Virginia Department of Health

Primary Care Workforce and Health Access Initiatives
Annual Report

July 1, 2005 to June 30, 2006

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Executive Summary

Section 32.1-122.22 of the *Code of Virginia* requires the Virginia Department of Health (VDH) to submit an annual report on recruiting and retaining health care providers for underserved populations and areas throughout the Commonwealth. The annual report is to include:

(i) the activities and accomplishments during the reporting period;
(ii) planned activities for the coming year;
(iii) the number and type of providers who have been recruited by VDH to practice in medically underserved areas and health professional shortage areas (HPSAs);
(iv) the retention rate of providers practicing in these areas; and
(v) the utilization of the scholarship and loan repayment programs authorized in Article 6 (§32.1-122.5 et seq.), as well as other activities in the Appropriation Act for provider recruitment and retention.

The mission of the VDH Office of Health Policy and Planning (OHPP) is to improve access to quality health care for all Virginians. It is responsible for the above activities and for preparing this report. During the reporting period July 1, 2005 through June 30, 2006, the VDH has focused a great deal of its efforts on improving capacity to be both more proactive and more efficient. This has led to the development of comprehensive data-driven processes and systems for identifying emerging needs and, when possible, addressing those needs through the use of technology.

For example, in the past year, the VDH has developed a Rational Service Area Plan for primary care. The plan provides a means of identifying potential primary care Health Professional Shortage Areas (HPSA) using Primary Care Service Area (PCSA) analysis, a technique developed for HRSA by the Dartmouth Medical School and Virginia Commonwealth University. This process has been useful in identifying small areas of the Commonwealth where a shortage of primary care physicians may exist and enables the VDH to proactively assess HPSA designation potential. This past year, the VDH has also integrated its existing statewide primary care physician, general dentist, and psychiatrist databases and statewide demographic and health statistics data with Geographic Information Systems (GIS) technology. This comprehensive data system facilitates the HPSA designation process with a much higher level of accuracy and efficiency.

A critical function of the VDH is to develop and identify policy initiatives at the state-level which encompass actions that improve access to health care for the underserved, uninsured, rural, ethnic and minority populated areas of the state. This past year, the VDH has found several effective and efficient ways to address these needs through the use of technology:

- The VDH has embarked upon a campaign to increase awareness of community initiatives, federal and state programs via marketing its revised website. The VDH web site now

features local events such as the Virginia Minority Organ and Tissue Donation Program, national initiatives such as the National Kidney Foundation

- "Make Health A Family Reunion Affair," Closing the Health Gap initiatives and other programs. The website now also includes comprehensive resource links to programs and information pertaining to minority health and showcases various grants and funding opportunities that focus on health initiatives facing minority populations.

- Under the leadership of VDH forty-five (45) individuals representing over twenty-five agencies/organizations provided input over a thirteen (13) month period to network, share resources, and brainstorm about ways to improve our capacity to delivery culturally and linguistically appropriate healthcare to the rapidly growing immigrant and refugee population in Virginia. The group established a "wish list" with seven priority areas. Through the efforts of VDH during the past year, all seven (7) of the priority areas have either been addressed or are in the process of being addressed. Three (3) of the seven (7) priority areas were addressed through a new VDH, web site, www.vdh.virginia.gov/ohpp/ClasAct.asp. Governor Kaine held a press conference to launch the website earlier this year.

- VDH has facilitated the developed of a pilot project to enhance care for TB patients in the Central Region of Virginia. The majority (50% - 80%) of reported TB cases in the Central Region are comprised of a population who are refugees and/or immigrants who are uninsured/underinsured. Telehealth technology, in combination with the establishment of formal partnerships/networks between the Virginia Department of Health, several primary care facilities (free clinics and federally qualified health care centers), academic medical centers, and the Northern Virginia AHEC, has allowed for an unprecedented continuum of care. The pilot project will be evaluated when it ends in December 2006 for its effectiveness and its potential for statewide replication.

- The VDH continues to manage a state-of-the-art web-based recruitment tool called Primary Practice Opportunities of Virginia (www.PPOVA.org) that was established with other VA partners. PPOVA represents a web-based marketing effort for promoting the advantages of practicing in the Commonwealth, advertising specific practice opportunities, and identifying candidates from a broad array of medical specialties. The PPOVA website generated 19,262 visits during the reporting year, averaging 1,738 hits per day. During the reporting year, the website had approximately one hundred (100) available new opportunities posted and by the end of the reporting year, PPOVA had approximately 175 listed active opportunities.

To fulfill its mission, the VDH often partners with communities, health professionals and providers, advocacy groups, and other stakeholders. In fact, the VDH motto is "Partner of Choice." The Virginia Recruitment & Retention Collaborative Team (R & R Collaborative Team) is a collaborative effort between the Virginia Department of Health, (VDH), Virginia's four (4) medical academic institutions, and private, public, corporate, federal and state organizations.

The VDH was instrumental in the formation of the R & R Collaborative Team in September 2003. During this reporting period, VDH was notified that the Virginia Recruitment and Retention Collaborative Team won First Place in the 2006 Linkage Awards presented by the Council on Linkages between Academia and Public Health Practice of the National Association of County and City Health Officials (NACCHO).

In addition to providing more information about the above highlighted accomplishments of this reporting year, the annual report also provides a detailed summary of other VDH activities to improve access to quality health care for all Virginians. These include the management and administration of the following programs:

- Virginia State Planning Grant Program
- Critical Access Hospitals (CAH) Program
- Conrad State-30/J-1 Visa Waiver Program
- Virginia Medical Scholarship Program
- Mary Marshall Nursing Scholarship Program
- Nurse Practitioner/Nurse Midwife Scholarship Program
- Virginia Loan Repayment Program
- National Health Service Corps-State Loan Repayment Program

Finally, the report also describes planned activities for the upcoming year.

I. Legislative Background

Section 32.1-122.22 of the *Code of Virginia* requires that the State Health Commissioner submit an annual report to the Governor and to the General Assembly regarding the activities of the Virginia Department of Health (VDH) in recruiting and retaining health care providers for underserved populations and areas throughout the Commonwealth. The annual report is required to include information on:

(i) the activities and accomplishments during the reporting period;
(ii) planned activities for the coming year;
(iii) the number and type of providers who have been recruited by VDH to practice in medically underserved areas (MUAs) and health professional shortage areas (HPSAs);
(iv) the retention rate of providers practicing in these areas; and
(v) the utilization of the scholarship and loan repayment programs authorized in Article 6 (§32.1-122.5 et seq.), as well as other programs or activities authorized in the Appropriation Act for provider recruitment and retention.

The report is also required to include recommendations for new programs, activities and strategies for increasing the number of providers in underserved areas.

The State Health Commissioner delegated the responsibility of preparing the report to the Office of Health Policy and Planning (OHPP). The OHPP, whose organizational placement within VDH and mission are described in the next section, prepared the report using the legislative requirements as guidelines.

II. The Office of Health Policy and Planning

The mission of the OHPP is to contribute to the development of health policy in the Commonwealth with research and analysis of the issues affecting the cost, quality, and accessibility of health care; to help rural and medically underserved communities recruit health care professionals and improve healthcare systems; and to develop as well as administer programs to increase and strengthen the healthcare workforce thereby improving health care accessibility for Virginia residents. Consistent with its mission, VDH, through the OHPP strives to:

- **Assist** Virginia's communities in developing the conditions in which their citizens can be healthy;
- **Consult** with communities to determine their vision for a healthy community and empower them for action;
- **Assemble** the best possible teams of experts to assist communities in meeting the challenges of access to health care;
- **Assess** the availability and accessibility of primary care services;
- **Disseminate** information and data, and promote research to find solutions to issues related to health care access, quality, and cost;

- **Facilitate** the recruitment and retention of healthcare professionals in medically underserved and health professional shortage areas of the Commonwealth; and
- **Seek** funding resources to develop new programs.

To fulfill its mission, the VDH partners with communities, health professionals and providers, advocacy groups, and other stakeholders concerned with improving access to quality health care for all Virginians. The VDH plans to continue its efforts to assess the emerging barriers to health care occasioned by ongoing changes within the health care market place. It plans to continue looking for new indicators of access to quality health care, apply cost effectiveness analyses to evaluate health care programs, assess health care technology in the context of the new electronic environment, and develop policies regarding health care workforce recruitment and retention.

III. Activities and Accomplishments

During the reporting period of July 1, 2005 through June 30, 2006, the VDH continued to review requests and submit applications for designation of primary care and dental health professional shortage areas; provide information and assistance regarding primary care practice opportunities; collaborate in the building of health access networks through public and/or private partnerships; provide technical assistance and information to improve health care access for vulnerable and uninsured populations; and still, continues to revise policies pertaining to the J-1 Visa Waiver and the National Interest Waiver Programs to improve the placement and retention of physicians in medically underserved and health professional shortage areas.

A significant new activity the VDH engaged in last year was the development of a state specific health workforce study. Two decades ago, the Graduate Medical Education National Advisory Committee predicted a surplus in the supply of physicians in the United States. While the number of physicians may have increased, considering the present demand for physician services, there may actually be a shortage. Retiring baby boomers, technologically superior diagnostic and treatment procedures, and increasing prevalence of chronic disease are but a few variables that need to be considered to better appreciate the demand for medical services.

The uncertainty around the physician shortage/surplus argument underscores the need for objective studies that assess the current and projected supply of physicians. The few studies that exist suggest that Virginia has fewer physicians per population than the country as a whole, a higher population growth rate, and a greater reliance on international medical graduates. Data-driven public health policy cannot be realized without additional studies.

The workforce study is the first of its kind thereby representing a watershed event for Virginia. The VDH is partnering with all four of the deans of Virginia's medical/osteopathic schools in their first fully collaborative effort. Other workforce study benefits include its predictive nature, analysis based on a comprehensive combination of full state data, and the replicable quality of its study design.

To overcome the weaknesses exhibited by traditional health workforce studies, the study will predict physician supply adequacy in five to ten year intervals based on robust data sets and differing methodologies for estimating physician demand. Physicians in Virginia were surveyed during the renewal of their medical licenses regarding the scope of their practices in the upcoming years. Questions addressed the number of hours of week that they work, number of years before retirement, possibility of adding a partner, ability to accept new patients, days new patients have to wait before getting an appointment, etc. These data will be supplemented by the American Medical Association (AMA) and American Osteopathic Association (AOA) Physician Masterfiles for Virginia.

Comprehensive analyses will then be performed to more descriptively identify the supply of physicians. The responses to the questions will be tabulated and matched with the physician's specialty and ZIP code of practice. The ZIP code will then be placed into one of several different geographical areas- counties, towns, health planning regions, and primary care service areas (PCSAs). PCSA data describe utilization patterns for a specific geographic area. The use of PCSAs represents a significant advantage for Virginia's Primary Care Office (PCO), an office within VDH, as they are the basis for its rational service area study as well as an advantage for Virginia's PCA as its Environmental Assessment is also based on PCSA data.

These rational service areas will then be associated with a current population number from the PCSA database. The current physician supply will then be analyzed by current patient care full-time equivalent (FTE) per population area for each specialty. The calculations are repeated based upon the projections supplied by individual physicians, with a five year and ten year projection. Added to these numbers are the historical supply of new physicians in Virginia averaged over the past five years while is the number of separations from the workforce will be subtracted.

Another significant advantage of the study's design over earlier studies is that more robust data will be used in the analysis of physician demand. The physician-to-population ration will be calculated for each PCSA. Use of PCSA data identifies clusters of historical demand for primary care within a ZIP code thereby assuring greater demand specificity. In addition, the Agency for Healthcare Research and Quality's Medical Expenditure Panel Survey will also be used in the analysis of physician demand.

One final, yet certainly significant, benefit of the health workforce study is its principal investigator - Dr. Stephen Mick. Dr. Mick received his Ph.D. in sociology from Yale University and received a Fulbright Senior Research Fellowship. He is responsible for defining PCSAs, which are now being heralded by HRSA as a superior approach to examine issues of resource distribution, need, and demand for federal Primary Care Offices across the nation. Thus, this workforce study provides a vehicle for the VDH to promote HRSA's policy objective to have more PCOs use PCSA data. Virginia's unique geographic variations, including major cities as well as part of Appalachia, advance the utility of PCSA for geographic conditions found throughout the country. Finally, because of the familiarity of PCOs nationwide with the principles underlying PCSA data, its use enhances the ability of PCOs to replicate the study.

During this reporting period, the study is still on-going. Dr. Mick intends to have the study complete and will present the findings at the annual September 2006 Health Workforce Advisory Committee Meeting.

A. Health Professional Shortage Area Designations: The VDH (a) reviews requests for health professional shortage designations and submits qualified requests to the shortage designation branch (SDB) of HRSA for approval; (b) conducts reviews of existing health professional shortage areas (HPSA) three years after their initial or previous designation anniversary, to determine if they should continue as shortage areas; (c) provides information on health professional shortage designations to all interested parties; and (d) conducts annual surveys of non-designated areas in the Commonwealth to determine if they qualify for health professional shortage area designations.

A.1. Overview of HPSA Process

The HPSA designation system was initially developed in the 1970's to assist in allocating National Health Service Corps placements. Since then, over thirty-five (35) state and federal programs use the various HPSA designations as qualification criteria for specific federal and state health care initiatives.

Health Professional Shortage Areas have been established for Primary Care, Dental Care and Mental Health Care. A general overview of some of the criteria for HPSA designation is summarized in the following table. **(TABLE 1)**

Table 1
Requirements for Geographic and Population HPSA

	Primary Care	Dental Care	Mental Health
Population:Provider Ratio Geographic (a shortage for the total population within a defined service area)	3,500:1	5,000:1	30,000:1 (Psychiatrist)
Population:Provider Ratio Sub-Population or High Needs(an underserved population in a geographic area such as Low-Income or Migrant Farm workers)	3,000:1	4,000:1	20,000:1
Travel Time	30 minutes	40 minutes	40 minutes

In addition to geographic and population HPSA there are institutional designations such as the Community Health Clinics, Rural Health Clinics, federal and state correctional facilities, that provide individual facilities with some of the same benefits as the other designations.

Because HPSA designation is an administrative process, it is continually being reviewed and areas that may have earlier qualified as a HPSA may no longer qualify at a later date usually because the designation has attracted practitioners to serve the area. These are "success stories" that, nevertheless, often present difficulties for both providers and communities. These areas are no longer targeted for special programs, grants and enhanced provider reimbursements. Equally

difficult, on the other hand, is the plight of communities in need of designation to support their struggling healthcare system that may be inadvertently overlooked and remain undesignated. Such difficulties require vigilance in administering the HPSA process and timely and accurate assessments of all areas of the Commonwealth need to be performed.

Because VDH is federally mandated through the HRSA, Primary Care Cooperative Agreement to oversee the designation process, all due diligence is exerted to proactively survey the entire Commonwealth for potential HPSA candidates. To this end, the VDH maintains primary care physician, general dentist, and psychiatrist databases and monitors the demographics and health statistics of health care service areas to bring to light potential HPSA sites. All existing HPSAs are currently reviewed on a three-year cycle to assure continuity and effectiveness of incentive programs. The VDH uses both small area analysis techniques along with Geographic Information Systems (GIS) to optimize the HPSA designation process and to provide the highest degree of accuracy possible. Phone surveys of all providers within a service area (and often within contiguous areas) are required for every HPSA designation and the VDH has incorporated these surveys into its ongoing responsibilities.

Nevertheless, a caveat is required: HPSA designation should not be considered to represent the provider supply needs of the Commonwealth. The FTE shortages noted in **Appendix 1** represent only the required FTE to remove the HPSA designation from a specific area and not the total FTE requirements for the Commonwealth. It is well documented that health professional shortages within HPSAs are a reflection of the geographic (mal) distribution of providers in the major metropolitan areas of the Commonwealth. As shown in the demographic analysis (Appendix 1), HPSAs are relatively poor, typically overly represented by minorities, increasingly elderly, and often rural. To overcome these challenges and barriers to accessing health care is the goal of the HPSA designation and its associated incentives.

A.2. Benefits of HPSA.

The HPSA designation process attempts to uncover communities that have too few primary care, dental, mental and behavioral health care providers based on clear empirical practice criteria. The designation process is built upon the idea that access to healthcare is ultimately limited by the supply of healthcare providers in a health care service area. These shortages continue to limit access to healthcare even if other barriers, such as the unavailability of health insurance, are removed. Therefore, from its inception, the HPSA program has been the foundation for incentive programs such as the NHSC clinician's scholarship and loan repayment program, to increase the number and distribution of providers. These and other programs such as the J-1 Visa Waiver program directly address increasing the supply of practitioners. Other programs that increase reimbursements, and therefore improve the economic demand for health care services, are also seen as key recruitment and ultimately retention incentives. The Rural Health Clinic's program and the Medicare Incentive Payments are supportive of practices in HPSA and are often crucial for the economic survival and retention of providers.

Appendix 1 shows a selected list of federal incentives for providers to locate and remain in a HPSA. **Note**: Numerous other grant incentives for communities are available in designated HPSA areas which are designed to increase the attractiveness of an area for health care practitioners and to improve the healthcare infrastructure.

A.3. Primary Care Health Professional Shortage Areas (HPSA)

HPSAs are designed to indicate shortages of primary medical care providers defined as family practice, general internal medicine, pediatrics, obstetrics and gynecology, and general practice. HPSA designations may be geographical areas or population groups, and specific medical facilities. Geographic HPSA designations, the most common primary care shortage designation, include the following criteria:

- Areas that qualify, generally speaking, have a population to primary care provider ratio greater than 3,500:1 or greater than 3,000:1 if the population has high needs. A high needs area is determined by one of the following: high poverty rates (more than 20% below poverty), high birth rates (more than 100 births per 1,000 women) or high infant mortality rates (more than 20 infant deaths per 1,000 live births).

- Qualifying areas must demonstrate that the primary medical care professionals in contiguous areas are over-utilized, with a primary care provider ratio greater that 2000:1, or that these areas are currently designated as primary care HPSAs.

If the contiguous areas are not over-utilized or designated, it must be demonstrated that barriers to accessing the services of primary medical care professionals in these areas exist due to excessive distance (greater than 30 minutes travel time) or other factors.

Description of Virginia's Primary Care Health Professional Shortage Areas.

Virginia has fifty-five (55) primary care HPSA designations in sixty-eight (68) counties and cities throughout the Commonwealth. Forty-eight (48) of these are geographic primary care designations and seven (7) of them are population-based primary care designations. There are also forty-nine (49) health care facilities with HPSA designations, of which twenty-one (21) are community health centers, six (6) are rural health clinics and twenty-two (22) are correctional centers. It is estimated that it would require an additional one hundred seventeen (117) primary care physicians who agree to serve the medically needy in these institutions and areas to eliminate the primary care shortages that are currently being experienced within the Commonwealth's primary care HPSA.

Demographics of Primary Care Health Professional Shortage Areas.

Virginia's fifty-five (55) separate Primary Care HPSA designations (both geographic and low-income) are demographically characterized as follows:

- 17.7% of all Virginians live within a primary care HPSA.
- Geographically, 47.3% of the Commonwealth (18,709 square miles) is within a primary care HPSA.
- 9.3% of all Virginia urban residents and 40.3% of all Virginia rural residents live within a primary care HPSA [Census defines rural as those living outside an Urban Area (UA) or an Urban Cluster (UC)].

- 61.6% of all Virginia's primary care HPSA residents live within a rural area with 38.4% living within an urban area.
- 31.8% of all Blacks, which represent 19.6% of all Virginians, live within a primary care HPSA.
- 30.8% of all individuals below 100% of the Federal Poverty Level (FPL), which represent 9.6% of all Virginians, live within a primary care HPSA.
- 23.2% of all elderly persons (over age 65), which comprise 11.2% of all Virginians, live within a primary care HPSA.

Appendix 2: Virginia's Primary Care HPSA demographics.

Primary Care HPSA Designation Requests

During the reporting period July 1, 2005 through June 30, 2006, the VDH evaluated thirty-nine (39) new and re-designation requests of primary care Health Professional Shortages Areas (HPSA) in the state. Of these thirty-nine (39) evaluations, thirty-one (31) applications were sent to the Health Resources and Services Administration (HRSA), Bureau of Health Professions, Shortage Designation Branch (SDB) for review and designation. These applications encompassed forty-eight (48) different state jurisdictions.
Appendix 3 lists the requests sent to the SDB and the status of each requests.

A.4. Dental Health Professional Shortage Areas (DHPSAs)

DHPSAs are designed to indicate shortages of general dental care and take into account the number (FTE) of dentists, which are, in turn, weighted by the age of the individual dentist and the number (FTE) of dental hygienists and assistants associated with each dentist. Dental HPSA designations may be geographical areas or population groups within rural or urban areas, and specific medical facilities (e.g., community health centers.) Geographic dental HPSA designations, the most frequent shortage designation, include the following criteria:

- Areas that qualify, generally speaking, have a population to general dental provider weighted ratio greater than 5,000:1 or greater than 4,000:1 with high needs. A high needs area is determined by high poverty rates (more than 20% below poverty) or by low fluoridation rates (more than 50% of the population has no fluoridated water).

- Qualifying areas must demonstrate that the dental care professionals in contiguous areas are over-utilized with a population to dentist ratio greater that 3,000:1 or these areas are currently designated as dental HPSAs.

- If the contiguous areas are not over-utilized or designated, it must be demonstrated that barriers to accessing the services of dental professionals in these areas exist due to excessive distance (greater than 40 minutes travel time) or other factors.

Description of Virginia's Dental Health Professional Shortage Areas.

Virginia has sixty-three (63) separate dental HPSA designations. The designations include geographic (25) and low-income (8) designations as well as facility designations (30). The twenty-five (25) geographic DHPSAs include twenty-seven (27) jurisdictions and the eight (8) low-income designations represent eleven (11) jurisdictions. The thirty (30) facility designations include twenty (20) community health centers, nine (9) correctional centers, and one (1) free clinic. It is estimated that it would require an additional 99.8 general dentists who agree to provide services to the dentally-needy in these facilities and areas to eliminate the dental health professional shortages that are currently being experienced within the Commonwealth's Dental HPSAs.

Demographics of Dental Health Professional Shortage Areas

Virginia's thirty-three (33) Primary Care geographic and low-income HPSA are demographically characterized as follows:

- 16.5% of all Virginians live within a Dental HPSA.
- Geographically, 37.4% of the Commonwealth (14,810 square miles) is within a Dental HPSA.
- 10.1% of all Virginia urban residents and 33.9% of all Virginia rural residents live within a Dental HPSA [Census defined rural, those living outside an Urban Area (UA) or an Urban Cluster (UC)].
- 55.4% of all Virginia's Dental HPSA residents live within a rural area with 44.6% living within an urban area.
- 30.5% of all Blacks, which represent 19.6% of all Virginians, live within a Dental HPSA.
- 27.9% of all individuals below 100% of the Federal Poverty Level (FPL), which represent 9.6% of all Virginians, live within a Dental HPSA.
- 21.3% of all elderly (over age 65), which comprise 11.2% of all Virginians, live within a Dental HPSA.

Appendix 4 shows the Virginia Dental HPSA demographics within the HPSAs.

Dental HPSA Designation Requests

The VDH evaluated forty-four (44) new and re-designation requests of dental HPSAs in the state. Of these forty-four (44) evaluations, thirty-eight (38) applications were sent to SDB. The remaining six did not meet one or more criterion needed for designation. These applications encompassed forty-one (41) different state jurisdictions.
Appendix 5: Summary request sent to SDB.

A.5. Mental Health Professional Shortage Areas (MHPSA)

MHHPSA are designed to indicate shortages of mental health care providers which are defined as psychiatrists and other core mental health providers (e.g., clinical psychologist, psychiatric nurses, marriage/family counselors, and clinical social worker). As a rule, however, because the supply of general psychiatric services within an area is insufficient, only the shortage of psychiatrists need be demonstrated. Mental HPSA designations may be geographical areas, population groups and certain institutions, and specific facilities (e.g., community health centers, correctional facilities, mental hospitals) within rural or urban areas of the Commonwealth. Geographic mental HPSA designations, the most common mental health shortage designation, include the following criteria:

- Areas that qualify, generally speaking, have a population to psychiatrist ratio greater than 30,000:1. High needs areas require the assessment of all core mental health professionals (CMHP) in the area and then the ratios are lowered to 9,000:1 CMHC including psychiatrists, or 6,000:1 CMHC and 20,000:1 psychiatrists.

- The contiguous areas, within 40 minutes drive time of the population center of the service area, must be already designated as a Mental HPSA, be over utilized with a population to psychiatrist ratio greater than 20,000:1, or experience access barriers rendering the contiguous mental health services unavailable. Because low income individuals are required to seek services from the CSB serving their area of residence, a sufficient barrier exists to define the CSB's respective catchment areas as isolated from neighboring service areas. Therefore, each CSB can generally be designated if shortages in mental health professionals are present within their respective catchment area. For this reason, the Office of Health Policy and Planning works closely with the Commonwealth's local CSB providers to assure optimum designation opportunities.

Description of Virginia's Mental Health Professional Shortage Areas.

Virginia has sixty-two (62) separate Mental Health HPSA designations (both geographic and low-income). Of this number there are twenty (20) community health centers and twenty-four (24) correctional centers, designated as facilities and fourteen (14) whole or partial mental health catchment areas of Virginia's Community Service Boards (CSB). The CSB designations represent sixty-seven (67) jurisdictions; fifty-nine (59) counties and seven (7) cities, designated in their entirety as geographic mental health HPSAs, and one (1) partial city, Chesapeake City, is designated as a mental health low-income population HPSA within a CSB catchment area. Two additional designations within Roanoke and Richmond are designated as low-income and homeless populations respectively, to meet the challenges of specific populations. It is estimated that it would require an additional sixty-one (61) psychiatrists who agree to provide services to the underserved in these institutions and areas to eliminate the mental health professional shortages that are currently being experienced within the Commonwealth's Mental HPSA.

Demographics of Mental Health Professional Shortage Areas

The demographic data for Virginia's non-institutional Mental HPSA designations (both geographic and low income) covers sixty-nine (69) whole or partially designated jurisdictions, including both geographic and low-income HPSA.

- 23.7% of all Virginians live within a Mental HPSA.
- Geographically, 56.7% of the Commonwealth (22,457 square miles) is within a Mental HPSA.
- 11.6% of all Virginia urban residents and 56.0% of all Virginia rural residents live within a Mental HPSA [Census defines rural as those living outside an Urban Area (UA) or an Urban Cluster (UC)].
- 63.8% of all Virginia's Mental HPSA residents live within a rural area with 36.2% living within an urban area.
- 21.5% of all Blacks, which represent 19.6% of all Virginians, live within a Mental HPSA.
- 36.0% of all individuals below 100% of the Federal Poverty Level (FPL), which represent 9.6% of all Virginians, live within a Mental HPSA.
- 31.2% of all elderly (over age 65), which comprise 11.2% of all Virginians, live within a Mental HPSA.

Appendix 6: Virginia Mental Health HPSA demographics.

Mental Health HPSA Designation Requests

Additionally, the VDH evaluated six (6) new and re-designation requests of mental HPSA in the state. Of these six (6) evaluations, all six applications were sent to SDB. These applications included thirty-one (31) different state jurisdictions.
Appendix 7 lists all requests sent to the SDB and the status of each requests.

A.1. Rational Service Area Plan

The VDH has developed in the past year a Rational Service Area Plan for primary care. The Plan provides a means of identifying potential primary care HPSA using Primary Care Service Area (PCSA) analysis, a technique developed for HRSA by the Dartmouth Medical School and Virginia Commonwealth University. This process has been useful in identifying small areas of the Commonwealth where a shortage of primary care physicians may exist and enables VDH to proactively assess HPSA potential.

Summary

In summary, the VDH has improved the responsiveness and efficiency of the shortage designation process by developing a comprehensive data-driven approach to assessing access to primary care, dental and mental health services. The VDH currently maintains statewide primary care physician, general dentist, and psychiatrist databases and monitors the demographics and health statistics of health care service areas across the Commonwealth. The OHPP uses both small area analysis techniques along with Geographic Information Systems (GIS) to facilitate the HPSA designation process and to provide the highest degree of accuracy possible. Phone surveys of all providers within a service area (and often within contiguous

areas) are required for every HPSA designation and the VDH has incorporated these surveys activities into its ongoing responsibilities. All existing HPSAs are currently reviewed on a three-year cycle to assure continuity and effectiveness of several incentive programs.

B. Health Care Access for Vulnerable and Uninsured Populations

A critical function of the VDH is to develop and identify policy initiatives at the state-level which encompass actions that improve the access to health care for the underserved, uninsured, rural, ethnic and minority populated areas of the state. Health status statistics have consistently shown that racial and ethnic minorities and rural communities are vulnerable populations. Racial and ethnic minorities at all stages of life suffer poorer health and higher rates of premature death when compared to the majority population. In Virginia, the racial and ethnic minority populations comprise nearly 30% of the state's total population of 7.3 million. Minorities include the following group populations: Black or African-Americans (1,458,697), Asian (297,661), Native Hawaiian or other Pacific Islanders (5,096), Hispanics or Latinos (378,060) and American Indians or Alaskan Natives (23,778).[1]

Available data for Virginia substantiates a disparity or "gap" in health status and health outcomes for racial and ethnic minorities. The life expectancy in 2001 for the minority populations (72 years) in Virginia was six years less than whites (78 years). The state's overall infant mortality and teenage pregnancy rates have shown downward trends in the last decade, yet the gap between minority populations and whites has continued.

B.1. Minority Health

The Office of Minority Health (OMH) advances the VDH activities by its identification and elimination of barriers to health care access for vulnerable, rural, minority and uninsured populations of Virginia. The VDH manages programs designed to eliminate health disparities that exist among racial and ethnic minority populations in Virginia. The five federally recognized minority populations are: African American/Black, Hispanic/Latino, Asian, Native Hawaiian or other Pacific Islander, and Native American. Efforts to eliminate health disparities for racial and ethnic minority groups will only succeed by enhancing access to quality health care for these populations. Barriers to access to health care include lack of transportation, lack of fiscal resources, lack of health insurance, lack of health care providers, location of health care facilities, lack of interpretation and translation services, lack of information and lack of awareness regarding health status, lack of available health services, reduction of behavioral risk factors and lack of preventive measures. These barriers to access lead to the emergence of health disparities in racial and ethnic minorities throughout the state.

The Virginia Department of Health addresses these access issues by:

[1]U.S. Census Bureau, Population Division, County Population Estimates by Race Alone Hispanic or Latino Origin: July 1, 2002. Release Date: March 10, 2004

a) Funding minority community-based organizations (CBO) to conduct health education, screenings, referrals for primary care, risk reduction activities and preventive measures at the community level;

b) Partnering with other programs within the Virginia Department of Health to help them appropriately target racial and ethnic minority communities, low income and rural communities and effectively address the health disparities that are pervasive in these communities; and

c) Establishing public/private partnerships with entities that have historical and cultural relationships with, and a vested interest in low income, rural, racial and ethnic minority communities to design and implement programs that effectively eliminate barriers to accessing health care services which would, in turn, lead to the reduction and elimination of health disparities.

In order to promote the reduction, and ultimately the elimination of health disparities for minority populations in Virginia, the focus was on the importance of the role that minority practitioners play in educating the public about minority health issues. Consequently, the VDH was involved in three specific activities related to minority health issues during the reporting period:

a) The VDH is assisting Virginia Commonwealth University in planning a Latino Health Summit, seeking to equip health care providers, community leaders and individuals involved in the provision of health services with information, knowledge and resources to better serve the growing Latino population in Central Virginia. The 2000 U.S. Census revealed that Latinos are the nation's fastest growing minority population and the Greater Richmond Area Immigration Health Needs Assessment (between 1990 and 2000) showed that more than 20,000 persons immigrated into the Greater Richmond Area. Latin Americans represent one of the largest population groups immigrating to the area, with a growth rate of five times the overall population.

Nationally known leaders and researchers will be brought together in a critical mass to share their knowledge and experience with regard to demographic trends, key health issues, current best practices in healthcare, and key provider and patient resources for achieving better health outcomes for Latinos. Plenary sessions will afford opportunities for interaction with speakers and colleagues and small breakout sessions on selected topics will provide further opportunities for learning and interaction. Program objectives include:

1. learning the demographics and trends of Latinos in Virginia;
2. learning and understanding the key health issues facing the Latino population in Virginia;
3. learning the cultural and linguistic barriers to healthcare encountered by Latinos;

4. learning effective strategies and best practices for overcoming the cultural and linguistic barriers to healthcare encountered by Latinos; and
5. learning the key provider and patient resources for Latinos in Virginia.

In an attempt to maximize attendance, a limited number of scholarships are available in cases of financial need. This event is scheduled for November 2006.

b) The VDH has embarked upon a campaign to increase awareness of community initiatives, federal and state programs via marketing its revised website. The VDH web site now features local events such as a Virginia Minority Organ and Tissue Donation Program, national initiatives such as the National Kidney Foundation "Make Health A Family Reunion Affair", Closing the Health Gap initiatives and other programs. The website now includes comprehensive resource links to programs and information pertaining to Minority Health. The VDH website showcases various grants and funding opportunities that focus on health initiatives facing minority populations.

c) The VDH initiated and sponsored several initiatives to educate VDH staff and other leaders of healthcare management programs on the specific needs of minority populations and cultural factors that impact access and quality of healthcare. The VDH sponsored events celebrating Black History Month in February 2006 and Asian-Pacific American History Month in May 2006. At both events attendees were afforded an opportunity to hear from local, regional and state leaders who addressed cultural and legislative issues that impact minority population. The VDH is planning similar cultural and healthcare related events for Hispanic History Month scheduled for October 2006 and a Native American History Month in November 2006. These initiatives targeted Virginia's federally designated minority populations.

d) The VDH conducted a comprehensive survey of 2000+ stakeholders. The purpose of the survey was to assess the effectiveness of past VDH initiatives and receive input regarding future initiatives. Information from the survey is being used to shape the direction of future VDH initiatives.

B.2. Refugee and Immigrant Health

Virginia consistently ranks among the top fifteen (15) states for refugee resettlement, the top ten (10) states with the largest immigrant resident population, and the top 10 states for intended residence of new arrivals. In Virginia, between 1990 - 2000, the Asian population grew by two-thirds and the Hispanic population more than doubled. Additionally, the number of students receiving English as a Second Language (ESL) through Virginia public schools has gone from 36,799 in 2000 to 66,970 in 2004, an 82% increase. According to the 2000 Census, 11% of Virginia residents over the age of five speak a primary language other than English. Forty one percent of this population speaks English "less than very well" and 21% live in "linguistically isolated households." These are households in which "no member 14 years old and over speaks only English or speaks English "very well." These individuals are considered limited English

proficient (LEP) in the health care context. The impact of these demographic changes has a tremendous impact on healthcare, with issues ranging from quality and patient compliance with care to cost of care to risk management to the healthcare workforce.

A 2002 Access Project study found that over 27% of patients who needed but didn't get an interpreter did not understand medication instructions as compared with 2% of patients who received an interpreter. VDH initiated a statewide research project aimed at identifying the healthcare needs of Virginia's racial and ethnic populations in 2000. Focus groups comprised of Virginia's multicultural healthcare consumers found that most needed an interpreter for their clinic visits. Of those who reported needing an interpreter, the majority (54.4%) said they relied on family and friends to meet their language needs. Only a small percentage (12.1%) had access to bilingual medical staff and an even smaller percentage (3%) had access to professional medical interpreters. A survey of public health professionals found language barriers to be the most frequently cited obstacle to delivering needed services to individuals and families. According to a 2003 study by Flores, et al., errors in medical interpretation are common, averaging thirty-one (31) per clinical encounter, with omissions as the most frequent type. Most errors have potential clinical consequences, and those committed by ad hoc interpreters are significantly more likely to have potential clinical consequences than those committed by bilingual medical staff or trained medical interpreters.

Under the leadership of VDH, an informal gathering of individuals took place in November 2003, June 2004, and January 2005 for the purpose of networking, sharing resources, and brainstorming about issues, needs, wants and resources for improving capacity to deliver culturally and linguistically appropriate healthcare to immigrants and refugees. Forty-five (45) individuals representing over twenty-five (25) agencies/organizations provided input during these three meetings. The group established a "wish list" with the following priority areas:

- access/availability of tested and trained health care/medical interpreters
- leveraging of funds/capitalizing on economies of scale for videoconference and/or telephonic interpreters
- use of standardized forms and translating those forms into a variety of languages
- a central clearinghouse on Virginia resources
- access to translated patient education materials
- access to translated commonly use phrases in the clinical setting, preferably with audio
- educational materials for new immigrants and refugees on how to navigate the western health care system

Through efforts of VDH, all of the priority areas have either been addressed or are in the process of being addressed.

- **Access/availability of tested and trained health care/medical interpreters:**
  Virginia has only had access to tested and trained health care/medical interpreters in two regions of the state: 1) Northern Virginia through the efforts of the Northern Virginia Area Health Education Center and 2) the Shenandoah Valley through the efforts of the Blue Ridge Area Health Education Center. Over the course of the past twelve months (12), VDH, OHPP has assisted to build capacity at Refugee and Immigration Services to

train health care interpreters in the Central Virginia area. In the past four months, two classes of health care interpreters, one in Richmond and one in Fredericksburg, have successfully completed the forty (40) hour health care interpreter training course. Additionally, VDH has put systems in place for this capacity to be developed in the Peninsula, Hampton Roads and Roanoke regions of Virginia in upcoming months. Finally, VDH is in the process of establishing a loan repayment program for bilingual individuals interested in serving as health care interpreters. Individuals who successfully pass a language proficiency test in English and in a target language will soon be eligible to waive the registration fees for the 40-hour interpreter course in exchange for forty (40) hours of community service as an interpreter.

- **Leveraging of funds/capitalizing on economies of scale for videoconference and/or telephonic interpreters:**
  The VDH has recently assisted with the drafting of a scope of services for a statewide Request for Proposals for telephonic interpretation. Until this time, each local health department has been responsible for establishing its own contractual agreements for services. Additionally, the VDH has proposed exploring the possibility of bringing in other public and/or private health care entities into the process.

- **Use of standardized forms and translating those forms into a variety of languages:**
  Through efforts of the VDH Nursing Council and the Commissioner's Office, VDH has developed a set of standardized forms and documents for use by all local health departments. The VDH has partnered in these efforts by assisting in the translation of these. All VDH standardized forms and documents are now available in Spanish, Arabic, and Somali.

- **Addition of statement in Spanish on OHPP staff's telephone voice messages:**
  In addressing increased communication needs, VDH, OHPP staff have learned some basic Spanish phrases and included a message in Spanish on their telephone messages. The caller then is referred to a number that is answered by staff member who can respond in Spanish.

- **A central clearinghouse on Virginia resources:**
  Governor Kaine recently held a press conference that launched VDH's new website, http://www.vdh.virginia.gov/ohpp/clasact.asp. This website serves as a one-stop shopping resource guide for Virginians regarding culturally and linguistically appropriate health care services. The following resources can be found on the website.

  - **Access to translated patient education materials:**
    The recently launched website provides a directory of translated patient education materials.

  - **Access to translated commonly use phrases in the clinical setting with audio files:**

These translated files and audio files are currently available on the web site in Spanish. The VDH, is working with organizations and individuals to add Vietnamese, Korean, Chinese, Tagalog, Hindi and Cambodian in the near future.

- **Educational materials for new immigrants and refugees on how to navigate the western health care system:**
  The VDH has contracted with the Northern Virginia Area Health Education Center to develop educational materials (both web-based and hard copy formats) targeted at refugees and immigrants to assist them in navigating the western health care system. Additionally, a training curriculum is also being developed to help individuals, agencies and organizations who work with refugees and immigrants teach their clients how to use the materials. These materials are targeted for completion in October 2006.

- **Virginia Latino Advisory Board (VLAB) participation:**
  The Director of the OHPP serves as a member of the VLAB, which is established as an advisory board with the power and duty to:

  1. Advise the Governor regarding the economic, professional, cultural, educational, and governmental links between the Commonwealth of Virginia, the Latino community in Virginia, and Latin America;
  2. Undertake studies, symposiums, research, and factual reports to gather information to formulate and present recommendations to the Governor relative to issues of concern and importance to the Latino community in the Commonwealth; and
  3. Advise the Governor as needed regarding any statutory, regulatory, or other issues of importance to the Latino community in the Commonwealth.

Finally, the VDH submitted a budget decision package during this past year and for the first time in Virginia's history, State funds have been made available to assist local health departments build capacity for delivering culturally and linguistically appropriate health care services.

B.3. Telehealth

Telehealth is the use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration. Telehealth is frequently viewed as a solution to overcoming the problems of limited local access to specialty providers, the barriers imposed by travel, and the isolation of practitioners in rural areas.

Under the VDH, leadership, an informal gathering of individuals involved in telehealth in Virginia took place in November 2002 and has since led to the establishment of the Virginia Telehealth Network (VTN). The primary goals of the VTN are to:

- facilitate networking
- explore opportunities for collaboration,
- improve the current telehealth infrastructure; and
- improve the current utilization of telehealth.

The VTN presently has a membership of over eighty (80) individuals representing more than fifty (50) public and private agencies/organizations. Last year, in partnership with the Virginia Rural Health Association/Virginia Rural Health Resource Center, the University of Virginia Health System Office of Telemedicine, and the Edward Via Virginia College of Osteopathic Medicine, the VDH co-sponsored the Virginia Telehealth Initiative Consensus Conference as a way to lay the foundation for a statewide strategic plan. Since that time, a statewide strategic plan has been drafted and efforts are underway to establish the VTN as a 501(c)(3) entity which would allow it to apply for federal loans and grants.

The VDH has also provided leadership for a pilot project to enhance care for TB patients in the Central Region of Virginia. The majority (50% - 80%) of reported TB cases in the Central Region are comprised of a population who are uninsured/underinsured. These patients generally have concurrent medical needs and are without a medical home. It is also not uncommon for the few who do have a medical home to report that their primary care physicians are hesitant or even unwilling to provide care for them once they have contracted TB. Primary care providers are generally ill equipped to deal with TB in their practices, not having adequate experience or training in the management of the disease and/or easy access to specialty care (e.g., pulmonology and infectious disease) consultative services. As a result, the local public health departments who are responsible for the investigation, control, and assurance of standards of care related to treatment, follow-up, and referrals, are struggling with the coordination of care for these TB patients. In 2004, of the fifty-one (51) reported cases of TB in the Central Region, approximately forty-five (45) were being cased managed by the local public health departments.

As a possible solution to the identified needs, the VDH has developed a pilot project that has established formal partnerships between the Virginia Department of Health, several primary care facilities in the Central Region (Fan Free Clinic, Cross Over Health Center and Vernon J. Harris Health Center) to serve as a medical home for TB patients, specialty care providers (infectious disease and Office of Telemedicine at UVA Health Systems and Pulmonology and Telemedicine at VCU Health System) to provide consults for TB patients via telehealth, and the Northern Virginia AHEC to provide videoconference interpreters for LEP patients. This pilot project has been the result of close to twelve (12) months of network development and planning. The pilot project has just recently begun and will be evaluated when it ends in December 2006 for its effectiveness and its potential for regional replication.

B.4. Virginia State Planning Grant Program

The U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA) State Planning Grants Program has awarded the VDH with three (3) rounds of grant funding for a total of just under $1.18 million to collect data, conduct research, and develop plans to provide greater access to affordable health insurance coverage for uninsured Virginians. With these grant funds, VDH has established a community-based participatory process for decision-making in health coverage expansion options, conducted the most comprehensive survey on health care access and health insurance in the State, developed a website for insurance information (http://www.InsureMoreVirginians.org), developed a website and hard copy version of "A Guide to Health Insurance Options for Small Businesses in Virginia", and is in the early stages of establishing a Virginia Foundation for Health Coverage Education.

B.5. Critical Access Hospital Program

The Critical Access Hospital Program was created by the Federal Balanced Budget Act of 1997 (P.L. 105-33). Also known as the Medicare Rural Hospital Flexibility Program, the program provides funding to states for the development of a statewide rural health plan; designation of Critical Access Hospitals (CAH); development and improvement of rural health networks; strengthening the statewide system for Emergency Medical Services, and improving the quality of care in CAHs. Hospitals with the CAH designation are eligible to receive cost-based reimbursement for services for Medicare patients, which can substantially improve a hospital's revenue.

Section 32.1-122.07 of the *Code of Virginia* establishes the responsibility of the Virginia Department of Health for the CAH program. Virginia has benefited substantially from the program, which has provided funding of over $1 million since Virginia began participating in the program in 1999. Much of the funding has gone to rural Virginia communities with hospitals that have converted to Critical Access Hospitals. A significant amount of the funds have been invested in telemedicine equipment that enables residents of rural areas to receive specialty care in their own communities, a real benefit to Virginians who might otherwise have to travel several hours for appropriate healthcare. Other program funds have been invested in the improvement of rural Emergency Medical Services and grants to hospitals for quality improvement and patient safety.

During this reporting period, one hospital received federal certification as CAHs: Page Memorial Hospital previously received grant funds for a community needs assessment and received federal certification in October 1, 2005. The network of CAHs in Virginia now includes:

- Bath County Community Hospital
- Carillon Giles Memorial Hospital
- Dickenson Community Hospital
- R.J. Reynolds-Patrick County Memorial Hospital
- Shenandoah Memorial Hospital
- Stonewall Jackson Hospital
- Page Memorial Hospital

B.6. J-1 Visa Waiver Program

Virginia continues to participate in the Conrad State-30 program, a federally authorized program that permits the Virginia Department of Health to act as an interested state agency and request visa waivers for American trained foreign physicians so that they can remain in the U.S. and practice in medically-underserved and health professional shortage areas within Virginia. This waiver option is called the State 30 Program because it is limited to 30 J-1 visa waivers per state per year.

Most international medical graduates enter the United States on a J-1 Exchange Visitor visa in order to train in a residency program in the United States. All of these foreign medical graduates

in J-1 visa status are subject to a requirement that they return to their home country for two years at the completion of the residency training program. Satisfaction or waiver of this requirement is necessary before moving from J-1 visa status to most any other visa status. Therefore, in most cases, a return to the home country for two years or a waiver of this requirement is necessary before a physician holding a J-1 visa can obtain employment in the United States.

The J-1 visa waiver removes the requirement for the physician to return to home country for two (2) years. The Conrad State-30 program allows every state to petition the U.S. Department of State (DOS) on behalf of 30 J-1 physicians per year for recommendations to the United States Citizenship and Immigration Service (CIS) to grant J-1 visa waivers. The states receive from each J-1 physician a three-year commitment to serve in a Health Professional Shortage Areas (HPSA) or a Medically Underserved Areas (MUA) in exchange for filing a petition for J-1 visa waiver on behalf of the J-1 physician.

The VDH also may recommend waivers for physicians participating in the Appalachian Regional Commission (ARC) J-1 Visa Waiver program. This program is similar to the Conrad State-30 program. Physicians in this program must practice for at least three years; however, the practice location must be in one of the twenty-three (23) Appalachian counties and eight independent cities in Southwest Virginia.

Physicians participating in the Conrad State-30 or ARC program do not displace American physicians. Practice sites wishing to hire a J-1 Visa Waiver physician must prove that they have advertised and recruited for American physicians for at least six months and were unsuccessful in their recruitment attempts before they are eligible to hire a J-1 Visa Waiver physician.

Additionally, the regulations now allow the Conrad program slots to be used for the practice of primary care or specialty medicine. States are now allowed to use five (5) of the thirty Conrad applications for J-1 exchange visitor physicians who will be practicing medicine (i.e., primary or specialty practice) in a facility that services patients who reside in one or more designated geographic areas without regard to whether such a facility is located within such a designated area. The aforementioned applications will be referred to as "non-designated" Conrad applications. Previously, all thirty Conrad applicants had to practice medicine at a medical facility physically located in a designated medically underserved area. Virginia has opted to use five (5) of its Conrad slots for "non-designated" applications. Virginia has allotted one non-designated waiver slot to each of its publicly supported Academic Medical Centers: Virginia Commonwealth University Medical College of Virginia and University of Virginia. The availability of additional physician services through this change will allow for the continual utilization primary care and specialty physicians with J-1 Visa Waivers to be recruited in health professional shortage areas in Virginia.

Accomplishments during the reporting year include:

- continued stream-lining of the waiver application review and approval request process, allowing for comprehensive reviews and expeditious processing;
- processed fourteen (14) J-1 Visa Waiver applications and forwarded them to DOS for approval**;**

- utilized five (5) of the non-designated slots; and
- issued letters of support for two (2) national interest waiver requests.

Appendix 8: J-1 Visa and National Interest Waiver requests and approval dates.

The VDH continues to be made aware of physician shortages in specialty areas that are jeopardizing the health care of communities. As such, the VDH reviews each situation and confers with the local health district directors to determine if additional recruiting mechanisms should be utilized to assure the stabilization of health care services within communities. The J-1 Visa Waiver physicians continue to be an important source of providing health professionals and access in many underserved areas of Virginia.

B.7. Networks and Partnerships

The activities and accomplishments of the VDH during the reporting period could not have been possible without its network of partners. The VDH considers the formation of partnerships and continued collaboration with partners as both an activity and an accomplishment. The VDH has collaborated with both public and private sector entities to maximize its efforts to enhance access to primary care services.
Appendix 9: Collaborative projects with the VDH Partners.

IV. Initiatives to meet the needs of Medically Underserved or Health Professional Shortage Areas

The VDH assists primary care practice sites in recruiting and placing health care professionals, marketing recruitment and placement services, and collaborating with the Virginia Primary Care Recruitment Network (VPCRN) and other partners to expand the provision of recruitment and placement services. A brief description of each activity follows.

A. Recruitment and Placement of Health Care Providers

The VDH provides recruitment and retention services for primary care and mental health practice sites located in medically underserved areas, health professional shortage areas, and in state or local government institutions in the Virginia. These services are provided by VDH's Recruitment Manager and the Web Manager/Recruitment Liaison. The VDH receives requests from physicians, nurse practitioners, and physician assistants interested in practicing primary care, specialty care, or psychiatry in Virginia. Additionally, requests are received from primary care, specialty care, and mental health practice sites interested in recruiting health professionals. The VDH works with the practice sites and the applicants in order to refer appropriate candidates. The primary outcome is the increased pool of applicants resulting in placement of health care professionals in primary care and mental health practice sites in medically underserved areas.

The activities and accomplishments during the reporting period were many. Health professionals' curriculum vita (CV) were reviewed and forwarded to practice sites that posted

their opportunities on Virginia's healthcare recruitment website Primary Practice Opportunities of Virginia, www.ppova.org.

Last year, ninety-seven (97) positions were posted and one hundred eighty-six (186) candidates used the system to identify positions of interest, which resulted in five hundred fifty-five (555) CV's being forwarded to practice sites.
Appendix 10: Recruitment Summary

B. Marketing of Recruitment and Placement Services

The VDH has a multi-faceted marketing program, which includes numerous presentations at residency programs and at various health care related symposiums and conferences. During the presentations, the VDH shares information on practice opportunities in Virginia as well as recruitment and placement services provided through the VDH.

The marketing focus is on serving those in medically underserved areas and health professional shortage areas. During the reporting period, recruiters made presentations at each of the Virginia medical schools residency programs (family medicine, pediatrics, ob/gyn) and regional annual conferences and exhibits. These efforts were aimed at marketing practice opportunities within Virginia and making potential candidates aware of the recruitment resources available at the VDH.

C. Collaboration with Other Entities

The VDH continues to manage a state-of-the-art web-based recruitment tool called Primary Practice Opportunities of Virginia (www.PPOVA.org) that was established with other VA partners. PPOVA represents a web-based marketing effort for promoting the advantages of practicing in the Commonwealth, advertising specific practice opportunities, and identifying candidates from a broad array of medical specialties. VA Partners continue to assist in the referrals to PPOVA.

The PPOVA website generated 19,262 visits during the reporting year, averaging 1,738 hits per day. During the reporting year, the website had approximately one hundred (100) available new opportunities posted; the most opportunities located were in the city of Norton, Virginia and the most frequently recruited specialty was that of Family Practice. By the end of the reporting year, PPOVA had approximately one hundred seventy-five (175) listed active opportunities.

Presently, practice opportunities and potential candidates are accepted for the following areas:

- **Physicians:** Family Practice, Internal Medicine, Pediatrics, Obstetrics/Gynecology, and Psychiatry
- **Nurse Practitioners:** Family/General Nurse Practitioners, Pediatric Nurse Practitioner, Adult Nurse Practitioner, and Psychiatric Nurse Practitioner
- **Physician Assistants**
- **Other Medical Specialties:** Anesthesiology, Dentistry, Dental Hygienist, General Surgery, Pharmacy, Urologist, Otolaryngology, Oncology, Radiology, Cardiology, Emergency Medicine, Gastroenterology, Orthopedics and Hospitalist.

In order to help meet the needs of all Virginians, PPOVA continues to list all opportunities in an effort to provide services to the entire state of Virginia. Even though the recruitment efforts provided through PPOVA have been expanded to include the maximum number of specialties and locations, the majority of practitioner vacancies are for primary care providers. Health Professional Shortage Areas continue to represent a significant portion of the vacancies in the Commonwealth. The Southwest region continues to have long term vacancies and continues to receive more intense recruitment efforts.

During this reporting year, the process for a candidate seeking a position in Virginia via PPOVA and the National Rural Recruitment and Retention Network (3Rnet), www.3Rnet.org, remained unchanged. However, the utilization of the new Practice Sights Software added greater efficiency to the operations. Specifically, responses to inquiries have been expedited.

Virginia Recruitment and Retention Collaborative Team.

The Virginia Recruitment and Retention Collaborative Team (R & R Collaborative Team) is a collaborative effort between Virginia Department of Health, Virginia's four (4) academic medical centers, private, public, corporate, federal and state organizations. The VDH was instrumental in the formation of the R & R Collaborative Team in September 2003. The R & R Collaborative Team's mission is to "Establish and enhance collaborative efforts in partnership with stakeholders to deliver improvements to recruitment processes and retention systems for health care providers with an emphasis on the medically underserved areas in Virginia." R & R Collaborative Team members are from localities throughout Virginia; therefore, the team meets on a monthly basis via teleconference and in order to maximize our time and expense. The VDH Recruitment and Retention Services coordinate meetings and facilitate the call.

During the initial meetings the R & R Collaborative Team identified tactical and strategic goals, such as enhancing communication. This effort was achieved in part by the linkage of shared information via website links and communications such as newsletters, web pages, brochures and various presentations. This effort continues to maximize communication efficiencies. Additionally, the R & R Collaborative Team has experienced success in contributing content and usability feedback resulting in enhancements and greater utilization of Virginia's free online healthcare recruitment website Primary Practice Opportunities of Virginia www.PPOVA.org. All R & R Collaborative member organizations are linked through this comprehensive website.

During this reporting period, the VDH's Recruitment and Retention Services was made aware of a national awards competition that was seeking nominations for outstanding collaborative healthcare workforce recruitment and retention initiatives. The VDH's Health Workforce and Minority Health Manager authored and submitted an abstract on behalf of the R & R Collaborative Team. The VDH was notified that the Virginia Recruitment and Retention Collaborative Team won First Place in the 2006 Linkages Awards presented by the Council on Linkages between Academia and Public Health Practice of the National Association of County and City Health Officials (NACCHO). On behalf of the team, the Health Workforce and Minority Health Manager will accept this award on September 14, 2006 at the Association of State and Territorial Health Officials Annual Meeting in Atlanta, Georgia.

National Rural Recruitment and Retention Network – 3RNET

The National Rural Recruitment and Retention Network (3RNet) is made up of state organizations such as State Offices of Rural Health, AHECs, Cooperative Agreement Agencies and State Primary Care Associations. These not-for-profit organizations help health professionals locate practice sites in rural areas throughout the country. Each organization has information regarding rural practice sites in their respective states. They will be able to assist health professionals and their families identify the resources necessary to meet the personal and professional requirements they seek.

For many years Virginia has been a member of the 3RNET and fully participates in its activities. Virginia's Health Workforce Manager requested that Virginia be the host state site for the 2007 annual conference. 3RNet members agreed accordingly and the 2007 annual conference will be held in Virginia (specific location not yet determined). Virginia's Health Workforce Manager has served on the 2006 conference planning committee and will lead the planning committee for the 2007 conference.

V. The Retention of Providers Practicing in Medically Underserved or Health Professional Shortage Areas

The number and type of providers who have been recruited by VDH to practice in medically underserved areas and health professional shortage areas (HPSAs) are described below. During the reporting period, the VDH accomplished the following with regard to the retention rate of providers practicing in medically underserved and health professional shortage areas in Virginia:

A. Retention of National Health Service Corps (NHSC) – State Loan Repayment Recipients

The retention rate of providers practicing in these areas is described in this section. During the reporting period, twelve (12) NHSC-State Loan Repayment practitioners with practice obligations were located in Health Professional Shortage Areas (HPSA) of the Commonwealth, namely Accomack, Cumberland, Danville, Dickenson, Fluvanna (three each), Nelson, Pittsylvania (two each), and Smyth Counties (two each). These practitioners included the following disciplines: Family Practitioner (three each), Pediatrician, Internist/Pediatrician (two each), General Internist (two each), Psychiatrist, Family Nurse Practitioner (two each), and a Psychiatric Nurse Practitioner. Two participants in Accomack and Dickenson Counties completed their service obligation during the reporting period. The Nurse Practitioner in Dickenson County continues to work there. The Pediatrician in Accomack County left the state of Virginia.

Since the receipt of the grant award from the federal government in fiscal year 1994, a total of twenty-five (25) practitioners have participated in this program. Sixteen (16) participants who completed their service obligations in a prior reporting period, twelve (12) continue to work in their original locations, namely Accomack (two each), Buchanan, Dickenson, Grayson, Highland, Lee, Nelson (two each), Northampton, Page, and Westmoreland Counties and in Richmond City (East End). One participant now practices in Mechanicsville in Hanover County,

which is not designated as a HPSA. The remaining two have moved out-of-state. There have been no defaults in this program. The overall retention rate for NHSC-State Loan Repayment Program practitioners in health professional shortage areas is seventy-five percent (75%).

VDH's planned recruitment and retention activities for the coming year will be to sustain and to possibly increase partners in its aforementioned activities.

B. Retention of J-1 Visa Waiver Physicians

During this reporting period, the VDH did not survey J-1 Waiver physicians due to a lack of funding. However, in the upcoming year, the VDH plans to contract with a consultant to conduct an in-depth study of the effectiveness of VDH Incentive Programs.

C. Collaborative Efforts

The VDH has continued its partnership with the Virginia Health Care Foundation, which administers the Healthy Communities Loan Fund. This program offers low-interest loans to providers who are located in medically underserved and health professional shortage areas. The availability of capital financing has proven to be an important service to support the retention of physicians and dentists in the Commonwealth's underserved areas. This effort is part of the VDH's broader program of practice management support for physicians practicing in underserved areas.

VI. Utilization of Scholarship and Loan Repayment Programs and Other Authorized Programs or Activities

The utilization of the scholarship and loan repayment programs authorized in Article 6 (§32.1-122.5 et seq.), as well as other activities in the Appropriation Act for provider recruitment and retention are further explored in this section. Federal and state medical scholarship and loan repayment programs were developed to attract primary care providers to medically underserved areas. By providing financial incentives through these programs for primary care physicians and psychiatrists to practice in high need regions of the state, the VDH hopes to improve the health of the underserved and provide access to quality health care, especially where health issues have the highest racial, ethnic, and socioeconomic disparities in treatment success.

Preference for recruitment or placement services is given to Virginia Medical Scholarship and Nurse Practitioner/Nurse Midwife Scholarship recipients because these programs require service in a HPSA or VMUA. In addition, the VDH assists the National Health Service Corps (NHSC) scholars with placement in practice sites located in medically underserved or health professional shortage areas within Virginia.

The Commonwealth of Virginia offers several programs that offer loan repayment for medical service in health profession shortage areas. In addition to the benefit of serving a community that highly values the practitioner's service, financial incentives include the recipient receiving:

- Up to $50,000 for a 2-year commitment;
- Up to $85,000 for a 3-year commitment;
- Up to $120,000 for a 4-year commitment; and
- Plus, the salary and benefit package offered by their employer.

The VDH acts as administrator and staff support for these programs. Therefore, it is imperative that efficient and effective application processing is in place.

The **Virginia Medical Scholarship Program** (VMSP) awards scholarships annually to medical students and first-year primary care residents in exchange for a commitment to practice in designated medically underserved areas. Qualifying medical students receive $10,000 per year for up to 5 years. This program is being phased out; however, all students that participated in the program last year will remain eligible for this program until they have reached their first year of residency. Once eligibility runs out for these students, the program will be discontinued. The last year that VMSP scholarships will be awarded is the academic year 2007-2008.

Budget cuts received in October 2002 are the primary reason for the discontinuance of this scholarship program. However, another reason for discontinuing this program is the high default rate experienced in the program. The high default rate, approximately 40%, is attributed to the fact that scholarships are awarded to students early in their medical education with a condition that upon completion of their medical education, they must work in primary care in a designated underserved area of the Commonwealth. At some point during their medical education, however, many scholarship recipients change their fields and go into specialties other than primary care, move out of state, or no longer want to work in a medically underserved area. Therefore, VDH is concentrating placement efforts using the Virginia Physician Loan Repayment Program (VPLRP) as an incentive.

The **Mary Marshall Nursing Scholarship Program** (MMNSP) provides financial incentives to Licensed Practical Nurse (LPN) and Registered Nurse (RN) students. The program requires one month of service by the recipient as a LPN or RN anywhere in the state for every $100 of scholarship awarded. Awards have ranged between $1,200 and $2,500 per year.

The **Nurse Practitioner/Nurse Midwife Scholarship Program** provides a $5,000 scholarship to individuals pursuing a nurse practitioner or nurse midwife education in Virginia. For every scholarship awarded, a year of service is required in a medically underserved area of the Commonwealth.

The award recipients for the nursing scholarship programs for the reporting year:

(TABLE 2)

Scholarship Program 2005-2006	# of Applications Received by VDH	# of Awards Offered
Nurse Practitioner/ Mary Marshall Scholarship Program	6	4
Practical Nurse Board of Nursing Funds	45	41
Registered Nurse	123	97
TOTALS	168	142

The **Virginia Physician Loan Repayment Program (VPLRP)** provides financial incentives to primary care physicians and psychiatrists who commit to serving a minimum of two years, with an option to renew up to four years, in a medically underserved area. Based on verified educational loan amounts, a recipient may receive up to $50,000 for the original two year commitment. If their verified educational loans total more that $50,000 and if funding is

available, a participant can renew for an additional year receiving up to $35,000. The maximum a recipient can receive is up to $120,000 for a four year commitment.

The **HRSA-Bureau of Health Professions State Loan Repayment Program (SLRP)** also provides financial incentives to primary care physicians, psychiatrists, nurse practitioners and physician assistants who commit to serving a minimum of two years in federally designated HPSA. The practice site must be a not-for-profit or public entity. Based on verified loan amounts a recipient can receive up to $120,000 for a four-year commitment. The SLRP is a federal grant and must be matched with state funds on a dollar for dollar basis.

The **Virginia Dental Scholarship Program** for Virginia Commonwealth University School of Dentistry students has been in place since 1952. Scholarship recipients must practice in a dentally underserved area upon graduation. Participation from 1986-1994 averaged nine (9) scholarships per year. Initially, the award was $2,500 per year, but in 1998 it was raised to $5,000. In 2000, the award amount was changed to equal one-year in-state tuition (about $10,500 in 2000). This had a marked impact on the number of potential recipients, since the appropriation of $25,000 for the scholarship program had not changed since 1952. The 2005 General Assembly made a combined appropriation of $325,000 for the scholarship and dental loan repayment programs. Fourteen (14) dental students received awards during the 2005-2006 academic year. The VDH Office of Family Health Services, Division of Dental Health, administers the Dental Scholarship Program.

The **Virginia Dental Loan Repayment Program** came into existence in 2000 *(Code of Virginia § 32.1-122.9:1)* but was not funded until the 2005 General Assembly appropriated funds to implement the program beginning July 1, 2005. The loan repayment program is open to graduates of any accredited US dental school who hold a valid Virginia license, are within five years of graduation, and who practice in a dentally underserved area. The loan repayment award is not fixed and is based on Virginia Commonwealth University School of Dentistry tuition for the year in which the loan was acquired. The first awards to dentists under this program were made in FY 2006. The VDH Office of Family Health Services, Division of Dental Health, administers the Dental Loan Repayment Program.

In addition to the programs listed above, the VDH will continue to identify and assist practice sites in Virginia eligible to recruit health professionals participating in the National Health Service Corps (NHSC) scholarship and loan repayment programs.
Appendix 12: Practice locations of incentive program recipients.

VII. Planned Activities for the Coming Year

A. Strategic Planning

Many of VDH's proposed activities are dependent on the availability of appropriate state, federal, and private resources. Additionally, during the reporting period, VDH experienced some staffing turnover, replaced staff and has redesigned its organizational structure and plans on increasing its workforce staff. The following are activities VDH plans to pursue from July 1, 2006 through June 30, 2007.

A.1. Health Professions Shortage Designations

In March 2006, Virginia received approval to use the SDB web-based system, the Application Submission and Processing System (ASAPS), for new and updated HPSA designations. ASAPS will enable VDH to more efficiently analyze an area and its contiguous areas for primary care designations utilizing an interactive demographic and physician FTE database. Because Dental and Mental health HPSA are not currently on the ASAPS system, VDH continues to provide SDB with extensive analysis without the benefit of the SDB interactive data and mapping system.

A.2. Health Care Provider Recruitment and Retention:

In an effort to effectively and efficiently recruit health care providers for Virginia for the upcoming year, VDH will:

- continue to manage, and market its online recruitment website, Primary Practice Opportunities of Virginia. Specifically, the web site will be revamped for easier navigation and utilization;
- continue to utilize VDH national and local partners as resources to increase the awareness of VDH recruitment and retention services for the state of Virginia;
- continue its local recruitment efforts with regional AHEC Directors, who act as local resources to VDH by referring potential professional candidates;
- continue its statewide mass marketing efforts for increased utilization of PPOVA by providers and health care professionals;
- continue in the recruitment of resident physicians into primary care specialties (Family and Internal Medicine, OB/GYN and Psychiatry). Visits are planned with the medical schools throughout the state of Virginia;
- continue to utilize Practice Sights, a recruitment and retention software package. Current efforts are underway for Practice Sites training for new personnel. However, this was the second year utilizing Practice Sights, which enables candidates to enter their credentials and positions of interest online and practice sites (employers) to list practice opportunities. Current training by new personnel should result in more effective recruitment efforts by VDH recruiters as well as a more efficient management of the package. As well, there should be increased utilization of Practice Sights by professionals from expanded recruitment efforts;
- download the Physician Recruiting for Retention workbook tool to PPOVA users, which provides training to providers and community organizations; and
- create and fill a position that will assist communities in developing and implementing recruitment and retention strategies;
- develop a healthcare workforce incentives video and develop and implement marketing plan for video; and
- conduct a retention survey of healthcare providers that have utilized state and federal incentive programs.

A.3. Scholarships and Loan Repayment Programs:

The VDH will continue to administer programs that require a service obligation in the Commonwealth. These programs include the Mary Marshall Nursing Scholarship, the Health Resources Services Administration (HRSA) Bureau of Health Professions-State Loan Repayment Program (SLRP), the Virginia Physician Loan Repayment Program (VSLRP) and the National Health Service Corps' (NHSC) Loan Repayment Program.

In addition to the programs mentioned above, the VDH will:

- continue to identify and assist practice sites (employers) in Virginia who are eligible to recruit health professionals participating in the (NHSC) scholarship and loan repayment programs; and

- advise and assist health professionals with placement opportunities in Virginia where they can complete their service obligations to the NHSC.

Once the NHSC publishes the Health Professional Shortage Area (HPSA) scores for primary care, mental health, and dental health indicating where scholars are eligible to fulfill their service obligation to the corps, the VDH will:

- conduct a mass mailing to all practitioners and practice sites in areas eligible for qualification criteria for a practice site and provide a NHSC Recruitment and Retention Site Application.

A.4. Health Workforce Issues

In 1999, the General Assembly directed the Joint Commission on Health Care to review the efficiency, effectiveness, and outcomes of the Commonwealth's health workforce efforts. The resultant document, the Health Workforce Study, contained a policy option that the Joint Commission on Health Care introduces legislation directing the VDH to coordinate the Commonwealth's efforts in recruiting and retaining providers for underserved areas and populations. The following year, HB 1076 was introduced. It established VDH's health workforce duties and responsibilities, and required it to establish a Health Workforce Advisory Committee to advise it on all aspects of VDH's health workforce duties and responsibilities.

Currently, plans are being made for the next Health Workforce Advisory Committee meeting which is scheduled for September 6, 2006. This meeting will include an update of VDH's initiatives and provide information on local and statewide health workforce initiatives and seek direction for future action. Furthermore, Dr. Stephen Mick will provide a final report on the health workforce study and Secretary Marilyn Tavenner will provide an overview of Virginia's Healthcare Workforce Initiatives.

The most recent Health Workforce Advisory Committee meeting was held in August 2005. The committee listened to panel presentations discussing the Health Workforce Study and VDH Health Care Workforce Initiatives. The committee members discussed future initiatives and developed the following list of suggested activities:

1. Consider a possible tax exemption for state loan repayment program.

2. Consider obtaining money to match State Loan Repayment Program Funding.

3. Consider retention initiatives for nursing and the aging workforce, such as awards for attention – showcase, All HEDIS professions (best practices).

4. Consider reinstating the Scholarship program with different criteria, such as; award in the 4th year or make award contingent upon completion of VA residency.

5. Consider studying what each of the health disciplines is doing to retain the aging workforce.

6. Consider initiatives to address language barriers to access.

As the listing was not as comprehensive as the previous year, the group suggested forwarding all of the ideas to the Commissioner for further consideration and action. It should be noted that substantial progress has been made in addressing language barriers to access.

VIII. Conclusion

This summary document provides information on the myriad of initiatives being managed by the VDH. During the reporting period of July 1, 2005 through June 30, 2006, the VDH made significant progress towards its mission of improving access to quality health care for all Virginians. During the upcoming year, the VDH will continue to find ways to identify and address needs in a proactive and efficient manner.

Select Federal Programs using the HPSA Designation

Program Name	Description	Designation Requirements
National Health Service Corps (NHSC) • Scholarship • Loan Repayment • Recruitment	Assists medically underserved communities recruit and retain primary care clinicians, including dental and mental and behavioral health professionals, through provision of scholarships, loan repayment, and recruitment assistance.	Services must be provided in a federally designated Health Professional Shortage Area (HPSA). Priority is given to areas with highest need as measured by HPSA scores.
J-1 Visa Waiver Program	Allows for an IMG on a J-1 Visa to be sponsored for a waiver of the two-year foreign residency requirement to return to his or her home country before re-entering the US, in exchange for a minimum 3-year commitment to provide primary care health services.	Services must be provided in either a federally designated primary care HPSA (or Medically Underserved Area) or mental health HPSA for psychiatrists.
State Loan Repayment Program (SLRP)	Provides loan repayment of up to $64,000 for physicians and general dentists and $40,000 for mid-level professionals for a four-year commitment.	Services must be provided in a federally designated HPSA
Medicare Provider Incentive Payments	Centers for Medicare and Medicaid Services (CMS) gives physicians a 10% bonus payment for Medicare-reimbursable services	Services must be provided in a **geographic** primary care HPSA or **geographic** mental health HPSA for psychiatrists
Rural Health Clinic Certification	Rural Health Clinic Services Act (PL 95-210) authorizes special Medicare and Medicaid payment mechanisms. For Medicare, the payment mechanism is a modified cost-based method of payment. For Medicaid, States are mandated to reimburse Rural Health Clinics using a Prospective Payment System (PPS).	Services must be provided in a rural area with a current (within past 3 years) HPSA or MUA (not MUP) designation
Higher "Customary Charges" for New Physicians in HPSA	CMS exempts new physicians opening practices in non-metropolitan geographic HPSA's from new Medicare limitations on "customary charges.	Non-metropolitan geographic HPSA

Appendix 2

Virginia Primary Care HPSA Demographics as a Percentage within the HPSA and as a Percentage of the Total Virginia Population

	Total in Geographic HPSA	Percent Total within Geographic HPSA	Percent within Geo HPSA within Virginia	Total in Low Income HPSA*	Percent Total within Low Income HPSA	Percent within Virginia in Low Income HPSA	Total in HPSA	Percent within HPSA	Percent within Virginia in all HPSA	Total within Virginia	Percent within Virginia
TOTAL POP (SF1)	972,015		13.7%	278,066		3.9%	1,250,081		17.7%	7,078,515	
URBAN	328,317	33.8%	6.4%	151,840	54.6%	2.9%	480,157	38.4%	9.3%	5,169,955	73.0%
RURAL	643,698	66.2%	33.7%	126,226	45.4%	6.6%	769,924	61.6%	40.3%	1,908,560	27.0%
TOTAL SQ MILES	16,633		42.0%	2,076	0.7%	5.3%	18,709		47.3%	39,594	100.0%
POP / SQ MILE	58			134			67			179	
WHITE	615,291	63.3%	12.0%	157,630	56.7%	3.1%	772,921	61.8%	15.1%	5,120,110	72.3%
BLACK	333,094	34.3%	24.0%	109,033	39.2%	7.8%	442,127	35.4%	31.8%	1,390,293	19.6%
ASIAN / PACIFIC ISLE	3,950	0.4%	1.5%	1,619	0.6%	0.6%	5,569	0.4%	2.1%	264,971	3.7%
AM INDIAN / ESK/ALUTE	2,406	0.2%	11.4%	540	0.2%	2.6%	2,946	0.2%	13.9%	21,172	0.3%
OTHER	7,200	0.7%	5.2%	6,297	2.3%	4.5%	13,497	1.1%	9.7%	138,900	2.0%
TWO OR MORE RACES	10,074	1.0%	7.0%	2,947	1.1%	2.1%	13,021	1.0%	9.1%	143,069	2.0%
HISPANIC	15,212	1.6%	4.6%	11,677	4.2%	3.5%	26,889	2.2%	8.2%	329,540	4.7%
POV STAT DETERMINED (SF3)	939,389	96.6%	13.7%	266,310	95.8%	3.9%	1,205,699	96.4%	17.6%	6,844,372	96.7%
BELOW 100% POVERTY	158,355	16.9%	24.1%	44,156	16.6%	6.7%	202,511	16.8%	30.8%	656,641	9.6%
BELOW 200% POVERTY	374,786	39.9%	22.1%	104,792	39.3%	6.2%	479,578	39.8%	28.3%	1,693,145	24.7%
MALE	472,739	48.6%	13.6%	135,329	48.7%	3.9%	608,068	48.6%	17.5%	3,471,895	49.0%
FEMALE	499,276	51.4%	13.8%	142,737	51.3%	4.0%	642,013	51.4%	17.8%	3,606,620	51.0%
MALE: UNDER AGE 18	119,466	12.3%	13.4%	32,833	11.8%	3.7%	152,299	12.2%	17.1%	889,102	12.6%
FEMALE: UNDER AGE 18	114,960	11.8%	13.5%	31,888	11.5%	3.8%	146,848	11.7%	17.3%	849,160	12.0%
MALE: AGE 18 TO 64	295,729	30.4%	13.1%	85,089	30.6%	3.8%	380,818	30.5%	16.9%	2,259,992	31.9%
FEMALE: AGE 18 TO 64	302,068	31.1%	13.2%	84,371	30.3%	3.7%	386,439	30.9%	16.9%	2,287,928	32.3%
MALE: OVER AGE 65	57,544	5.9%	17.8%	17,407	6.3%	5.4%	74,951	6.0%	23.2%	322,801	4.6%
FEMALE: OVER AGE 65	82,248	8.5%	17.5%	26,478	9.5%	5.6%	108,726	8.7%	23.2%	469,532	6.6%
TOTAL: UNDER AGE 18	234,426	24.1%	13.5%	64,721	23.3%	3.7%	299,147	23.9%	17.2%	1,738,262	24.6%
TOTAL: AGE 18 TO 64	597,797	61.5%	13.1%	169,460	60.9%	3.7%	767,257	61.4%	16.9%	4,547,920	64.2%
TOTAL: OVER AGE 65	139,792	14.4%	17.6%	43,885	15.8%	5.5%	183,677	14.7%	23.2%	792,333	11.2%

Appendix 3

Status of Primary Care HPSA Designation July 1, 2005 to June 30, 2006				
Area or Facility Considered for Designation	**Area Designation**	**Type of Designation**	**Application Submission Date**	**Status of Application as of 6/30/06 (D=Designated and P=Pending at SDB)**
Amelia	Single County	Geographic	10/05/05	D-03/03/06
Appomattox	Single County	Geographic	03/06/06	P
Bath	Single County	Geographic	02/13/06	P
Bedford	Minor Civil Divisions (MCD)-Center and Peaks	Geographic	08/08/05	D-06/13/06
Bedford City	Single City	Geographic	08/08/05	D-06/13/06
Bland	Single County	Geographic	10/17/05	D-03/28/06
Botetourt	Census Tracts (CT) -401 and 402	Geographic	12/16/05	P
Campbell	CTs-204, 205, 206, 207, 208, 209	Geographic	05/16/05 (last fiscal year)	D-02/22/06
Caroline	Single County	Geographic	12/16/05	D-03/31/06
Carroll	Single County	Geographic	03/6/06	P
Chesapeake	CTs-201, 202, 203, 204, 205.01, 205.02, 206, 207, 209.03	Geographic	07/26/05	D-06/19/06
Charles City	Single County	Population-Low Income	10/28/05	P
Craig	Single County	Geographic	02/16/06	P
Danville	CTs-1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14	Population-Low Income	12/15/05	D-06/28/06
Dickenson	Single County	Geographic	10/01/05	P
Dinwiddie	Single County	Geographic	07/25/05	D-03/03/06
Essex	Single County	Geographic	10/07/05	D-04/10/06
Floyd	Single County	Geographic	02/23/06	P
Fluvanna	CTs-202, 203	Geographic	12/16/05	D-06/15/06
Franklin	Single County	Geographic	02/27/06	D-06/20/06
Grayson	Single County	Geographic	03/06/06	P
Galax City	Single City	Geographic	03/06/06	P

Status of Primary Care HPSA Designation (cont.) July 1, 2005 to June 30, 2006				
Area or Facility Considered for Designation	**Area Designation**	**Type of Designation**	**Application Submission Date**	**Status of Application as of 6/30/06 (D=Designated and P=Pending at SDB)**
Goochland	CTs-4002, 4003, 4004, and 4005	Geographic	08/03/05	D-03/02/06
Greene	Single County	Geographic	02/22/06	P
Henrico	CTs-2008.04, 2008.05, 2010.01, 2010.02, 2010.03, 2011.01, 2011.02, 2015.01	Geographic	10/26/05	P
Henry	Single County	Population-Low Income	11/29/05	P
Highland	Single County	Geographic	08/09/06	D-06/13/06
King and Queen	Single County	Geographic	02/07/06	P
King George	Single County	Geographic	10/05/05	D-04/10/06
Louisa	Single County	Geographic	03/03/06	P
Madison	Single County	Geographic	02/22/06	P
Martinsville City	Single City	Population-Low Income	11/29/05	P
New Kent	Single County	Geographic	01/31/06	P
Newport News	CTs-301, 303, 304, 305, 306, 308, 309, 311, 312, 313	Geographic	07/08/05	D-03/17/06
Norfolk	CTs-50, 51, 52, 53	Geographic	07/26/05	D-06/19/06
Northumberland	Single County	Geographic	10/07/05	D-02/16/06
Pittsylvania	CTs-108, 109, 110, 111, 112, 113, 114	Population-Low Income	12/15/05	D-06/28/06
Pittsylvania	CTs-101, 102, 103, 104, 105, 106, 107	Geographic	05/16/05 (last fiscal year)	D-02/22/06
Richmond City	CTs-601, 602, 603, 604, 605, 607, 608, 609, 706, 707, 708.01, 708.02, 709, 710.02	Geographic	07/08/05	D-12/14/05

Status of Primary Care HPSA Designation (cont.) July 1, 2005 to June 30, 2006				
Area or Facility Considered for Designation	**Area Designation**	**Type of Designation**	**Application Submission Date**	**Status of Application as of 6/30/06 (D=Designated and P=Pending at SDB)**
Richmond City	CTs-103, 104, 105, 106, 107, 108, 109, 110, 111, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 301, 302, 305, 402, 403, 404, 411, 412, 413, 414	Geographic	10/26/05	P
Richmond County	Single County	Geographic	10/07/06	D-04/10/06
Roanoke City	CTs-1, 2, 7, 8, 9, 10, 11, 23	Geographic	09/30/05	D-06/13/06
Rockbridge	MCD-Natural Bridge	Geographic	08/08/05	D-06/13/06
Russell	Single County	Geographic	09/08/05	D-02/03/06
Smyth	MCDs-North Fork and Saltville	Geographic	06/30/05 (last fiscal year)	D-02/22/06
Smyth	CTs-9907	Geographic	07/01/05	P
Surry	Single County	Geographic	08/08/05	D-06/01/06
Sussex	Single County	Population-Low Income	12/16/05	P
Washington	MCD-Jefferson	Geographic	06/30/05 (last fiscal year)	D-02/22/06
Westmoreland	Single County	Geographic	10/05/05	D-04/10/06

Appendix 4

Virginia Dental HPSA Demographics as a Percentage within the HPSA and as a Percentage of the Total Virginia Population											
	Total in Geographic HPSA	Percent Total within Geographic HPSA	Percent Total Geo HPSA within Virginia	Total in Low Income HPSA*	Percent within Low Income HPSA	Percent within Virginia in Pop HPSA	Total in HPSA	Percent within HPSA	Percent within Virginia in HPSA	Total within Virginia	Percent within Virginia
TOTAL POP (SF1)	**821,681**		**11.6%**	**347,562**		4.9%	**1,169,243**		16.5%	7,078,515	
Urban	**330,006**	40.2%	**6.4%**	**191,682**	55.2%	3.7%	**521,688**	44.6%	10.1%	5,169,955	73.0%
Rural	**491,675**	59.8%	**25.8%**	**155,880**	44.8%	8.2%	**647,555**	55.4%	33.9%	1,908,560	27.0%
Total Sq Miles	**11,148**		**28.2%**	**3,663**		9.3%	**14,810**		37.4%	39,594	100.0%
Pop/Sq Mile	**74**			**95**			79			179	
WHITE	**517,680**	63.0%	**10.1%**	**266,098**	76.6%	5.2%	**783,778**	67.0%	15.3%	5,120,110	72.3%
BLACK	**283,620**	34.5%	**20.4%**	**73,064**	21.0%	5.3%	**356,684**	30.5%	25.7%	1,390,293	19.6%
ASIAN/PACIFIC ISLE	**3,924**	0.5%	**1.5%**	**2,193**	0.6%	0.8%	**6,117**	0.5%	2.3%	264,971	3.7%
AM INDIAN/ESK/ALUTE	**1,989**	0.2%	**9.4%**	**761**	0.2%	3.6%	**2,750**	0.2%	13.0%	21,172	0.3%
OTHER	**6,832**	0.8%	**4.9%**	**1,688**	0.5%	1.2%	**8,520**	0.7%	6.1%	138,900	2.0%
TWO OR MORE RACES	**7,636**	0.9%	**5.3%**	**3,758**	1.1%	2.6%	**11,394**	1.0%	8.0%	143,069	2.0%
HISPANIC	**13,323**	1.6%	**4.0%**	**4,281**	1.2%	1.3%	**17,604**	1.5%	5.3%	329,540	4.7%
POV STAT DETERMINED (SF3)	**794,718**	96.7%	**11.6%**	**327,892**	94.3%	4.8%	**1,122,610**	96.0%	16.4%	**6,844,372**	**96.7%**
BELOW 100% POVERTY	**136,672**	16.6%	**20.8%**	**46,823**	13.5%	7.1%	**183,495**	15.7%	27.9%	**656,641**	**9.6%**
BELOW 200% POVERTY	**312,882**	38.1%	**18.5%**	**115,766**	33.3%	6.8%	**428,648**	36.7%	25.3%	**1,693,145**	**24.7%**
MALE	**397,831**	48.4%	**11.5%**	**167,776**	48.3%	4.8%	**565,607**	48.4%	16.3%	3,471,895	49.0%
FEMALE	**423,850**	51.6%	**11.8%**	**179,786**	51.7%	5.0%	**603,636**	51.6%	16.7%	3,606,620	51.0%
MALE: UNDER AGE 18	**100,090**	12.2%	**11.3%**	**41,103**	11.8%	4.6%	**141,193**	12.1%	15.9%	889,102	12.6%
FEMALE: UNDER AGE 18	**96,620**	11.8%	**11.4%**	**39,162**	11.3%	4.6%	**135,782**	11.6%	16.0%	849,160	12.0%
MALE: AGE 18 TO 64	**250,399**	30.5%	**11.1%**	**105,904**	30.5%	4.7%	**356,303**	30.5%	15.8%	2,259,992	31.9%
FEMALE: AGE 18 TO 64	**257,970**	31.4%	**11.3%**	**109,557**	31.5%	4.8%	**367,527**	31.4%	16.1%	2,287,928	32.3%
MALE: OVER AGE 65	**47,342**	5.8%	**14.7%**	**20,769**	6.0%	6.4%	**68,111**	5.8%	21.1%	322,801	4.6%
FEMALE: OVER AGE 65	**69,260**	8.4%	**14.8%**	**31,067**	8.9%	6.6%	**100,327**	8.6%	21.4%	469,532	6.6%
TOTAL: UNDER AGE 18	196,710	23.9%	**11.3%**	80,265	23.1%	4.6%	276,975	23.7%	15.9%	1,738,262	24.6%
TOTAL: AGE 18 TO 64	508,369	61.9%	**11.2%**	215,461	62.0%	4.7%	723,830	61.9%	15.9%	4,547,920	64.2%
TOTAL: OVER AGE 65	116,602	14.2%	**14.7%**	51,836	14.9%	6.5%	168,438	14.4%	21.3%	792,333	11.2%

Appendix 5

Status of Dental HPSA Designation July 1, 2005 to June 30, 2006				
Area or Facility Considered for Designation	**Area Designation**	**Type of Designation**	**Application Submission Date**	**Status of Application as of 6/30/06 (D=Designated and P=Pending at SDB)**
Accomack	Single County	Geographic	07/08/05	D-03/08/06
Amherst	Single County	Geographic	07/28/05	D-11/04/05
Appomattox	Single County	Geographic	02/07/06	P
Bedford	Single County	Geographic	07/26/05	D-12/19/05
Bedford City	Single City	Geographic	07/26/06	D-12/19/05
Brunswick	Single County	Geographic	03/27/06	P
Buchanan	Single County	Geographic	03/27/06	P
Buckingham	Single County	Geographic	02/07/06	P
Campbell	Single County	Population-Low Income	08/24/05	D-03/17/06
Charlotte	Single County	Geographic	07/28/05	D-12/13/05
Cumberland	Single County	Geographic	11/16/05	D-04/12/06
Dickenson	Single County	Geographic	06/14/05 (last fiscal year)	D-01/17/06
Dinwiddie	Single County	Geographic	03/27/06	P
Essex	Single County	Geographic	12/09/05	P
Floyd	Single County	Geographic	02/07/06	P
Halifax/South Boston	Single County	Geographic	03/27/06	D-06/16/06
Henrico	CTs-2008.04, 2008.05, 2010.01, 2010.02, 2010.03, 2011.01, 2011.02, 2015.01	Geographic	09/23/05	05/02/06
Highland	Single County	Population-Low Income	09/19/05	D-02/03/06
King George	Single County	Geographic	02/07/06	P
Lee	Single County	Geographic	03/27/06	D-06/16/06
Lunenburg	Single County	Geographic	02/21/06	P
Lynchburg City	Single City	Population-Low Income	08/24/05	D-03/17/06
Mecklenburg	Single County	Geographic	03/27/06	P

Status of Dental HPSA Designation (cont.) July 1, 2005 to June 30, 2006				
Area or Facility Considered for Designation	**Area Designation**	**Type of Designation**	**Application Submission Date**	**Status of Application as of 6/30/06 (D=Designated and P=Pending at SDB)**
Nelson	Single County	Geographic	03/27/06	P
Newport News	CTs-301, 303, 304, 305, 306, 308, 309, 313	Population-Low Income	03/28/06	P
Northampton	Single County	Geographic	07/08/05	D-03/08/06
Norton	Single City	Geographic	03/30/06	P
Nottoway	Single County	Geographic	02/07/06	P
Page	Single County	Geographic	03/29/06	P
Patrick	Single County	Geographic	03/30/06	P
Portsmouth City	CTs-2105, 2107, 2111, 2114, 2117, 2118, 2119, 2120, 2121, 2126, 2127.01, 2127.02	Population-Low Income	03/30/6	P
Prince Edward	Single County	Population-Low Income	11/16/05	D-04/12/06
Richmond City	CTs-103, 104, 105, 106, 107, 108, 109, 110, 111, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 301, 302, 305, 402, 403, 404, 411, 412, 413, 414, 601, 602, 603, 604, 605, 607, 608, 609, 706, 707, 708.01, 708.02, 709, 710.01, 710.02	Geographic	09/23/05	D-05/02/06
Richmond County	Single County	Geographic	12/09/05	P
Russell	Single County	Geographic	03/30/06	P
Shenandoah	Single County	Geographic	10/27/06	D-04/07/06

Status of Dental HPSA Designation (cont.) July 1, 2005 to June 30, 2006				
Area or Facility Considered for Designation	**Area Designation**	**Type of Designation**	**Application Submission Date**	**Status of Application as of 6/30/06 (D=Designated and P=Pending at SDB)**
Surry	Single County	Geographic	02/21/06	P
Sussex	Single County	Geographic	02/21/06	P
Tazewell	Single County	Population-Low Income	03/30/06	P
Warren	Single County	Geographic	03/30/06	P
Wise	Single County	Geographic	03/30/06	P

Appendix 6

Virginia Mental Health HPSA Demographics as a Percentage within the HPSA and as a Percentage of the Total Virginia Population

	Total in Geographic HPSA	Percent Total within Geographic HPSA	Percent Total Geo HPSA within Virginia	Total in Low Income HPSA*	Percent within Low Income HPSA	Percent within Virginia in Pop HPSA	Total in HPSA	Percent within HPSA	Percent within Virginia in HPSA	Total within Virginia	Percent within Virginia
TOTAL POP (SF1)	**1,579,007**		22.3%	**97,659**		1.4%	**1,676,666**		23.7%	7,078,515	
Urban	**509,757**	32.3%	9.9%	**97,659**	100.0%	1.9%	**607,416**	36.2%	11.7%	5,169,955	73.0%
Rural	**1,069,250**	67.7%	56.0%	0	0.0%	0.0%	**1,069,250**	63.8%	56.0%	1,908,560	27.0%
Total Sq Miles	22,431		56.7%	26.0		0.1%	22,457		56.7%	39,594	100.0%
Pop/Sq Mile	70.4			**3753.8**			74.7			179	
WHITE	**1,237,039**	78.3%	24.2%	**35,294**	36.1%	0.7%	**1,272,333**	75.9%	24.8%	5,120,110	72.3%
BLACK	**301,687**	19.1%	21.7%	**58,244**	59.6%	4.2%	**359,931**	21.5%	25.9%	1,390,293	19.6%
ASIAN/PACIFIC ISLE	**10,358**	0.7%	3.9%	**1,559**	1.6%	0.6%	**11,917**	0.7%	4.5%	264,971	3.7%
AM INDIAN/ESK/ALUTE	**3,518**	0.2%	16.6%	**276**	0.3%	1.3%	**3,794**	0.2%	17.9%	21,172	0.3%
OTHER	**11,736**	0.7%	8.4%	**619**	0.6%	0.4%	**12,355**	0.7%	8.9%	138,900	2.0%
TWO OR MORE RACES	**14,669**	0.9%	10.3%	**1,667**	1.7%	1.2%	**16,336**	1.0%	11.4%	143,069	2.0%
HISPANIC	**27,383**	1.7%	8.3%	**1,407**	1.4%	0.4%	**28,790**	1.7%	8.7%	329,540	4.7%
POV STAT DETERMINED (SF3)	**1,514,547**	95.9%	22.1%	**92,684**	94.9%	1.4%	**1,607,231**	95.9%	23.5%	**6,844,372**	**96.7%**
BELOW 100% POVERTY	**210,512**	13.3%	32.1%	**25,579**	26.2%	3.9%	**236,091**	14.1%	36.0%	**656,641**	**9.6%**
BELOW 200% POVERTY	**528,781**	33.5%	31.2%	**48,971**	50.1%	2.9%	**577,752**	34.5%	34.1%	**1,693,145**	**24.7%**
MALE	**777,748**	49.3%	22.4%	**45,735**	46.8%	1.3%	**823,483**	49.1%	23.7%	3,471,895	49.0%
FEMALE	**801,259**	50.7%	22.2%	**51,924**	53.2%	1.4%	**853,183**	50.9%	23.7%	3,606,620	51.0%
MALE: UNDER AGE 18	**181,376**	11.5%	20.4%	**11,816**	12.1%	1.3%	**193,192**	11.5%	21.7%	889,102	12.6%
FEMALE: UNDER AGE 18	**173,248**	11.0%	20.4%	**11,818**	12.1%	1.4%	**185,066**	11.0%	21.8%	849,160	12.0%
MALE: AGE 18 TO 64	**499,722**	31.6%	22.1%	**29,522**	30.2%	1.3%	**529,244**	31.6%	23.4%	2,259,992	31.9%
FEMALE: AGE 18 TO 64	**489,924**	31.0%	21.4%	**32,291**	33.1%	1.4%	**522,215**	31.1%	22.8%	2,287,928	32.3%
MALE: OVER AGE 65	**96,650**	6.1%	29.9%	**4,397**	4.5%	1.4%	**101,047**	6.0%	31.3%	322,801	4.6%
FEMALE: OVER AGE 65	**138,087**	8.7%	29.4%	**7,815**	8.0%	1.7%	**145,902**	8.7%	31.1%	469,532	6.6%
TOTAL: UNDER AGE 18	354,624	22.5%	20.4%	23,634	24.2%	1.4%	378,258	22.6%	21.8%	1,738,262	24.6%
TOTAL: AGE 18 TO 64	989,646	62.7%	21.8%	61,813	63.3%	1.4%	1,051,459	62.7%	23.1%	4,547,920	64.2%
TOTAL: OVER AGE 65	234,737	14.9%	29.6%	12,212	12.5%	1.5%	246,949	14.7%	31.2%	792,333	11.2%

Appendix 7

Status of Mental HPSA Designation July 1, 2005 to June 30, 2006				
Area or Facility Considered for Designation	**Area Designation**	**Type of Designation**	**Application Submission Date**	**Status of Application as of 6/30/06 (D=Designated and P=Pending at SDB)**
Amelia	Crossroads Mental Health Catchment Area (MHCA) 9	Geographic	08/10/06	D-06/01/06
Buckingham	Crossroads MHCA 9	Geographic	08/10/06	D-06/01/06
Charlotte	Crossroads MHCA 9	Geographic	08/10/06	D-06/01/06
Chesapeake	Chesapeake/Norfolk-CTs 0205.01, 0206.00, 0202.00, 0209.03, 0204.00, 0203.00, 0207.00, 0205.02, 0201.00	Geographic	08/17/06	P
Clarke	Northwest MHCA 27	Geographic	11/28/05	D-06/19/06
Cumberland	Crossroads MHCA 9	Geographic	08/10/06	D-06/01/06
Danville City	Planning District XII	Geographic	03/01/05 (last fiscal year)	D-03/14/06
Floyd	New River Valley MHCA 25	Geographic	08/23/05	D-03/02/06
Franklin	Planning District XII	Geographic	03/01/05 (last fiscal year)	D-03/14/06
Frederick	Northwest MHCA 27	Geographic	11/28/05	D-06/19/06
Giles	New River Valley MHCA 25	Geographic	08/23/05	D-03/02/06
Henry	Planning District XII	Geographic	03/01/05 (last fiscal year)	D-03/14/06
Lee	Lenowisco	Geographic	08/09/05	D-06/01/06
Lunenburg	Crossroads MHCA 9	Geographic	08/10/06	D-06/01/06
Martinsville City	Planning District XII	Geographic	03/01/05 (last fiscal year)	D-03/14/06

Status of Mental HPSA Designation July 1, 2005 to June 30, 2006				
Area or Facility Considered for Designation	**Area Designation**	**Type of Designation**	**Application Submission Date**	**Status of Application as of 6/30/06 (D=Designated and P=Pending at SDB)**
Norfolk	Chesapeake/Norfolk-CTs 50, 51, 52, 53	Geographic	08/17/06	P
Norton City	Lenowisco	Geographic	08/09/05	D-06/01/06
Nottoway	Crossroads MHCA 9	Geographic	08/10/06	D-06/01/06
Page	Northwest MHCA 27	Geographic	11/28/05	D-06/19/06
Patrick	Planning District XII	Geographic	03/01/05 (last fiscal year)	D-03/14/06
Pittsylvania	Planning District XII	Geographic	03/01/05 (last fiscal year)	D-03/14/06
Prince Edward	Crossroads MHCA 9	Geographic	08/10/06	D-06/01/06
Pulaski	New River Valley MHCA 25	Geographic	08/23/05	D-03/02/06
Radford City	New River Valley MHCA 25	Geographic	08/23/05	D-03/02/06
Richmond City	CTs 0109, 0110, 0201, 0204, 0205, 0206, 0207, 0208, 0301, 0302, 0303, 0304, 0305, 0403, 0404, 0405, 0406, 0407	Population-Homeless	09/08/05	D-12/02/05
Shenandoah	Northwest MHCA 27	Geographic	11/28/05	D-06/19/06
Scott	Lenowisco	Geographic	08/09/05	D-06/01/06
Warren	Northwest MHCA 27	Geographic	11/28/05	D-06/19/06
Winchester	Northwest MHCA 27	Geographic	11/28/05	D-06/19/06
Wise	Lenowisco	Geographic	08/09/05	D-06/01/06

Appendix 8

J-1 Visa Waiver Requests July 1, 2005 to June 30, 2006				
Location	**Specialty**	**VDH Waiver Request Date**	**DOS Approval** (as of 6/30/06)	**Non-Designated Slot (√)**
Richmond City	Family Practice	7/20/05	08/10/2005	
Northampton	Internal Medicine	7/20/05	08/10/2005	
Richmond City	Neurologist	9/27/05	10/3/2005	√
Mecklenburg	Neurology	11/29/05	12/19/05	
Richmond City	Cardiologist	02/03/06	04/04/06	
Lee County	Pediatrician	12/16/05	01/13/06	
Halifax County	Hematologist/Oncologist	02/24/06	03/27/06	
Fredericksburg	Pediatric Cardiologist	02/03/06	03/01/06	√
Winchester	Pediatric Cardiologist	02/06/06	03/02/06	√
Prince George	Psychiatrist	05/08/06	06/06/06	
Charlottesville	Pediatric Cardiologist	06/14/06	P	√
Richmond City	Pathologist	05/05/06	06/06/06	√
Petersburg	Internal Medicine/ Infectious Disease	06/14/06	07/20/06	
Russell City	Internal Medicine	06/14/06	07/20/06	

√ = pending DOS approval as of this reporting period.

National Interest Waiver July 1, 2005 to June 30, 2006		
Location	**Specialty**	**VDH Waiver Request Date**
Amherst	Family Practice	02/07/06
Roanoke City	Psychology	02/07/06

Appendix 9

VDH Partners

July 1, 2005 to June 30, 2006

Partner	Services and Accomplishments
Virginia AHECs **Virginia Primary Care Association**	**Recruitment and Retention (http://www.ppova.org):** Primary Practice Opportunities is an interactive web site displaying practice opportunities for physicians, nurse practitioners and physician assistants. The site offers links to information and resources to assist health care practitioners who are considering practicing in Virginia.
	Accomplishments During the Reporting period ▪ Ongoing review and revision to the content of the PPOVA web site to make it more user-friendly; ▪ Implemented an electronic application submission process in order to integrate the efforts of the VDH Health Workforce and Minority Health Manager with the web-based PPOVA; and ▪ Track correspondence with applicants to assure timely updates of all applicant information.
Northern Virginia AHEC	**Multicultural Health:** This collaboration with the Northern Virginia Area Health Education Center (NVAHEC) has strengthened NVAHEC's Education and Training Program and in turn, has enhanced the capacity of health care providers in Virginia to provide culturally and linguistically appropriate health care services. This training program. The NVAHEC provides training to bilingual individuals in professional interpretation, trains professionals on how to communicate through interpreters, trains professionals and others on issues related to cultural competence, and in this past year has begun training trainers of professional interpreters.

	Accomplishments during the reporting period: The NVAHEC continues to provide language access services which included: ▪ interpretation services to health and human service agencies (over 4,000 hours) ▪ translation services to health and human service agencies (over 75 documents) ▪ language proficiency testing to bilingual individuals hoping to serve as interpreters (over 150 tests administered) ▪ health care interpreter training (over 75 students trained) ▪ how to communicate effectively through an interpreter training (over 300 students trained) ▪ development of interpreter training curriculum for volunteers with the Virginia Medical Reserve Corp. Additionally, as described previously, VDH has contracted with the NVAHEC to develop educational materials (both web-based and hard copy formats) targeted at refugees and immigrants to assist them in navigating the western health care system. A training curriculum is also being developed by the NVAHEC to help individuals, agencies and organizations who work with refugees and immigrants teach their clients on how to use the materials. These materials are slated for completion in October 2006.
Partner	**Services and Accomplishments**
Network for Latino People	The Virginia Department of Health (VDH) is a major partner and member organization of the Network for Latino People (NFLP). Other representation includes organizations from social services, public schools, police department, faith based organizations, the Hispanic Chamber of Commerce, the American Red Cross (Colonial Chapter) and many others. The goal of NFLP is to support a community coalition to address the effective provision of services, particularly health services, to the growing Latino population, as well as to provide training overcoming barriers to the provision of those services and to identify and address the diverse needs of low and moderate income families.
	Accomplishments during the reporting year: The NFLP has made tremendous advances this year to include: • Hiring a Network Coordinator to complete the work of the coalition; • Organizational membership expansion of NFLP; • Increasing the availability of translators available to community service providers. The number of volunteer Spanish translators to assist in the delivery of medical services and the number of translators working in community settings have increased; • Conducting events to increase community understanding of immigration rights and culturally sensitive services such as two (2) training sessions on Immigrant's Rights to Services in Virginia in July and November 2005, with attorneys Jill Hanken from the

	Virginia Poverty Law Center and Dustin Dyer, an expert in immigration law, for interested community organizations and individuals; • Sponsoring an "Information Night" for Spanish families in May 2006 to provide information about community needs in Spanish; and • Organizing a school-drive in August 2005 to provide school supplies to needy families and an immunization clinic in June to ensure that children were properly immunized before school enrollment.
Virginia Primary Care Association	**Access to Health Care** The Virginia Primary Care Association (VPCA) and the VDH, jointly work on issues relating to improving access to primary care services throughout the Commonwealth. Over the last year these efforts have included the refinement within the primary care setting, the integration of health professional recruitment efforts and assistance with the Health Professional Shortage Area Designations.
	Accomplishments During the Reporting period: • Maintained a collaborative recruitment effort with the VDH to assure effective recruitment of National Health Service Corp and J-1 Visa waiver physicians. • Developed a methodology for prioritizing the Health Professional Shortage Designation process and assist the VDH with data collection for designations.

Appendix 10

Recruitment and Placement of Health Care Providers – July 1, 2005 to June 30, 2006

City	Specialty									
Abingdon	EM	GE	HOS	ON	ORTHO	PA				
Big Stone Gap	UROL									
Boydton	PHARM									
Burkeville	FNP									
Callao	FP									
Catawba	PSY									
Clintwood	FNP	FP								
Damascus	IM	FNP								
Farmville	PED									
Fredericksburg	FP									
Fries	FP									
Galax	CARD	EM	HOS	ORTHO	OTO					
Grundy	ORTHO									
Hot Springs	FP									
Independence	FP									
Kilmarnock	FP									
Lawrenceville	PNP									
Lebanon	ANES	FP	GS	IM	ORTHO	UROL				
Leesburg	PSY									
Lexington	FNP	FP	IM							
Lynchburg	PA									
Marion	HOS	PED	PSY	FNP						
Monterey	DDS	FP								
Nassawadox	PED									
Newport News	DENTAL HYG									
North	ORTHO									
Norton	CARD	EM	ENT	FP	GE	GS	IM	OTO	RAD	UROL
Palmyra	PHARM									
Pennington Gap	FP	GS	ORTHO							
Pennington Gap										
Pennington Gap										
Richlands	FNP	IM	ORTHO							
Richmond	DDS									
Roanoke	FP									
Saltville	FNP	FP	IM							
Smithfield	FP									
South Hill	FP	HOS	OTO	UROL						
Stuart	IM									
Tazewell	IM	UROL								
Vansant	FNP									
Vansant	FP									
Victoria	FP	PA/FNP								
White Stone	FP									
Winchester	FNP									

Recruitment and Retention Health Care Providers (cont.) Medical Specialty Codes			
ID	**Area**	**Type**	**Code**
1	Physician	Family/General Practice	FP
2	Physician	Internal Medicine	IM
3	Physician	Pediatrics	PD
4	Physician	Obstetrics/Gynecology	OB
6	Physician	Other Primary Care Physician	OP
7	Nurse Practitioner	Family/General Practice	FNP
8	Nurse Practitioner	Pediatrics	PNP
9	Nurse Practitioner	Adult	ANP
10	Nurse Practitioner	Certified Nurse Midwife	CNM
11	Nurse Practitioner	Geriatric	GNP
12	Nurse Practitioner	Other Primary Care Nurse Practitioner	ONP
13	Physician Assistant	Primary Care	PA
14	Physician	Anesthesiology	ANS
15	Physician	Cardiology	CRD
16	Physician	Psychiatry	PSY
17	Physician	Ear, Nose & Throat	ENT
18	Physician	General Surgery	GS
19	Physician	Hospitalist	HOS
20	Physician	Geriatrics	GER
23	Physician	Certified Nurse Anesthetist	CN
24	Physician	Dentist	DEN
25	Physician	Emergency Medicine	EM
26	Nurse Practitioner	Psychiatric Nurse Practitioner	PSNP
27	Physician	Otolaryngology	OTO
28	Physician	Radiologist	RAD
29	Physician	Gastroenterology	GAS
30	Physician	Orthopedics	ORT
31	Physician	Urology	URO
32	Physician	Oncologist	ON

Appendix 11

Practice Site Locations of Participants in the Bureau of Health Professions – State Loan Repayment Program (SLRP), Virginia Medical Loan Repayment Program (VLRP), and the Federal National Health Service Corps (NHSC) July 1, 2005 to June 30, 2006		
Location of Facility	**Specialty**	**Program Type**
Accomack County	Pediatrics	SLRP
Alleghany County	Family Practice	VLRP
Bristol City	Family Practice	NHSC
Caroline County	Internal Medicine	NHSC
Carroll County – Galax	Internal Medicine	VLRP
Cumberland County	Family Practice	SLRP
Cumberland County	Family Practice	VLRP
Danville City	Family Practice	SLRP
Danville City	Family Practice	VLRP
Danville City	Physician Assistant	VLRP
Dickenson County	Nurse Practitioner	SLRP
Dickenson County	Internal Medicine	VLRP
Fluvanna County	Internal Medicine/Pediatrics (2)	SLRP
Fluvanna County	Internal Medicine	SLRP
Franklin County	Internal Medicine	VLRP
Greenville County – Jarrett	Physician Assistant	VLRP
King William County	Family Practice	VLRP
Lee County	Dentistry	NHSC
Marion County	Psychiatry	SLRP
Nassawadox County	Nurse Practitioner	VLRP
Nelson County	Family Practice	SLRP
Nelson County	Family Practice	NHSC
Nelson County	Psychiatry	SLRP
Newport News City	Family Practice/ OB/GYN	VLRP
Newport News City	Family Practice	VLRP
Northampton County	Adult Nurse Practitioner	NHSC
Wise County - Norton City	Internal Medicine	VLRP
Wise County - Norton City	OB/GYN	VLRP
Wise County - Norton City	Pediatrics	VLRP
Pittsylvania County	Family Practice (2)	SLRP
Pittsylvania County	Family Practice	VLRP
Richmond City	Pediatrics	VLRP
Richmond City	Psychiatry	VLRP
Richmond City	Physician Assistant	VLRP

Practice Site Locations of Participants in the Bureau of Health Professions – State Loan Repayment Program (SLRP), Virginia Medical Loan Repayment Program (VLRP), and the Federal National Health Service Corps (NHSC) July 1, 2005 to June 30, 2006		
Richmond County	Family Practice	VLRP
Russell County	Family Practice (2)	VLRP
Russell County	Physician Assistant	VLRP
Caroline County - Ruther Glen	Pediatrics	VLRP
Smyth County	Family Practice	NHSC
Suffolk County	Family Practice/Internal Medicine	VLRP
Tazewell County	Nurse Practitioner	VLRP
Tazewell County - Richland	Nurse Practitioner (2)	VLRP
Washington County	Internal Medicine	SLRP
Washington County	Internal Medicine	VLRP
Westmoreland County-Dahlgren	Physician Assistant	VLRP
Wise County	Family Practice	VLRP
Wythe County	Family Practice	VLRP
Wythe County – Wytheville City	Family Practice	VLRP