health as a Virginia Medically Underserved Area (VMUA), as well as health professional shortage areas (HPSAs) that are designated in accordance with the criteria established in 42 C.F.R. Part

5 (federal regulations). The criteria for designating HPSAs and VMUAs are illustrated in Figure 6.

Figure 6

Criteria For Designating Health Professional Shortage Areas (HPSAs) 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.

VMUA - Virginia Medically Underserved Area (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

Recent Media And Journal Articles Across The Country Indicate There Is A Shortage Of Pharmacists; Several Pharmacy-Related Organizations Believe The Shortage Is Critical

Over the past year, there have been numerous media and journal articles regarding difficulties that many communities are experiencing in hiring pharmacists. Across the country, all sectors of the health care marketplace which employ pharmacists to provide various types of services report that the shortage is problematic, and likely will worsen as the number of prescriptions continues to increase. These groups indicate that if a Medicare prescription drug benefit is approved, the shortage of pharmacists will have severe repercussions that will affect the ability of the marketplace to respond to the demand for pharmacy services.

National Association of Chain Drug Stores: The National Association of Chain Drug Stores (NACDS) represents approximately 53,000 pharmacies that provide practice settings for nearly 128,000 pharmacists. The NACDS indicates that there currently are more than

5,000 unfilled chain community pharmacist positions across the country, as well as a shortage in hospitals, and in Federal health care agencies, such as the Public Health Service. NACDS expects the shortage to increase in the next few years as the number of prescriptions continues to rise.

American Society of Health Systems Pharmacists: The American Society of Health Systems Pharmacists (ASHSP) represents those pharmacists who work in hospitals, health system pharmacies, HMOs, long-term care facilities, and home care. ASHSP reports that pharmacy directors in hospitals and health systems continue to have serious difficulty recruiting qualified pharmacists. In a 2000 ASHSP survey of 432 hospital and health system pharmacy directors, 87% of respondents reported that they believe the supply of entry-level frontline pharmacists has diminished. Seventy percent of the pharmacy directors who were surveyed rated the current pharmacist shortage as "severe," compared to 48% in ASHSP's 1999 survey.

Another indication of a national shortage of pharmacists is data from a major health care recruiting company which reports that its searches for pharmacists skyrocketed between 1997 and 1999. Dallas-based Allied Consulting indicates that its searches for pharmacists increased by over 1,000% during 1997-1999, from just 20 searches to over 219.

The Shortage Of Pharmacists Appears To Exist In Urban As Well As Rural Areas

Most other health professional shortages (e.g., physicians and dentists) typically are limited to rural areas. These shortages generally reflect more of a maldistribution of providers rather than an actual shortage of trained professionals. However, JCHC staff's review of periodical, newspaper, and journal articles from all over the country indicates that pharmacies in both urban and rural areas are having difficulty hiring pharmacists. While rural communities may find it more difficult than urban areas to recruit a pharmacist, urban pharmacies nonetheless are reporting difficulties as well.

Several Reasons Are Offered As Explanations For The Shortage Of Pharmacists, Including Expanded Job Opportunities And The Rapid Increase In The Number of Prescriptions Being Filled

The organizations which believe there is a shortage of pharmacists have cited a number of reasons for the shortage. Among the most commonly identified reasons are: (i) expanding job opportunities beyond the traditional community and hospital pharmacists, (ii) tremendous growth in the number of prescriptions that are being filled; (iii) consumer demand for increased pharmacy hours (e.g., 24-hour pharmacies); (iv) increasing number of chain drug stores being opened; (v) a greater number of pharmacy school graduates wanting to work part-time; (vi) administrative demands on pharmacists' time that detract from time spent filling prescriptions; and (vii) an increasing role in consumer counseling regarding drug therapies, etc.

Increased Job Opportunities: With respect to increased employment opportunities, the traditional view of a pharmacist working in a community or hospital pharmacy has changed dramatically. Now, pharmacists are employed in a wide range of pharmacy-related positions, including positions with HMOs/insurance companies, consulting firms, pharmacy benefit managers (PBMs), mail order pharmacies, computer technology firms, and others. The expanded career paths for pharmacists increase the competition among community and hospital pharmacies for a limited number of pharmacists.

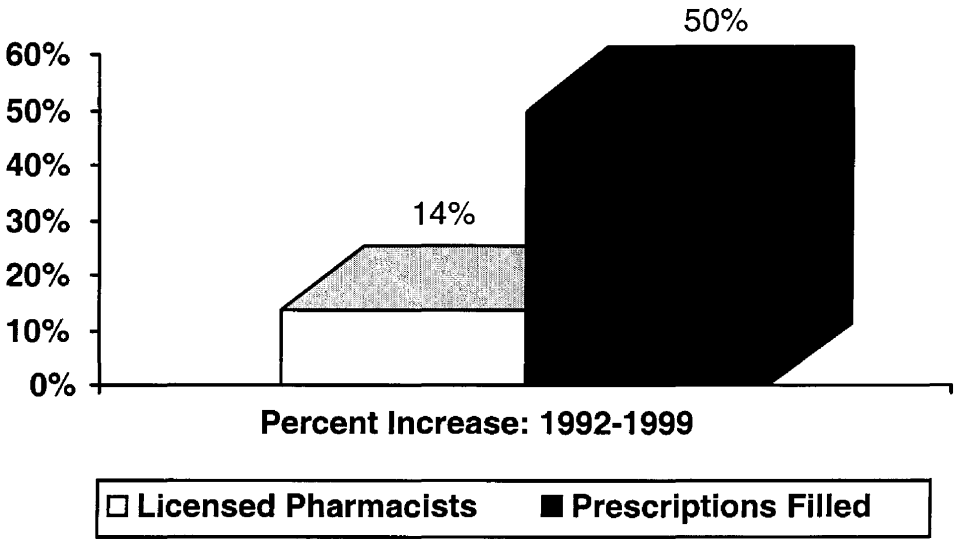
Increasing Number of Prescriptions: Unquestionably, the number of filled prescriptions has increased rapidly in recent years. According to the Health Care Financing Administration (HCFA), the number of filled prescriptions increased by almost 600 million growing from 1.9 billion in 1993 to 2.5 billion in 1998. Health experts also note that as the "baby boom" generation enters middle age and continues to grow older, the number of prescriptions will rise at an even faster rate. The National Association of Chain Drug Stores estimates that the volume of prescription drugs will increase from 3 billion in 1999 to 4 billion in 2004, a 33% increase in just 5 years. Should a prescription drug benefit be approved for Medicare enrollees, the growth rate in the number of prescriptions will increase exponentially. The expected increase in the number of filled prescriptions becomes even more of a critical factor in light of NACDS' projection that the number of pharmacists will increase by only 6 % during the same time period.

While the number of filled prescriptions has increased by 50% in the past several years, the percentage increase in the number of licensed pharmacists has not kept pace. Figure 7 illustrates the marked contrast in

the percentage increase in the number of prescription drugs filled and the number of licensed pharmacists between 1992 and 1999.

Figure 7

Percentage Increase In Number Of Prescriptions Filled And Number Of Licensed Pharmacists: 1992-1999



Source: National Association of Chain Drug Stores, National Association of Boards of Pharmacy

Increasing Number of Pharmacies: Another factor that is contributing to a shortage of pharmacists is the increasing number of chain drug stores, many of which are open 24 hours per day. For example, CVS, which currently operates about 4,100 stores, plans to open about 135 new stores (not counting relocations) each year for the foreseeable future, many of which will be larger stores that are open 24 hours per day, 7 days per week. Similarly, Walgreens, which has doubled its number of stores since 1990 expects to double again by 2010. This unprecedented growth has caused some experts to question whether there is a shortage of pharmacists or a glut of drug stores.

The Number Of Pharmacy School Graduates Also Has Affected The Pharmacist Shortage

In addition to the large differences in the percentage increase of licensed pharmacists to prescriptions filled, the number of pharmacy school graduates has increased at a much lower rate. According to the American Association of Colleges of Pharmacy (AACP), the number of students earning their "first professional" degree (i.e., B.S. Pharmacy, Pharm.D. or B. Pharmacy) has increased only 4% from 1992 to 1998. One of the reasons for the very modest increase is that all pharmacy schools changed their curriculum from a four or five year degree program to a 6-year Pharm.D program. (Pharmacy school curricula must provide for the Pharm.D degree by 2003 in order to maintain their accreditation through the American Council on Pharmaceutical Education.) As schools began transitioning to a 6-year Pharm.D program, the number of pharmacy school graduates actually declined from 8,003 in 1996 to 7,400 in 1998 (AACP).

The Federal Health Resources And Services Administration (HRSA) Is Conducting A Study To Determine If There Is A Pharmacist Shortage

The Healthcare Research and Quality Act passed by Congress in 1999 directs the Health Resources and Services Administration (HRSA) to conduct a study to determine if there is, in fact, a shortage of pharmacists. The National Center for Healthcare Workforce Information and Analysis in HRSA's Bureau of Health Professions will conduct the review.

As part of its review, HRSA invited all interested parties to submit resource information, data and documented studies that verify pharmacist shortages during a 45-day Federal Register comment period which began in March, 2000. HRSA's report is not scheduled to be presented to Congress until December, 2000.

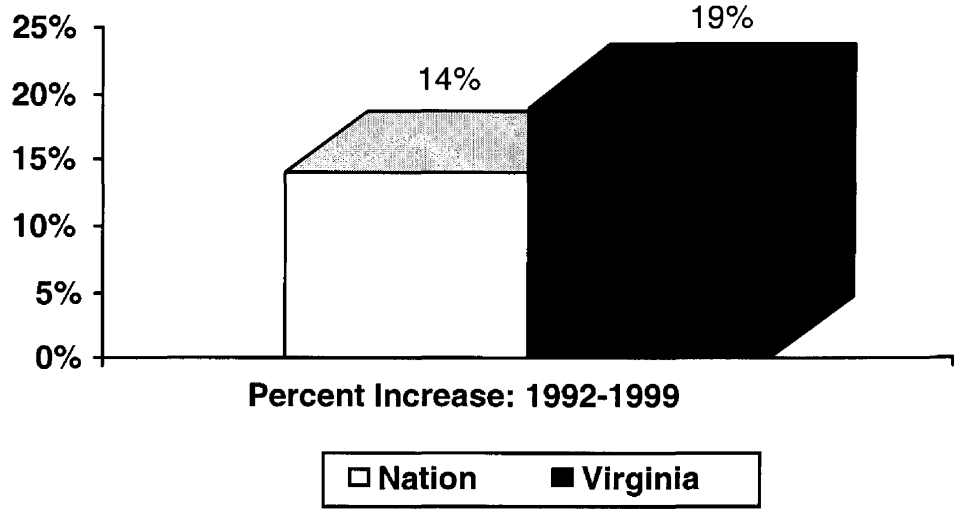
In Virginia, The Number Of Licensed Pharmacists Has Increased Approximately 19% From 1992 To 1999; A Significant Number Of Pharmacists Licensed In Virginia Live Out-of-State

The total number of pharmacists licensed by the Virginia Board of Pharmacy has increased approximately 19% during the period 1992 to 1999. As seen in Figure 8, the percentage increase in Virginia is somewhat greater than the national average.

Licensed Pharmacists With In-State Addresses: Currently, there are 7,649 pharmacists licensed by the Virginia Board of Pharmacy. However, based on information available from the National Association of Boards of Pharmacy, about 31% of the pharmacists licensed in Virginia have out-of-state addresses. Presumably, a large number of those pharmacists who live out-of-state, work outside of Virginia. Therefore, the number of pharmacists who work in Virginia is smaller than the total number who are licensed in Virginia. Figure 9 illustrates the total number of pharmacists and those with in-state addresses over the past several years. The impact of the change to a Pharm.D degree can be seen in Figure 9 as evidenced by the smaller than normal increase in the number of licensed pharmacists between1998 and 1999.

Figure 8

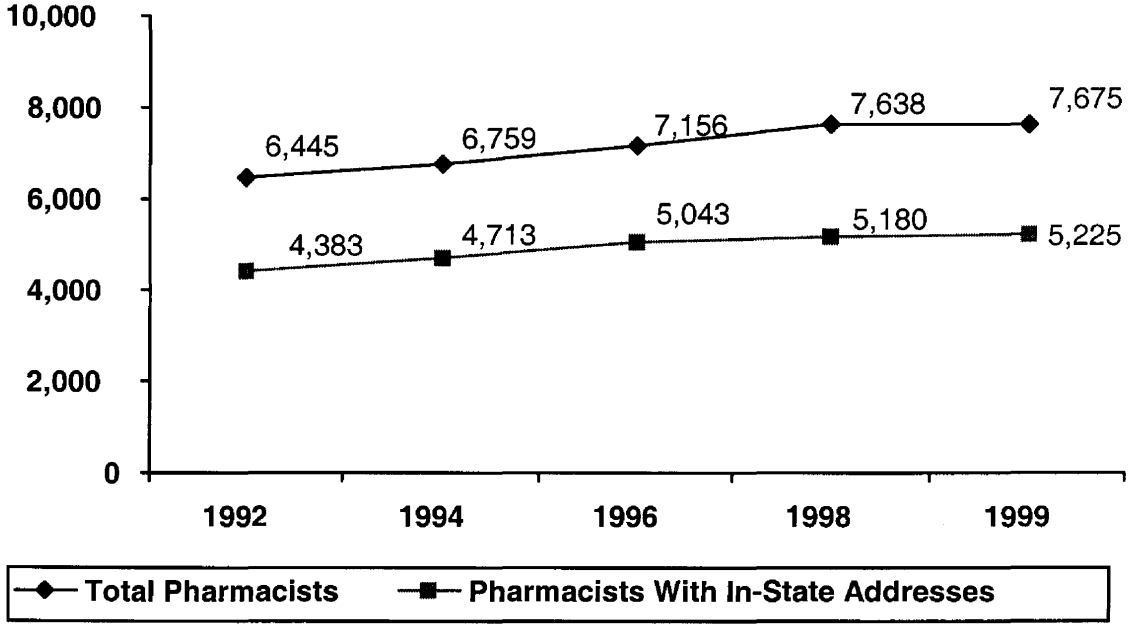
Percentage Increase In The Total Number Of Pharmacists Licensed In Virginia And The Nation: 1992-1999



Source: Virginia Board of Pharmacy, National Association of Boards of Pharmacy

Figure 9

Pharmacists Licensed In Virginia:
1992-1999



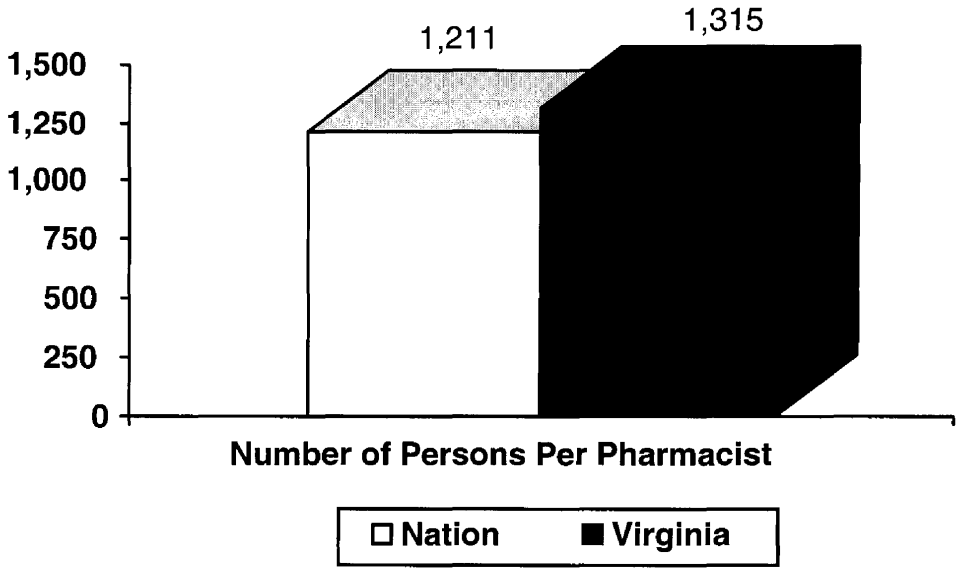
Source: Virginia Board of Pharmacy, National Association of Boards of Pharmacy

In Virginia, The Population To Licensed Pharmacists Ratio Is Slightly Higher Than The National Average

Based on information provided by the National Association of Boards of Pharmacy (NABP), the population to licensed pharmacist ratio in Virginia is slightly higher than the national average. As seen in Figure 10, Virginia's ratio is one pharmacist per 1,315 persons, whereas the national average is one per 1,211 persons. (Ratios were calculated using only those pharmacists with in-state addresses.)

Figure 10

Population To Licensed Pharmacist Ratio: Virginia And The Nation



Note: The number of pharmacists used in analysis includes only those with in-state addresses
Source: National Association of Boards of Pharmacy

Several Pharmacy-Related Health Care Organizations In Virginia Believe There Is A Shortage Of Pharmacists In The Commonwealth

Similar to the concerns of national pharmacy-related groups that there is a shortage of pharmacists across the U.S., in Virginia, several health care organizations also have expressed concern about a shortage of available pharmacists to fill various positions. Representatives of the Virginia Pharmacists Association, the Virginia Association of Health-Systems Pharmacists, the Academy of Managed Care Pharmacists, and the Virginia Association of Free Clinics all indicated that there is a shortage of pharmacists in Virginia. In addition, a representative of the National Association of Chain Drug Stores located in Virginia agreed that a shortage of pharmacists exists in Virginia.

Preliminary Analysis Of The Number Of Pharmacists In Rural Virginia Counties Indicates There Are Some Areas With Significant Shortages

In order to determine precisely where pharmacist shortages may exist, licensure data from the Board of Pharmacy must be analyzed by zip code. To determine which counties and cities may be experiencing shortages, the number of licensees by zip code must be assigned to the appropriate locality. While this type of analysis is feasible, only a portion of the analysis could be completed in time for this report.

JCHC staff conducted follow-up analysis of data developed for the Virginia Association of Pharmacists in 1998 by the University of the Pacific, which identified the number of pharmacists in every rural zip code in Virginia. The analysis included only those zip codes which were completely outside of a metropolitan statistical area (MSA). This methodology significantly limited the number of counties in which all zip codes were included, resulting in a small number of meaningful pharmacist to population ratios that could be developed. Nonetheless, JCHC staff took the useable data and matched the rural zip codes with the appropriate county to determine the number of pharmacists in each county. Due to the limitations of the data, few counties could be appropriately analyzed.

The analysis identified several counties which appear to have pharmacist to population ratios that significantly exceed the state average of one pharmacist per 1,315 persons (as reported earlier). The data indicated there were no pharmacists in Highland County which has a population of 2,607. For the following counties, the data produced pharmacist to population ratios significantly higher than the state average: Accomack (1:3131); Bath (1: 5164); Bland (1:6562); and Dickenson (1:2219). In addition, the following counties had ratios that exceeded the statewide average, but were not as severe as those counties listed above: Buchanan (1: 1388); Essex (1:1365); and Giles (1:1665).

Again, it must be recognized that the analysis presented here represents only those localities in which complete data were available. Further study is needed to identify all of the localities that have pharmacist to population ratios significantly higher than the statewide average. The data are available from the Board of Pharmacy to conduct the analysis; however, a significant amount of time is needed to complete the analysis

for all Virginia localities. Moreover, determining an appropriate definition of an underserved area will require more than a simple pharmacist to population ratio. Additional criteria would need to be incorporated into the designation process that reflect other geographic and demographic aspects of the community.

There Are Three Schools Of Pharmacy In Virginia; Two Of The Schools Have Been Established In The Past Few Years And Are Just Beginning To Graduate Students

In Virginia, there are three schools of pharmacy: Virginia Commonwealth University/Medical College of Virginia (VCU/MCV), Shenandoah University, and Hampton University. VCU/MCV is the only state-supported school; Shenandoah University and Hampton University are private institutions.

For many years, VCU/MCV has accepted approximately 100 students each year, and graduates typically 90 each year. (The change to a Pharm.D. degree resulted in only about 45 graduates in 1998, however, the number of graduates now has returned to about 90.)

Shenandoah University enrolled its first pharmacy students in 1996 and graduated its first class in May, 2000. Shenandoah typically enrolls about 75 students each year. There were 65 students in the University's first graduating class. While there has only been one graduating class thus far, the school expects the number of graduates to be approximately 65 each year. Hampton University began its pharmacy school in 1998, with the first class set to graduate in 2002. Currently, there are 30 students in the Hampton University class scheduled to graduate in 2002.

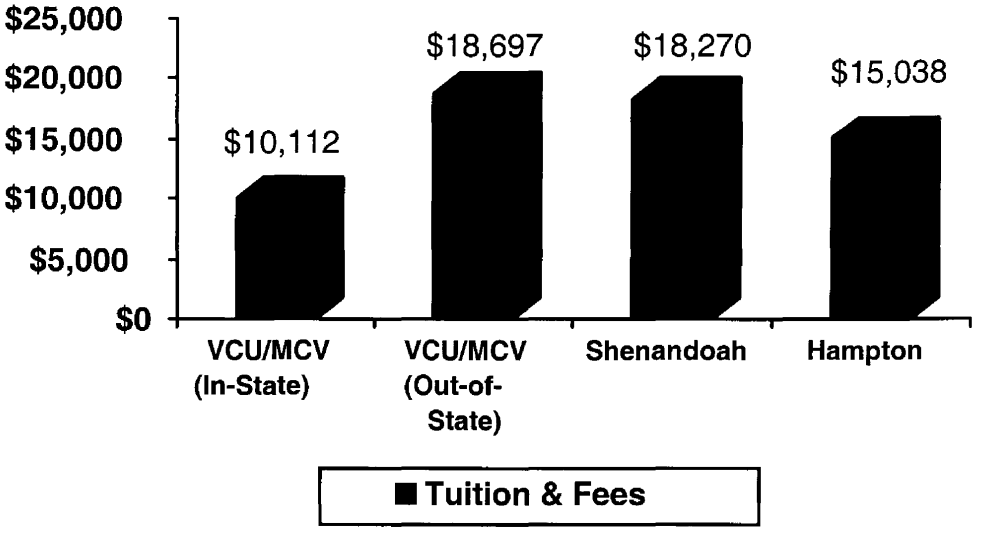
Prior to the establishment of the pharmacy schools at Shenandoah and Hampton Universities, a total of approximately 90 pharmacy students would be graduating each year and seeking licensure as a pharmacist. The additional graduates from Shenandoah raises the number of graduates to approximately 155 per year. Assuming Hampton University graduates 30 students per year, the total number of graduates will increase to 185 per year beginning in 2002.

Tuition And Fees: Inasmuch as VCU/MCV is the only state-supported pharmacy school in the Commonwealth, the cost of tuition and fees for in-state students is substantially less for Virginia students

attending VCU/MCV than the out-of-state costs at VCU/MCV and the tuition and fees at both Shenandoah and Hampton. Figure 11 compares the costs of the three universities.

Number of Graduating Students Who Remain In Virginia: The degree to which graduating pharmacy students will increase the number of pharmacists in Virginia will depend on the number who decide to work in Virginia. There were no data immediately available on where Virginia's pharmacy graduates are working. However, VCU/MCV data indicate that approximately 87% of its students are from Virginia. (A major determining factor is the state support provided to in-state students at VCU/MCV.) Shenandoah's initial data indicate that approximately 60% of its students are from Virginia, Maryland or West Virginia, and the remaining 40% are from 13 other states. Similar data were not available from Hampton University. However, given the fact that, like Shenandoah, there is no state-support to lower tuition fees, the mix of Virginia and out-of-state students at Hampton is likely to be more similar to Shenandoah than VCU/MCV.

Figure 11
Tuition And Fees: VCU/MCV, Shenandoah University, And Hampton University



Note: Tuition and fees do not include room and board charges; tuition and fees for Hampton students in first 2 years of professional training are lower than final 2 years; the $15,038 amount shown here is an average for the four years.
Source: VCU/MCV, Shenandoah University, Hampton University

Given the high percentage of students from Virginia attending VCU/MCV, it is more likely that a greater percentage of these students will remain in Virginia to practice than the percentage of Shenandoah or Hampton graduates. Thus, while the two newer schools will be graduating a total of approximately 95 students each year beginning in 2002, a number of these students likely will be returning to their home states to work. It is too early to tell how many of the 95 additional graduates will remain in Virginia. However, the percentage staying in Virginia likely will be at least somewhat lower than the percentage of VCU/MCV graduates who remain in Virginia.

A Pharmacist Scholarship And Loan Repayment Program Could Help Address The Shortage Of Pharmacists Working In Underserved Areas; However, Criteria Would Have To Be Established To Determine Which Areas Would Be Considered As Underserved

Just as the other health professional scholarship and loan repayment programs attract providers to underserved areas, a similar program could be established for pharmacists. However, further work is needed to determine what criteria would be used to identify an underserved area. Unlike the physician and dentist scholarship and loan repayment programs where there are federal criteria that can be used, no similar criteria have been established specifically for pharmacists. Should such a program be established in Virginia, it may be appropriate to use the primary care HPSA designation (see Figure 6) to identify underserved areas until such time as more specific criteria can be developed. Given the fact that national and state pharmacy organizations indicate the shortage of pharmacists is in urban as well as rural communities, it may be appropriate to award the scholarship/loan repayment to a pharmacy student who works anywhere in Virginia as is the case with the nurse scholarship program.

It Appears That Only One Other State Has Implemented A Program Designed To Attract Pharmacy Students To Underserved Areas; However, It Is Not A Scholarship/Loan Repayment Program

JCHC staff were able to find only one other state which has implemented some form of a program to recruit pharmacists to work in an underserved area. The University of Texas at El Paso (UTEP) and University of Texas at Austin (UT Austin) have established a program

called the UTEP/UT Austin Cooperative Pharmacy Program. The objective of the program is for El Paso to "grow its own" pharmacists to help alleviate a severe shortage of pharmacists in the community. The program allows high school seniors living in El Paso to enroll at UTEP as undergraduates and also be accepted directly into the UT Austin College of Pharmacy. The students accepted into the program spend their first two years as undergraduates at UTEP, then spend two years at UT Austin before returning to EL Paso to complete their pharmacy education.

While this program is designed to increase the number of pharmacists in an underserved area, the program does not provide scholarship or loan repayment money to students. Rather, it gives admission preference to El Paso students who wish to go to pharmacy school, and modifies the curriculum to increase the likelihood that the students in the program will work in El Paso.

A Pharmacist Scholarship/Loan Repayment Program May Only Address A Portion Of The Problem; Increasing The Number Of Pharmacy Students At VCU/MCV Also Would Help To Address The Shortage Of Pharmacists

Scholarship and loan repayment programs typically are used to re-distribute providers such as physicians and dentists to underserved areas. With respect to these two provider groups, there is general agreement that there is no statewide shortage in the overall number of physicians or dentists. Instead, there is a maldistribution of providers wherein more providers locate in the urban areas, and fewer locate in rural areas. The scholarship and loan repayment programs are designed to re-distribute the number of providers such that more providers choose to practice in an underserved area than would have been the case without the program. However, in the case of pharmacists, there appears to be general agreement that there simply are too few to meet the demand for pharmacist services. As such, a scholarship/loan repayment program alone may simply redistribute an insufficient number of pharmacists rather than reduce the shortage of workers that has been cited by nearly all areas of the health care system in which pharmacists work. The end result may be that some areas would benefit from the program, but others may still have too few pharmacists to meet the demand for services.

To address the problem of having too few pharmacists available in all areas of the Commonwealth, the General Assembly may wish to

consider increasing the number of students graduating each year at VCU/MCV. By 2002, Shenandoah and Hampton Universities will be graduating a combined 95 students each year which essentially will double the number of students that have been graduating from VCU/MCV. However, not all of these additional students will be staying in Virginia. Moreover, given the projected increases in the number of prescriptions that will be filled in the coming years (i.e. 33% in 5 years), the additional number of graduates may not be sufficient. If a prescription drug benefit is added to Medicare, the increase in the number of prescriptions filled in future years will increase dramatically, far more quickly than 33% in five years. Increases in the number of pharmacy graduates, combined with a scholarship and loan repayment program may be necessary to meet the demand for pharmacists in all areas of the Commonwealth.

V.
Policy Options

The following Policy Options are offered for consideration by the Joint Commission on Health Care. They do not represent the entire range of actions that the Joint Commission may wish to pursue.

Option I. **Take no action**

Option II. **Introduce a budget amendment to provide funding for two full-time positions at the Virginia Department of Health to enhance the health care provider recruitment and retention activities of the agency and increase the number of providers practicing in underserved areas of the Commonwealth**

Option III. **Introduce legislation and accompanying budget amendments to return scholarship and loan repayment amounts that are forfeited and repaid by recipients to the respective program rather than reverting to the General Fund.**

Option IV. **Include in the Joint Commission on Health Care's workplan for 2001 further study of the pharmacist shortage issue, including: (i) a review of the Federal Health Resources And Services Administration's (HRSA) study, (ii) further analysis of the number of pharmacists in each Virginia locality, (iii) the development of criteria that could be used in administering a pharmacist scholarship and loan repayment program, and (iv) further analysis of the need to increase enrollment at VCU/MCV School of Pharmacy.**

Option V. **Introduce legislation and an accompanying budget amendment to establish a pharmacist scholarship and loan repayment program. Three different approaches could be taken:**

A. The legislation could include a delayed effective date to allow for criteria to be established for identifying underserved areas in which recipients would have to work for a given period of time as a condition of receiving the award.

B. The legislation could specify that award recipients would be required to work in a primary care HPSA until such time as other criteria are established for identifying underserved areas.

C. The legislation could offer scholarship or loan repayment to students who agree to work in any area of Virginia for a given period time and not condition the award on working in an underserved area.

Option VI. Introduce a budget amendment to increase funding at VCU/MCV School of Pharmacy so as to increase the number of students graduating each year.

APPENDIX A

ITEM 11, 2000 APPROPRIATIONS ACT

"The Joint Commission on Health Care shall continue its study of the various health workforce programs and initiatives related to improving access to care in underserved areas. The Joint Commission's continuing work shall: (i) assess the impact of the programmatic and administrative changes enacted by the 2000 General Assembly on the various workforce programs; (ii) recommend any further improvements to the existing programs and identify additional cost-effective initiatives; and (iii) assess the need for and feasibility of establishing a pharmacist scholarship and loan repayment program for pharmacists who agree to practice in underserved areas of the Commonwealth. The Joint Commission shall conduct its review in cooperation with the House Appropriations Committee and Senate Finance Committee. The Joint Commission shall also consult with and involve the Department of Health and the affected workforce programs and initiatives in its review activities."

APPENDIX B

JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS:
Health Workforce Study
(Item 11)

Individuals/Organizations Submitting Comments

Three organizations submitted comments in response to the Health Workforce Report.

- Virginia Academy of Family Physicians
- Virginia Pharmacists Association
- Virginia Statewide AHEC Program

Policy Options Included in the Health Workforce Issue Brief

Option I. **Take no action**

Option II. **Introduce a budget amendment to provide funding for two full-time positions at the Virginia Department of Health to enhance the health care provider recruitment and retention activities of the agency and increase the number of providers practicing in underserved areas of the Commonwealth.**

Option III. **Introduce legislation and accompanying budget amendments to return scholarship and loan repayment amounts that are forfeited and repaid by recipients to the respective program rather than reverting to the General Fund.**

Option IV. **Include in the Joint Commission on Health Care's workplan for 2001 further study of the pharmacist shortage issue, including: (i) a review of the Federal Health Resources and Services Administration's (HRSA) study, (ii) further analysis of the number of pharmacists in each Virginia locality, (iii)**

the development of criteria that could be used in administering a pharmacist scholarship and loan repayment program, and (iv) further analysis of the need to increase enrollment at VCU/MCV School of Pharmacy.

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B. The legislation could specify that award recipients would be required to work in a primary care HPSA until such time as other criteria are established for identifying underserved areas.

C. The legislation could offer scholarship or loan repayment to students who agree to work in any area of Virginia for a given period of time and not condition the award on working in an underserved area.

Option VI. **Introduce a budget amendment to increase funding at VCU/MCV School of Pharmacy so as to increase the number of students graduating each year.**

Overall Summary of Comments

Options II and III were supported by the three organizations that submitted comments. Further, Option IV was supported by the Virginia Academy of Family Physicians and the Virginia Statewide AHEC Program but opposed by the Virginia Pharmacists Association (VPhA). VPhA also commented in support of Option V (B) and in opposition to Option V (A).

Summary of Individual Comments

Virginia Academy of Family Physicians

James Ghaphery, M.D., physician representative, commented in support of Options II, III, and IV. Dr. Ghaphery stated: "The Virginia Academy of Family

Physicians believes the legislation enacted by the 2000 General Assembly was a good first step in addressing some of the issues concerning recruitment and retention of physicians for underserved areas of the state, but more must be done. We believe that designating one agency such as the Virginia Department of Health to oversee these activities is a positive move, however it seems only logical that the department must be given the resources to accomplish the task assigned. Therefore we support Options 2 and 3. Concerning the issue involving the shortage of pharmacists in Virginia, it appears that Option 4 may be the most comprehensive approach to address the issue at this time."

Virginia Pharmacists Association

Rebecca P. Snead, Executive Director, commented in support of Options II, III, and V (B). Ms. Snead indicated in support of Option II that recruitment and retention efforts "must include pharmacists" and that Option III would be "a great way to maintain funding for a pharmacist scholarship and loan repayment program." In support of legislation and a budget amendment to establish a pharmacist scholarship and loan repayment program, Ms. Snead commented in favor of the approach proposed in Option V (B).

Ms. Snead indicated opposition to Options IV and V (A). In opposing Option IV, Ms. Snead indicated: "The state should address the pharmacist shortage in underserved areas now. The shortage does not require further study. Adequate information to design a system is available from state and national studies....Information from these sources and the Virginia Department of Health is sufficient to create a pharmacist scholarship and loan repayment program tailored to Virginia's needs."

Virginia Statewide AHEC Program

Woody B. Hanes, Program Director, commented in support of Options II, III, and IV. In support of Option II, Ms. Hanes stated: "The Virginia AHEC program and its centers currently work collaboratively with the Virginia Department of Health in its recruitment and retention activities. It would be hoped that VDH would ensure that these positions would be available to the AHEC regional centers on a need basis in areas experiencing greater health profession shortages."

JOINT COMMISSION ON HEALTH CARE

Executive Director

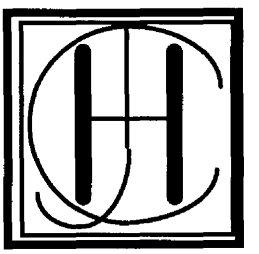
Patrick W. Finnerty

Senior Health Policy Analysts

Joseph J. Hilbert
E. Kim Snead

Office Manager

Mamie V. White



Joint Commission on Health Care
Old City Hall
1001 East Broad Street
Suite 115
Richmond, Virginia 23219
(804) 786-5445
(804) 786-5538 (FAX)

E-Mail: jchc@leg.state.va.us

Internet Address:

http://legis.state.va.us/jchc/jchchome.htm