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ABSTRACT

Proceedings of the November 1986 Workshop on Health Manpower Shortage Area (HMSA) Designation are presented. The workshop was designed to facilitate cooperative efforts among the different federal and state health agencies that are involved in the planning and delivery of health care services. The purpose of the workshop was to improve understanding and use of the HMSA designation criteria and guidelines and to solicit recommendations on how to improve the process and procedures. Contents include: a review of the mission and organization of the Health Resources and Services Administration, background information on health manpower shortage area designation, the current criteria for designating shortage areas, and the role of state agencies. Additional contents cover: trends in the geographic distribution and diffusion of physicians and the projected impact on the number of HMSAs and number needed; the involvement of the American Medical Association in the HMSA review process; problems with HMSA designation; federal and state programs related to HMSA designation; professional association involvement in the HMSA review process; and current efforts at revising HMSA criteria and guidelines. The workshop agenda and a list of participants are appended. (SW)

HEALTH MANPOWER SHORTAGE AREA DESIGNATION WORKSHOP

VOLUME I

NEW ORLEANS, LOUISIANA
NOVEMBER 5-7, 1986

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Health Resources and Services Administration
Bureau of Health Professions
Office of Data Analysis and Management

ODAM Report No. 7-87

PREFACE

The Office of Data Analysis and Management (ODAM) of the Health Resources and Services Administration's (HRSA) Bureau of Health Professions (BHPr) sponsored workshops on Designation of Health Manpower Shortage Areas (HMSAs) in November 1986 and March 1987. The purpose of these workshops was to improve understanding and use of the HMSA designation criteria and guidelines and to solicit recommendations on how to improve the process and procedures. Attendees included Federal and State representatives involved in the HMSA review process as well as professional association representatives who provided information on practitioner data resources.

This volume presents the proceedings of the first of the two HMSA workshops held in New Orleans on November 5-7, 1986. The workshop was co-chaired by Howard V. Stambler, Director of ODAM, and Richard C. Lee, Chief of the Distribution and Shortage Analysis Branch of ODAM. Administrative and logistical services and proceedings of the workshop were provided by HCR, Inc., under contract to the Bureau of Health Professions of HRSA. Barbara Robinson, vice president and Suzanne Lirette served as co-project directors for HCR. Philip C. Salladay of ODAM was the project officer for the contract.

Thomas D. Hatch
Director
Bureau of Health Professions

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INTRODUCTION

The Bureau of Health Professions of the Health Resources and Services Administration (HRSA) sponsored a Workshop on Health Manpower Shortage Designations. The workshop was held from November 5-7, 1986 at the Sheraton Hotel in New Orleans, Louisiana. It was attended by representatives from the state health and health planning agencies in Regions III, IV, V, VI and VII; Bureau of Health Professions, HRSA; Bureau of Health Care Delivery and Assistance and professional health associations. A list of participants who attended the workshop is presented in Appendix A.

The program for designating areas in which shortages of health manpower exist is administered by the Office of Data Analysis and Management under the Bureau of Health Professions. The success of the designation process and its effectiveness in alleviating health manpower shortages is dependent on the interaction among the different Federal and state health agencies involved in the planning and delivery of health care services. Thus, the purpose of the workshop was to facilitate cooperative efforts among these groups in achieving this goal.

The workshop was chaired by Howard V. Stambler, Director of the Office of Data Analysis and Management of the Bureau of Health Professions of the Health Resources and Services Administration, and Richard C. Lee, Chief of the Distribution and Shortage Analysis Branch. Presentations included a review of HRSA's mission and organization, background on shortage area designation, the current criteria for designating shortage areas and the role of state agencies. A copy of the workshop agenda is contained in Appendix B.

Following are the proceedings of the Workshop on Health Manpower Shortage Area Designation.

WORKSHOP PROCEEDINGS

WELCOME AND INTRODUCTORY REMARKS
OVERVIEW OF ODAM/BHPr/HRSA
ORGANIZATION AND FUNCTIONS

Howard V. Stambler
Director
Office of Data Analysis and Management
Bureau of Health Professions

MR. STAMBLER: Good morning. My name is Howard Stambler. I am the Director of the Office of Data Analysis and Management of the Bureau of Health Professions, Health Resources and Services Administration. The purpose of this workshop is to foster a better understanding of the Health Manpower Shortage Area designation program. We will explain our activities (for example, how we identify shortage areas, what quarrels we have with the data) and will welcome your feedback on issues and concerns.

The workshop is on Health Manpower Shortage Areas, or HMSAs. This is the first of the acronyms that we will be using. HMSAs are the officially designated areas for many purposes, particularly for the National Health Service Corps and placement of obligated scholars and volunteers.

We have a number of other acronyms that you may hear us use. We have, starting from the top down, HHS, which is the Department of Health and Human Services. A major subdivision is the PHS or Public Health Service. HRSA, which is probably new to many of you, is the Health Resources and Services Administration. HRSA is part of the Public Health Service and its newest component.

Speaking of the Department of HHS, we have a new Secretary of Health and Human Services, Dr. Otis Bowen, who is an MD from Indiana. Dr. Bowen was formerly Governor of Indiana and has taken over the department with a very specific agenda in mind. He has discussed his plans publicly and has already touched base with other departments and with major organizations, associations, etc. So, we look forward to new initiatives coming out of HHS.

The Public Health Service also has a new head, Assistant Secretary for Health Dr. Robert E. Windham. Dr. Windham, who is from Sarasota, Florida, is fairly recent in terms of holding government office. He taught and was a practicing MD before taking over the reins at PHS.

Now to the Health Resources and Services Administration. HRSA, as I mentioned, is fairly new and is one of the five agencies of the Public Health Service. The others, which are generally much better known, are the Centers for Disease Control, the Food and Drug Administration, the Alcohol, Drug Abuse and Mental Health Administration, and the National Institutes of Health.

HRSA is also under new leadership. Dr. Robert Graham, our former head, is now the executive director of the American Academy of Family Practice. Our new administrator is Dr. David Sundwall, an MD from Utah. David is a very important addition to HRSA. He worked for Senator Hatch, on the Senate Labor and Human Resources Committee. He has had a great deal to do with all of the legislation that covers our programs, as well as for a number of other health programs.

Having a new assistant secretary and head of the department gives everyone an opportunity to move in a direction that is now, hopefully, going to be set for a while. Our mandate is much clearer, and I think we will be able to do our work in HRSA much more effectively.

Within HRSA, there are four major groups. The Indian Health Service (IHS) provides health care to native Americans, on the reservation and in other locations. The Bureau of Health Care Delivery and Assistance (BHCDA) supports the community health centers and maternal and child health and National Health Service Corps programs. We work very closely with the National Health Service Corps but, as you will hear later, our responsibilities are quite different. A third group, now called the Bureau of Resources Development, has changing responsibilities at this time, as Congress recently eliminated its planning activities with state agencies. The final component of the HRSA is the Bureau of Health Professions (BHPr), of which we are a part. This bureau provides support, funding, grants and contracts for the development of resources needed to staff the health care system.

BHPr had, at one time, about a half-billion dollar budget, mainly to increase the supply of physicians, dentists and nurses. Now the budget has been significantly reduced and the programs are aimed more at alleviating geographic maldistribution, and supporting education and training in primary care for minorities; generally, the goal is to improve the quality of care as opposed to just creating additional numbers.

The bureau has three major categorical units -- these are the Division of Nursing, Division of Medicine and Division of Associated and Dental Health Professions. This set of three divisions basically provides grants and funding and reviews the awards. Another part of BHPr is functional in nature, providing a variety of services (such as data processing, debt management) which supports the bureau broadly.

We have people in our office, the Office of Data Analysis and Management (ODAM), who handle databases for a number of the programs. We maintain information on the bureau's programs, the awards, etc. Many of the information systems are analytically oriented, and some of you may have heard of the Area Resource File. This is one of the major databases used throughout the government to analyze health manpower, health services and a variety of health activities.

We also do a number of other things, not the least of which is the health manpower shortage area designation. ODAM has a variety of its own analytical responsibilities in the bureau, and provides technical assistance for all of the Bureau's analytical programs. We have a modeling and research branch that does forward-looking modeling on an econometric basis, developing models that will help us predict supply, requirements and geographic distribution.

Besides the Information Systems Branch, there is a Debt Management Branch that basically tracks individuals who have obtained loans under the Health Profession Student Loan Progam and tries to get the money back. This is one of the major thrusts of the whole area of loans and scholarships now -- to get the money repaid or to obtain the promised services.

Finally, there is the Distribution and Shortage Analysis Branch (DSAB). This is the part of the Office of Data Analysis and Management that is responsible for the health manpower shortage area designation. DSAB develops the criteria and works with you to determine the proper identification of shortage areas. This activity is essentially analytical. Dick Lee, who is the chief of the branch, must see that areas are designated based on published data, statistics and criteria.

DSAB's analytical function has been intentionally separated from the other programs that actually place the physicians, including the National Health Service Corps. Many years ago it was deemed appropriate first to identify the areas and then take into consideration other determining factors, such as receptivity of the local community, cooperation of the medical and dental societies, needs of the individual physicians, etc. This separation of functions has continued, although the letters we receive from members of Congress and the public, reflect some confusion about our mission. Correspondents often do not recognize the difference between ODAM and BHPr and the Bureau of Health Care Delivery and Assistance (BHCDA) and the National Health Service Corps. The Corps works with us; they do not designate the shortage areas, this office does. The separation of our activities has worked well for more than a decade. This is an important point.

Our next speaker will have more to say about the designation process, and will give us some background on it. Let me introduce Dick Lee, chief of the Distribution Shortage Analysis Branch.

PRESENTATION: BACKGROUND AND OVERVIEW
OF HMSA DESIGNATION AND WORKSHOP

Richard C. Lee
Chief, Distribution Shortage Analysis Branch
Bureau of Health Professions

Wednesday, November 5, 1986

MR. LEE: Thank you. We are delighted to have you all here.

The Health Manpower Shortage Area designations, as we know them today, were authorized by the Health Professions Educational Asistance Act. This law, which was passed by Congress in 1976, set up new criteria beginning October 1, 1977.

Two programs preceded this legislation. From 1974 through 1977, critical health manpower shortage areas were authorized in the original National Health Service Corps legislation. Another set of shortage areas, for the Loan Repayment Program, dated back to 1971. At one time, the loan repayment shortage areas were designated by the former Bureau of Health Manpower and the critical health manpower shortage areas by the National Health Service Corps. It was decided, around 1973-74, to place these two functions in one office, the Bureau of Health Professions. We combined the designation activities at that time. But, in 1976, Congress decided to have just one list to avoid confustion. So, the criteria we have now date back to that time.

The Congressional report language that accompanied the act indicated that the Health Manpower Shortage Area standards should be less stringent than the ones that had been used for the National Health Service Corps. Legislators decided to bring in more variables, such as infant mortality, health status and access. They wanted HSMAs oriented towards urban areas, as well as rural areas, and they wanted to permit designations of population groups and facilities. Specific facilities were mentioned: prisons, state mental hospitals and a variety of other public and non-profit private facilities.

Members of our staff drafted standards to meet these various requirements. We put out the Interim Final Criteria in 1978, which were made final (with minor changes) a few years later. Betty Hambleton is going to discuss, later, the general criteria and some of the specific problems that come up when there is a request for a designation. I would like to focus, now, on the process of designation.

The legislation requires that we seek comments on any proposed designation from health systems agencies, where active; from state planning and development agencies, where no health systems agency is active; and from the governors. That is why you are here. As has already been mentioned, we cannot do this without you. We need people in the field who are informed, and who can help us to apply the criteria properly. Any individual, any project, any agency can make a request. If it is written over a letterhead, the first assumption is that it is based on the truth. We can then check reported facts against national data that we have, but it is extremely helpful if someone in the local area or at the state level can validate the information. (People who can confirm, for example, if they left out a physician or have included one who has retired, or if they are calculating a half-time worker as full-time.) For this kind of corroboration, we really need to have input from knowledgeable people at the regional or state level.

During the 1978-81 period, when these criteria had first been published and we were developing a list, we worked closely with the health systems agencies (HSAs). Most of the HMSA requests came to us from an HSA or were commented on in significant detail by an HSA. And, although we routinely provided copies of proposed designations to the SHPDAs, many SHPDAs did not play an active role in commenting because the HSAs were doing it, except in those areas of their state where no HSA was active. During that period we held regional workshops, such as this, with HSAs and SHPDA representatives. Then, as the activity by HSAs began to decline, in 1981-82, we recognized a need to improve our links with the SHPDAs and we held some workshops specifically oriented towards them. You may have attended the Nashville workshop, in the fall of 1982, or the one held in San Diego the following year.

At this point, we want to update what we told you all in those workshops, which presents a new problem: How do you coordinate with SHPDAs if SHPDAs do not exist? We hope that your SHPDA will survive. We will be trying to stay in contact with people with whom we have worked in the past, and we hope that you will help us to cross all necessary bridges as organizations change, as funding fluctuates and as offices are eliminated or are no longer able to provide a coordination on HMSAs. Your assistance in finding the people who would be able to help us in some way will be very important. We need to renew our ties with you at the state level: to explain the process and criteria to those of you who may be new to the HMSA review process, and to update the process for those of you who have been involved for some time.

Legally, the list of HMSAs must be published in the Federal Register and be reviewed on an annual basis. In fact, the review process is continuous. At any time a new area may be designated or an old area updated or withdrawn. The first list of HMSAs was published in 1978. Since then we have published one list, essentially, per year in the Federal Register. The first few lists were basically simple snapshots of the sum total of individual cases that we had dealt with to date. In 1981 we conducted a review in which the SHPDAs and HSAs were asked to confirm the existing designations; but that survey was done on a voluntary basis with no areas being retired from the list for failure to update.

In 1983 we felt that the time had come for a major review. The 1980 census data and 1981 data from the national professional associations were readily available from which we could construct population and practitioner ratios, at least at the county level. Many of the designations made in 1978, 1979 and 1980 were badly outdated, in some cases having been based on data from 1976 or previous years. In August of 1983, we wrote to the SHPDAs, HSAs, state medical and dental societies and asked them to renew, or to review, all designations made prior to January 1, 1981, and we provided our 1980 and 1981 data for comparison purposes. Without their cooperation, we indicated that we would use national data to update the list. If we could not get any updated data on sub-county areas, we were just going to purge them from the list. This task turned out to be more arduous than anticipated, and it took us until April of 1984 to complete the review. It had a dramatic impact. About 22 percent of the areas were de-designated. This led to a significant number of appeals during 1984, with areas being restored to the list after the necessary data were provided.

We have made an effort to institutionalize this process. The 1981-designated primary care HMSAs were reviewed in 1984, and the 1982-designated HMSAs were examined in 1985. This year we are looking at 1983-designated areas and some of those designated in 1984. A major review of all the psychiatric HMSAs, which was initiated last June, is now nearing completion. Both the Bureau of Health Professions, of which we are a part, and the Bureau of Health Care Delivery and Assistance, which is responsible for any NHSC placements, feel that these annual reviews are necessary; they guarantee that NHSC personnel and other federal resources are allocated only to legitimate, recently updated HMSAs. But, again, we cannot correctly review HMSA designations without your help. We welcome your participation in this workshop and we want to hear your comments on the process, as well as your problems with getting designations for what you feel are legitimate shortage areas. Only if we hear from you can we work with you to achieve mutually satisfying results.

Right now I want to introduce John Drabek; he is going to set the scene for us with a discussion of the current geographic distribution of physicians and trends in the diffusion process, i.e., the movement of physicians in the rural areas and, perhaps, even in the city areas. This is something that affects, in a very important way, the number of HMSAs, to the extent that physicians do disperse into areas that heretofore had seemed to be less than adequately served. Such trends reduce the number of HMSAs and the number of professionals needed to serve them, which has implications for the National Health Service Corps. For these reasons, we thought it would be interesting to discuss physician distribution, and that is our next topic.

PRESENTATION: TRENDS IN GEOGRAPHIC DISTRIBUTION/ DIFFUSION OF PHYSICIANS; PROJECTED IMPACT ON NUMBER OF HMSAs AND NUMBER NEEDED THEREIN

John Drabek, Ph.D.
Chief, Technical Analysis and Coordination Branch
Bureau of Health Professions

DR. DRABEK: Thank you, Dick. I have prepared some tables that have a lot of numbers on them, but I plan to illustrate a few of the numbers I think are very informative about what has been happening in recent years and what is likely to happen in the future. Also, I want to call your attention to some reports and publications that cover particular subjects in detail.

The major report of the Bureau of Health Professions (BHPr) is its biennial report to Congress on the status of health personnel, with the Fifth Report to Congress being the most recent one available. The projections of physician supply, or the number of physicians that will be active in future years, are represented on the first chart handed out. This is from the Fifth Report.

To arrive at this estimate, a computer model takes the supply of physicians in some base year and describes them by age, year of graduation and other characteristics of physicians. In this case, the base year was 1981. The supply is then decreased by the number of deaths and retirements of physicians expected in future years and increased by the expected supply of physicians graduating from U.S. medical schools and immigrating from foreign medical schools.

From the table, you can see that we had approximately 521,000 active physicians in 1985. This group was composed predominantly of MDs trained in the U.S. (387,000); a few Canadian physicians who have immigrated to the U.S., and 105,000 physicians trained in other countries. Also, 22,000 osteopathic physicians were in active practice in 1985, according to our data.

We have seen a tremendous increase in the supply of physicians in the 1970s and early 1980s. This trend will continue into the future, with nearly 700,000 physicians anticipated by the year 2000. BHPr also projects the requirements for health professionals and, by the year 2000, we are predicting a need for about 619,000 physicians which leaves a surplus of nearly 70,000. These numbers are an indication of the pressures that are occurring; a much more competitive situation is evolving and, as a result, we will undoubtedly see some adjustments.

In 1985 approximately 20 percent of physicians were trained in foreign medical schools. That number will decrease to about 18 percent as the migration of foreign-trained physicians declines. In the past, most of the foreign-trained physicians were nationals of other countries. In the future more and more physicians will be U.S. citizens trained abroad returning to the United States. But because there is already such a tremendous supply, we will still have 123,000 foreign-trained physicians by the year 2000.

Now, in the case of U.S. medical schools we are projecting an approximate five percent decline in enrollments from the peak reached in the early 1980s; nevertheless, medical schools will still be producing large numbers of physicians in future years. Although it is not shown on the chart, by the year 2000 approximately 20 percent of the nation's supply of physicians will be women.

In the Fifth Report to Congress, and also in another study that we produced on the supply of physicians, there is an expansion of the material contained in the fourth report. We have projected by specialty and by state of practice. Since I did not photocopy the table relating to specialties, let me give you some of the highlights.

Between 1981 and 1990 we anticipate an approximate 26 percent increase in the number of physicians in all specialties. (Some specialties will increase more than others.) We make these projections by looking at the preferences of the physician supply by year of graduation. This approach takes into account the specialties chosen by young physicians who have recently graduated from medical school, and the shifts in those specialties as they engage in their careers.

Obstetrics and gynecology will approximate the average growth for all specialties. Pediatrics and internal medicine will experience a higher growth than average. In sum, about a 26 percent increase in all specialties, a 40 percent increase in pediatrics and a 33 percent increase in internal medicine. On the other hand, general and family practice and psychiatric will exhibit below average growth, in part because of the retirement of general practitioners and a less rapid increase in the growth of family practitioners. Only a 19 percent growth for general and family practices and a 17 percent growth for psychiatry are expected by 1990.

In terms of the state projections, I would direct your attention to Chart 2, which is based on the observed behavior of young physicians as they select practice locations. In this set of projections we have not considered the migration of physicians who are established, who have been graduated from medical school for more than 20 years. We have another study that will update these projections and will look more completely at change over the entire careers of physicians. In this table the physician supply and expected increases are tabulated with the most recent figures on population growth in the early 1980s. In a number of states, there appears to be a significant correlation between recent population growth and an increase in the supply of physicians; there are, however, some exceptions.

Alaska and Nevada had very high growth rates, in both population and physicians. On the one hand, a state such as Texas had a very substantial population growth, but it ranked 25th in terms of the estimated increase in physician supply. (The 27 percent projected MD growth in Texas is slightly above the all-area average of 26 percent, which I mentioned in the specialty projections.) Then there are states, such as Oregon, that combine relatively low population growth with a substantial physician growth in recent years. This situation is based on the preferences of young physicians as they continue their career.

Some of the states differ considerably in the way they attract physicians. For example, New York has a great deal of graduate training available. Many physicians go there as residents for their first few years after medical school, then migrate to other states. Florida presents the opposite case: the state offers relatively little graduate medical education, but many physicians come in after that. We try to take into account the different characteristics of the states in our projections.

I would like to turn your attention now to Charts 4 and 5, skipping 3 for the moment. These tables are taken from the most recent Physician Characteristics and Distribution volume produced by the American Medical Association. They summarize what has been happening to the supply of physicians in the 1970s and early 1980s. Note the figures on the bottom of Chart 4, which give the number of MDs as of the end of the year in 1983. There were 353,000 physicians in patient care in metropolitan areas at that time, and 55,000 in non-metropolitan counties. So, about 13 percent of the physician supply was in non-metropolitan or rural counties. There were 16,000 general practitioners who are relatively more common in rural areas than in metropolitan areas. Thirty-one percent of the general practitioners in office-based practice were in rural areas. Medical and surgical specialists were also available in rural areas in significant numbers at that time, but they were less common.

Chart 5 shows the percentage changes from 1970 to 1983. Patient care physicians increased by 60 percent during these years. There was much greater growth in the metropolitan counties than there was in the non-metropolitan areas: 62 percent versus 48 percent.

We see that there has been very little net growth in general practice, only one percent growth over the entire time period. There has been much greater growth in the specialities. There has actually been a loss of general practitioners in rural areas, reflected in a 1.5 percent decline. Therefore, in spite of the increase in supply of physicians, we are seeing different patterns by specialty, different patterns by state and type of area.

I would like to call your attention to several studies on developments in the physician supply area. One of the best known was produced by the Rand Corporation in 1982. Chart 3 is a table drawn from the Rand Report, and I would like to summarize some of its findings. First of all, the methodology of the Rand Report is based on the standard economic location theory. This theory supposes that when producers or, in this case, physicians, distribute themselves so that each will maximize profits, they wind up making

about the same level of profit in all areas. This means that there are greater numbers of producers, or physicians, in areas of high demand and that market areas will decrease in size.

One conclusion of the Rand Report is best illustrated by the table reproduced in Chart 3. If you start at the top of the table you have "Group I, General and Family Practice." (These figures are based on American Medical Association data for 1970 and 1979.) The report covered 23 states, looking at towns ranging in size from a population of 2,500 all the way up to a 200,000-plus population, reading across the table. The interpretation is that general and family practitioners are found in nearly all communities, but much more frequently in large communities. Almost every town with a population size of 20,000 has at least one general practitioner. In smaller towns only 89 percent had a physician in 1970, and this number actually fell to 86 percent in 1979. Apparently, some of the general and family practitioners either retired from practice and were not replaced or else moved to other towns.

The opposite is true of internal medicine. White practitioners are much less available in smaller towns, seventeen percent of the small towns had internists in 1970. This rate increased to 23 percent in 1979. The other type of physician common in a smaller town is the general surgeon. That growth has been relatively constant. There is quite a diversity among the surgical branches, with general surgery growing at much lower rates. You can see the rapid growth of plastic surgery by the figures.

This data does not say anything about the actual numbers of physicians that are located in rural or metropolitan areas. It just indicates what happens as the physicians migrate to these areas. The total number of physicians is best given by the tables in Charts 4 and 5.

The Bureau of Health Professions, through our office, also did a study based on an economic model. This report, Diffusion and the Change in Geographic Distribution of Primary Care Physicians was prepared in 1983. It looked at how the distribution of primary care physicians was changing over the entire U.S. We calculated how many counties would have more than 3,500 people per primary care physician in future years. We found that 1,500 of the nation's counties were either wholly or partially designated as HMSAs in 1982, and we expect this number to fall to 810 in 1994. Therefore, the number of primary care physicians needed to bring areas to the level of 3,500 people per physician decreases from 5,076 to 3,200 in 1994. In these figures we see the diffusion described in the Rand Report. That diffusion will continue in the future. As the supply increases, not all areas will benefit at the same rate: only the more desirable areas will have enough physicians to be removed from the HMSA list.

We are in the process of updating this study, using more recent data and somewhat improved modeling techniques. We are also looking at the characteristics of counties in the U.S. and how they have changed over time. There is a Department of Agriculture study that describes counties by type and various indicators. We have tabulated some of those indicators along with the HMSA data.

Looking at counties that have low income, 476 had the lowest fifth of per capita income in 1983. Of these counties, only 25 percent were not designated as HMSAs, We can conclude that poor counties in rural areas tend to be designated as Health Manpower Shortage Areas. For counties that were in the lowest fifth in the United States over a longer period of time, say, from 1959 to 1983, the portion not designated drops to 20 percent. Recent income appears, then, to be a good predictor of whether or not a county will have shortage of physicians; low income over time is also a good indicator. We will have more on the characterization of counties in future studies.

Another study of interest is on the distribution of psychiatrists and psychologists and the factors affecting this distribution. Psychiatrists are much more likely to be in urban areas than are primary care physicians. According to our calculations, about 10 percent of the primary care physicians were in rural counties in 1983, in contrast to three percent of the psychiatrists and psychologists (some of whom were located in mental institutions which, typically, would not serve the rural areas but would just be located there.) Perhaps, only two percent of the psychologists and psychiatrists in office-based practice were located in rural areas, compared with a much larger percentage of primary care physicians.

Our studies in the future will be served by recently collected data that are being made available. The American Medical Association (AMA) is just completing its professional activity census for 1985 and 1986, which is a very complete description of national medical practices. We have produced a set of volumes from previous AMA data, The Characteristics of Physicians, with which many of you are familiar. At this time, we have two studies underway to look more closely at the data in the census; one on practice patterns and hours of work by specialty and type of practice, and another on recent developments and practice locations of young physicians. These data from the AMA will be completed by census of osteopathic physicians being completed by the American Osteopathic Association. The American Dental Association will have comparable data on dentists available in the near future for further studies in that area. Thank you.

PRESENTATION: AMERICAN MEDICAL ASSOCIATION INVOLVEMENT IN HMSA REVIEW PROCESS

Dewitt C. Baldwin, Jr., M.D.
American Medical Association

MR. STAMBLER: It is obvious that a lot of work is going on within our Office of Data Analysis and Management. Much of what is being done throws light on the whole shortage area designation and provides knowledge to the policy makers in Congress and in the department.

We have heard quite a bit about the American Medical Association data and physicians. I would like to introduce to you, now, Dr. DeWitt Baldwin, who is the director of the Office of Education Research of the American Medical Association. He will give us some AMA views on present-day realities for physicians and what may be expected in the future.

DR. BALDWIN: Before I begin I would like to expand on my background. I previously headed an Office of Rural Health for 10 years in Nevada and I have worked closely with HSAs, SHPDAs and the Bureau. We even had a National Health Service Corps contract, so I feel I understand that side. However, my role today is to present some things that are happening at the AMA that may be helpful in understanding the total picture.

Basically, the AMA has been supportive of the concept of the National Health Service Corps and of HMSA designations. We know that there are always going to be shortage areas -- places that will have difficulty attractiong physicians. I spent much of my time in Nevada trying to make matches -- marriages if you like -- between health providers and underserved communities. It takes a lot of community development work, and it is from that point of view that I would like to discuss the AMA's interest and participation in this process.

One factor to be considered in community placements are the existing health professionals. They know the community and have made a commitment to it, so it is very important to them who comes in. They want to know if these people are qualified. If they will fit in socially and culturally. . For example, if you are working with a predominantly Mormon town in southeast Nevada, you probably would be wise to go with a Mormon physician, because he or she will simply fit in better.

The AMA want to participat in HMSA designation policies and decisions for many reasons, not just self-prctecionism. We want the community to be well served and we believe that continuity of care - and compatibility of

values - are a part of quality. Therefore, we would like to see doctors who will stay in the community.

I also see flexibility as being very important. I recall in Nevada that we had one ideal community that had had no trouble attracting dentists and physicians. But there was an Indian reservation located on the edge of town that wasn't being adequately served. The tribe had raised money to build there own clinic, including a complete dental operatory, because their dental needs were enormous. Well, there were several good dentists in town, but it was obvious that the Indian tribe had not been, nor were they likely to be well served by these particular dentists. So we went all out to create a HMSA shortage area that would enable this tribe to get its NHSC dentist. I think we carved pieces out of three counties in order to make it happen.

This kind of experience made me aware that we need to build in flexibility which can take into account these unique local situations. It should be obvious that a rule which fits urban New York or Pennsylvania is not necessarily going to fit rural Idaho, Nevada or New Mexico. There is a need then, I believe, to maintain a flexibly, responsive attitude and be adaptable to community needs.

I realize the pressures on both sides. The pressures on the AMA come from unhappy local physicians, who feel the threat of competition, as well as from unhappy Corps assignees. I'm afraid there has been a small "crybaby" element; someone from the East who studied in the East, who wants to be a super specialist and simply does not want to practice primary care in the desert Southwest and complains about it to his Congressman. Frankly, I'm not terribly sympathetic with this. I think that Corps services is an obligation which clearly is supported by the law and by our value system. People serve in wartime. I do not see why the war on illness should be any less important. I think we should deal sympathetically, but firmly, with these persons, while working with, and supporting the NHSC and the community.

Probably the single most important factor in this picture is the growing physician surplus. This has occasioned some changes in AMA policy which may be useful to discuss. During the 1960s and 1970s, everyone felt that there was a health manpower shortage. The Federal government responded with legislation and funding which stimulated the entry of students into medicine and the other health professions. Loans and scholarships became available, and the number of students entering medical school more than doubled from 7,081 in 1960 to 16,318 in 1985. By the mid-1970s, it became apparent that we were in danger of overshooting the mark and, in 1976, Congress passed legislation restricting the influx of alien foreign medical graduates. In 1980, the GMENAC Report projected surpluses of 70,000 physicians by 1990, and 145,000 by the year 2000. This scared a lot of people. And while there has been a lot of criticism of that report, it certainly got everyone's attention. By the 1985 annual meeting of the House of Delegates of the American Medical Association, concern reached the point of a resolution to form an AMA Task Force on Manpower. The feeling was that AMA policies which had long advocated increasing the supply of physicians needed to be updated.

The AMA Task Force concluded that 1) there <u>is</u> a surplus of physicians - (regardless of specialties) - in many areas of the U.S.; 2) there <u>is</u> a sur-

plus of physicians in some specialties in most areas of the U.S.; and 3) in most areas, there is an impending surplus of physicians in most specialties.

They also concluded that, paradoxically, this impending surplus of physicians is likely to have negative consequences on the quality and cost of patient care. I realize that statement may sound self-serving; however, we believe that this may lead to specialists trying to do more procedures, or trying to carry on primary care in an effort to maintain income, but doing it more expensively because they are more accustomed to high tech, high cost medicine.

For a long time the AMA seemed to believe that market forces were the best guide and that the normal economic pressures of supply and demand would work. We know now that health does not respond in that way and that we cannot count on market forces alone to assure cost-effective medical care. Apparently, we needed to change AMA policies in this regard.

The Task Force went on to recommend that the AMA intensify its efforts to analyze physician manpower issues. These are to be reported annually to the House of Delegates and the Board of Trustees, which will review the numbers and projected needs. They also proposed that the AMA encourage U.S. medical schools to review these data and to act appropriately in curbing enrollment. Fortunately, this is already happening in some places. Oklahoma and Washington, for example, have already begun to reduce their incoming freshman classes. In part, this is due to fewer applicants. Indeed, the number of applicants to medical school has been declining for about ten years now - 14.5% since 1978. At this point, the quality of the applicant pool begins to become an issue and we are calling on schools to begin voluntarily to reduce their student enrollments.

It is further recommended that the Council on Medical Education should continue to monitor closely the relationship between the size of medical school enrollment and the quality of educational programs. Also, the AMA should support repeal of Federal legislation and regulations that mandate maintaining specific enrollments in U.S. medical schools and should urge repeal of state quotas on medical schools. In other words, the figures that were set arbitrarily high in the 1960s and 1970s ought to be reduced and made more flexible to bring them back into line with the times. Happily, the Board of Trustees specially voted that the AMA continue to support the enrollment and retention in U.S. medical schools of under-represented groups, because of a falling off in the number of minority students applying to and entering medical school in the last five years.

The AMA will continue to support policies that maintain appropriate standards and criteria in the practice of medicine. There has been some concern about the quality of care, particularly among foreign-trained medical students. As medical school enrollments decrease, we believe we should guard against a concomitant rise in graduates from elsewhere simply filling up the places.

It was also recommended that the AMA more actively disseminate information to the general public about the changing characteristics of medical practice. The AMA will coordinate efforts with the state medical societies

to provide legislators and administrators -- and I assume that means you -- with information that will allow them to determine which health manpower policies are best suited to their states, along with a plea for flexibility and decentralization.

The AMA will work towards a more favorable geographic distribution of physicians by making efforts to provide physicians with more extensive information on which to base their location decisions. We will continue to provide the booklet on opportunities for physicians.

Medical students should be provided with appropriate information so that they can make the best choice of specialty training. It is beginning to look as if it is no longer a completely free market and, although students often seem to be attracted to the higher paying specialties, they need to know that those spaces are rapidly being filled or are already over-filled.

One of the important factors in student choices is going to depend on the decisions of the HMOs and proprietary hospital organizations concerning what they want, and are willing to pay for - which is more primary care physicians. I think that this pressure could lead to the institution or re-training programs for some specialists.

Finally, it was recommended that the AMA institute programs that would assist physicians seeking transition from full-time practice. In other words, we are starting to look at people leaving the profession earlier or partially. As I talk to young physicians, many of them are looking forward to a lifestyle that will be quite different from that of their elders. Many of them are saying: I want to practice until age 50 or 55, and then change careers or take an early retirement and do something else. This sort of thing could change our productivity and manpower figures.

These are the key issues, then, from the AMA standpoint: we would like to continue to be involved with HMSA placement policy at the local and national levels; we would like to see flexible criteria so that local and regional differences can be accomodated; and we need to develop better and more current data on health needs and health manpower. It is difficult to shoot at a moving target and things are changing very fast. The AMA is taking serious aim, however, and is committing substantial resources to this task in the coming years.

Finally, I have a question for Howard or Dick. I did not hear the role of professional associations mentioned in the current consultation process. I am wondering if this was an oversight or if that step has been eliminated.

MR. LEE: It was not an oversight. We have professional society involvement on tomorrow's agenda, and I was just concentrating on the topic at hand. Be assured, we routinely send all requests to the state medical and dental associations; we need their input.

DR. BALDWIN: I have nothing else to say, unless there are questions.

FROM THE FLOOR: My question concerns criticism of the GMENAC study, which has come about because of significant changes that have occurred in

the last several years. The predominant and specialty choices of physicians have changed, the hours of practice have shortened, and medical school enrollments have declined. It is anticipated that, during at least the next four years, there will be a steady decrease in enrollments. Has that been factored into the projection? Perhaps we should look again at those GMENAC numbers.

DR. DRABEK: That is a good question, but there are a few different things to consider.

First of all, the GMENAC methodology is different than ours. It was based on the deliberations of experts and their view of what should be in 1990, given a realistic opportunity for some changes to be made. Because we project a greater growth in the number of physicians required than GMENAC did, we are more optimistic in terms of the outlook.

Also, our projections on the supply of physicians were done more recently than GMENAC and we have tried to factor in new developments. We have already factored in a decline in enrollments from the peak in 1980, however it is not going to make a significant difference in terms of the supply of physicians unitil the year 2000. A more immediate change in the supply can occur from restrictions on the entrance of foreign-trained medical graduates, which is a very volatile area. There is a decline in foreign medical graduates, but, again, it takes a long time for these changes to work their way through the system.

DR. BALDWIN: Because this whole business of fitting manpower projections to community needs is so methodologically complex, there are many possible approaches to the answer. I do not think there is any single or easy answer. We are in the midst of such a rapidly shifting marketplace, that it is almost impossible to project exact figures. These uncertainties will continue, I think, for the next 10 years - and probably a lot longer.

MR. STAMBLER: To add to what has been said about the GMENAC, there is a new Council on Graduate Medical Education which will hold its first meeting in Washington on December 4th and 5th. The council has a legislative mandate and is chartered for nine years. This means that there will be a continuing re-evaluation of specialty distribution, manpower policies and a variety of other issues associated with physicians: demand, supply, requirements, education, etc.

This is going to be very helpful. With the AMA, Rand and the government at work, we will at least move closer to the truth. I think that this is a very salutary development and it will be a continuing one over quite a while.

MR. LEE: Our next speaker will explain what we call the "cookbook approach" to designations, or what to do with a request when you need to get it through the system. Betty Hambleton is going to go through some of the materials that we have available for use in either developing designation requests or commenting on them, and she will review some of the recurring problems.

PRESENTATION: CURRENT HMSA CRITERIA AND GUIDELINES; DESIGNATION PROCEDURES

Betty Hambleton
Distribution and Shortage Analysis Branch
Bureau of Health Professions

MS. HAMBLETON: Thank you, Dick.

I am sure that most of you are familiar with the designation process from your standpoint in developing the request, getting the material together, and sending the information on to us. Today, I want to focus primarily on what happens once that request is received by our office, and how you can help us to hasten the process, to be more objective and to achieve results that accurately reflect the situation.

You have a copy of the Federal rules, published in the November 1980 Federal Register, which are the basis for the designation process. There are three basic criteria: the rational service area, the population-to-practitioner ratio, and the accessibility of contiguous resources.

Every request that we receive should contain the data needed to address each one of these basic criteria. This way we can complete the analysis as quickly as possible, and minimize communication with you, or to the applicant, for clarification of data or any other issues. (We are, generally, at a disadvantage, being unfamiliar with the geographic area and the population.)

The basic categories of data that are required for designation have not changed since the HMSA criteria were issued on November 17, 1980. However, as we have had more experience in applying these standards to different types of designation requests and unique situations, it has become apparent to us that a greater level of detail is necessary, in many cases, to evaluate correctly an area's need for health care services or a population's special access problems.

I would like to consider, first of all, rational service area definitions. One thing to remember, from both viewpoints, is that there is no "best way" to define the service area. It depends on the characteristics of the area, of the region of the country and the population involved. However, for all types of designations, whether they be geographic areas or population groups, our analysis is facilitated by the use of maps. These maps should be on a scale that clearly illustrates the area under consideration, showing the boundaries of the area and adjacent territory. They should include particular topographical features and any barriers, such as major highways, bridges and waterways, that separate that area from the rest of the county or its immediate surroundings.

For urban areas, maps showing census tracts are necessary. In addition, it is helpful to have a map that shows the street names. Very often the request will refer to the location of hospitals or health centers and we have a great deal of difficulty knowing exactly where they are in relation to the population of the service area unless we have some sort of a map with streets that clearly point out these facility locations.

A description of your service area needs to have a great deal of narrative on what comprises this area unit. What are the characteristics (topographic, socio-economic, cultural) that make it distinct from the rest of the county or the city? This is especially important when we review a request for a geographic designation of a poor, urban area: How do we decide whether to approach that request on a geographic or population group basis? The rule of thumb that we follow is, if an area of a city can be clearly defined as having high poverty rates (in excess of 20 percent according to census tracts), and it is in some way isolated from the rest of the city, then it is an obvious candidate for a geographic designation. But where you have an urban area with a health center located among a group of census tracts that have varying poverty rates, it becomes more difficult to define an area that is isolated from the rest of the resources in the city. Then it is more logical to look at that request from the standpoint of a population group designation.

On this subject, the medical service area of any population group should be defined by the county or by the city-wide area where the population resides. In those urban areas where there are populations that we are focusing on, list all of the census tracts where the population resides, then we can deal with it as the city of Syracuse or whatever the geographic area may be. However, where a population group does not encompass the whole city, please define the geographic area of residence of that population for us. Also, define the special access barriers of that population. Many requests fall short of providing us with sufficient information about the characteristics that make that population group distinct from the rest of the population residing in that area.

Provide quantifiable data to us to measure language or socio-economic characteristics of the population group against the area's population. We must be able to compare the population group with the remaining population of the area. If there is a Portuguese-speaking population in an urban area, we need to know its exact size and be able to compare it to the total population of the area to determine the validity of the service area or population group.

Now, let us focus for a moment on how to count the population in the area. For a geographic area, the most recent official population count should be provided. Official population estimates that you have available are acceptable as long as they are not projections beyond the current time period. Where you do not have new estimates available for sub-county areas, we will accept an assumption that the total county growth rate, based on an earlier census, applies for all parts of that county. Then we can apply that percentage of growth rate to populations from the earlier census.

The data base that we work with currently includes the 1982 Census population for all counties. We do not have sub-county data available on populations, which is why we rely on you for that information.

Where areas are defined at the sub-county level, we also request that you provide us with the population count for each component part. For example, your service area may be comprised of a number of towns within a county. Instead of giving us only the total population of that county, please identify the population for each one of those towns, CCDs, census tracts (however you may define it.) In all cases, cite the source and derivation of your data so that we do not have to question the validity of the population estimates.

You all have a two-page sheet which provides the basic information that is required for population group designations, including how to define the population and the practitioners who are accessible to that population.

Very briefly, the poverty population is defined as those persons with incomes below the federal poverty level established by the 1980 census. The Medicaid-eligible population comprise persons eligible for state or federal medical assistance payments, such as Medicaid or California's MediCal. The medically indigent population includes persons with incomes below the poverty level who are ineligible for these government assistance programs. This refers mainly to Spanish-speaking and other populations that are experiencing language barriers (meaning those who do not speak English well or at all.) The migrant farmworkers category includes the family members traveling with them, as estimated by federal or state labor authorities. That number is further adjusted by multiplying it by the percent of the year that they are present in the area.

Now let us turn to counting the providers who are serving these populations or areas. In geographic designations you must consider all primary care physicians with a practice address within the service area, and a very clear explanation of any full-time equivalency (FTE) adjustments made for the number of hours of their practice. FTE is based not only on office hours but also on time devoted to other patient care activities, such as nursing home or hospital visits.

We developed guidance some time ago to provide an appropriate method to determine FTE when only office hours are given and this is the only information available for your area. New guidance has been developed recently and a copy of it is in your jacket. You may notice on the new table a significant change in the multiplier that is used to determine the FTE. The old multiplier was based on the 1981 AMA Profiles of Medical Practice. This new one is based on the 1985 AMA figures for the number of hours that each type of primary care physician spends with patients in the office and in other patient care activities. The guidance contains a summary if you do not have a breakdown by the different types of primary care specialties. The summary number here represents an average for all primary care physicians.

In urban areas, it is preferable to know by census tract locations the physicians you are counting in your FTE. Many times we receive only a total FTE for the area. It is helpful for us to be able to include census tract

information in our database to compare any changes that might occur in future. In all cases, however, be absolutely sure that the number of physicians you are reporting in those census tracts are actually within the service area. You can confirm this by checking the office addresses of these physicians against the zip code number for the census tract.

The handout that I referred to just a moment ago describes the providers that you would be counting for each different population group. These descriptions are fairly straightforward; however, one provider count does cause us a bit more difficulty than the others, and that is Medicaid physicians. I would like to discuss briefly, the ways that we have found most accurately reflect the amount of time Medicaid physicians provide services to an area.

The provider count includes non-Federal, primary care physicians accepting Medicaid patients. One approach is to conduct a survey. You may telephone the doctors to find out whether they accept Medicaid patients and determine what percentage of their time is devoted to providing services to these Medicaid patients. The FTE is then adjusted accordingly.

Another acceptable approach, which will probably require less effort on your part and give more accurate results, is to determine the total amount of primary care Medicaid reimbursement for the whole county. Divide that figure by the average cost per primary care Medicaid visit. (Both of these figures are usually available at the state level.) The result gives you the total number of primary care Medicaid visits. Then divide that number by 5,000, which represents the assumed number of visits for a primary care physician for one year, and that result is the Medicaid FTE.

For those populations with language barriers, you would count the physicians who are bilingual, as well as those who employ bilingual staff, determine if there is the capability there to communicate with the patient. And, once more, the FTE is adjusted to reflect the percentage of time spent serving that monolingual population.

Now we'll turn to the last part of our analysis, which concerns contiguous resources. We look at all of the resources that are outside of the service area, as it is defined in the application, to determine the accessibility or utilization of those resources.

Contiguous areas to be considered for primary care designations are measured by a 30-minute travel time out in all directions from the geographic or population center of an area. In urban areas, this means 30 minutes travel time into the contiguous census tracts, usually measured in terms of the public transportation system. Because most of the urban designations involve disadvantaged populations, the public transportation system becomes a key factor here. Documentation of transportation schedules and routes are very helpful to us.

In geographic areas with two towns having populations of nearly the same size, the population center becomes less distinct. In those cases, take a point halfway between the population centers and measure 30 minutes out into contiguous areas from that particular point. Resources must be

more than 30 minutes away from both towns. If they are not, it becomes less clear that this is a rational service area.

For those urban areas where there is a contiguous ring around a population center, we use a formula to determine the utilization of adjacent resources calculated on the basis of a 2,000-to-one ratio for the whole area, including the service area that you have defined. If the total exceeds the 2,000-to-one ratio, we will accept that the contiguous area is overutilized.

Before closing, I would like to mention responses to annual reviews, since a great many of the requests or designations are involved with the annual review process.

This process focuses on all areas that had been designated or updated during the year specified a particular review period. For example, the review that we just completed examined those areas last updated or designated during 1982. For the review, we need the same detailed information and data as was required when that area was initially designated. It is not just a matter of updating the county population or an FTE. We are looking at the whole area again as if designation were being requested for the first time. This holds true, also, for those areas more recently designated or updated and which we are reviewing because they are on the latest HPOL.

Right now, as we are beginning our 1986 annual review, the focus is on those areas designated or last updated during 1983. We will also be looking at 1984 designations because many of those areas are on the HPOL.

For every county-level designation that you request some action on, please include the ratios for all contiguous counties within 30 minutes of that area. In other words, do not just provide updated data for the county, we also need the basic population and provider data for all of the counties within a 30-minute travel time.

That is all I have on the designation process. We will now open the floor to questions.

MR. DAVID BRAND: In terms of urban areas, will you comment on the need to go two to three levels deep into the contiguous census tracts or to present some kind of information which indicates that the buses do not go that far in 30 minutes?

MS. HAMBLETON: I believe I alluded to that in talking about contiguous resources in urban areas by saying that you have to measure travel time by public transportation. Whether 30 minutes travel takes you one, two or three census tracts deep, is going to depend on the individual urban area. That is something you will have to determine as you assess the availability of transportation to the service area.

MR. LEE: I think Dave is alluding to the fact that some people provide only the data for the next ring of census tracts, one census tract deep away. Somewhere along the line, the idea took told that that is all we need. However, according to criteria, we have to determine that the contiguous area resources within 30 minutes are either overutilized or, for some reason, in-

accessible. The ones beyond 30 minutes are assumed to be excessively distant. So, we must deal with all the tracts within 30 minutes.

FROM THE FLOOR: In the counting of practitioners, are you referring only to primary care physicians or are you including all physicians, regardless of speciality.

MS. HAMBLETON: I am referring only to primary care physicians.

FROM THE FLOOR: Betty, what about National Health Service Corps obligated physicians? Are they included in the FTEs as long as they are in their service period?

MS. HAMBLETON: We count only non-Federal primary care practitioners. The National Health Service Corps is Federal; therefore, the NHSC physicians are not counted.

FROM THE FLOOR: Sometimes we find National Health Service Corps obligated physicians who are in default and are not assigned to an area. Do you have any policies that address these situations?

MR. LEE: I believe we evaluate the area as if the doctors were not there. We are not looking at federal positions, including those of obligated scholars. I presume we let them fight it out with the National Health Service Corps and its scholarship Program as to whether they are going to be assigned there, whether their service there is going to be considered as satisfying. But their presence does have a bearing on the area being defined as an HMSA. That is a difficult question. We would have to deal with each case on an individual basis.

FROM THE FLOOR: We deal with a number of counties where there are no nursing home facilities and/or no hospital facilities. In addition, some areas have surveys which indicate whether or not local practitioners have hospital admitting privileges or any hospital practice at all. Is it appropriate, then, to use national statistics instead of local statistics and vary the multiplier in trying to judge whether the office hours are, in fact, extended into other areas of direct care? Could we say, for example, that based on data this doctor has no hospital practice and does not work with a nursing home and, as a result, we will use a different multiplier?

MS. HAMBLETON: Yes. For each area you should take into consideration what is appropriate for that particular place.

MR. LEE?: If you have the data, we will take it. If you only have the office hours, you can convert that information to an FTE.

FROM THE FLOOR: I have a question about contiguous areas. Using the simple example of a county with a population center that is roughly in the middle: Would the rational service area take in anything within 30 minutes of that population center?

MS. HAMBLETON: Correct.

FROM THE FLOOR: I thought you said that contiguous area resources had to be within 30 minutes of the outer edge of that service area.

MS. HAMBLETON: No. Contiguous resources are measured as 30 minutes from the population center, the center of your service area. In a county, if all of the population is within 30 minutes of the center, that is a well-defined service area. It could be that there are no contiguous resources because everything may be beyond 30 minutes from the population center.

FROM THE FLOOR: I understand. I was just wondering if we could have a scenario where you need 30 minutes to get from the population center to the edge of your service area, and another 30 minutes to arrive at the population center of the contiguous area.

MR. LEE: Let us take a county with two population centers of similar size about 15 minutes apart. One of those centers might have resources within 30 minutes and the other one may not. If it can be determined that one of those centers is adequately served by contiguous area resources and the other is not, then you begin to question whether the county is a rational service area. At that point, the county may be divided into two parts.

There is a lot of interplay between rational service areas and contiguous area resources when you start to apply the 30-minute rule.

FROM THE FLOOR: Did you say that you could adjust the 1980 census population for partial county designation for a 1985 or 1986 figure when we designate those areas or should we stay with the census population?

MS. HAMBLETON: If you have information available on the growth rate for the whole county, we will accept an application of that growth rate to the service area that you are defining.

FROM THE FLOOR: On the subject of annual reviews, you said that you required the same detailed information each time. Is that just for redesignations, or de-designations or on every area?

MS. HAMBLETON: What I was trying to emphasize is that during an annual review, we focus on designations or updates in a particular year. For older designations we require the same level of detail and data that you provided when you first requested designation. This applies for all requests: redesignation, withdrawal or whatever. We need that higher level of detail. We also need complete information for those designations on the HPOL that we will also be examining.

MR. LEE: This is important for the areas at risk in a particular year. If you do not write to us, we are going to take them off the list. If you do write to us, we want the original level of detail, at least to the extent possible.

FROM THE FLOOR: My questions are specific to the District of Columbia. Let me mention, first of all, that D.C. has a very large homeless population. The D.C. human services provider would like to get a designation for the area, but how do you go about counting and handling the homeless population? This

is a geographic location which provides shelter services as well as health services to a very changing population. I would like to ask if other areas have had this problem and, if so, how is it being resolved? What type of data do we need to collect?

MS. HAMBLETON: We have had some requests for designation of homeless populations. I will let Dick answer that because he is familiar with a few specific cases.

MR. LEE: A major problem with the homeless is you cannot count them. Typically, a local health agency will have some estimate. There is a range of estimates and a lot of disagreement about the numbers. Given a choice, we would look towards the low side of any range.

I remember a case in New York City, I think it was called the Chelsea Outreach Program. They actually counted the people that they had in single room occupancy (SRO) hotels and in some large facilities that were specifically for homeless people. They had an outreach program to the SRO hotels which permitted them to count the people that were being served through those clinics. Only a small group of census tracts were involved, and I believe we added in people below the poverty line that were recorded as residents because it was a high poverty tract.

So, depending on what data you have, you have to do it on a case-by-case basis. If there are some counts of the people that are at least being housed in a shelter, if you have the different numbers of people in SROs that are looking for care, you can add those in. It may be appropriate, in some cases, to add in the poverty or Medicaid-eligible population of the particular tracts where the shelters are located.

For a case in Oregon, it was clear that there was a particular area of the city where the homeless people either were sheltered or hung out. Estimates were made of their numbers and also of the number of physicians. In that case they had a program of volunteer physicians rotating through one night a week, so they gave us a full time equivalency for that and then they had somebody working at a shelter and added those two together.

In the Chelsea case, again, they had some numbers on the people, a clinic that was at a shelter and a clinic that was in a SRO. So, it is a question to be resolved. Those are two examples that I know of and we can work with you on trying to solve your problems.

FROM THE FLOOR: Thank you. Let me direct my second question to you. What happens when an HMO, with perhaps 60 to 100 physicians, locates itself in the middle of what was once a health manpower shortage area? This has happened in Washington and we know that we will have to account for it in the next annual review. We can do a survey, but HMOs are not bound to answer our questions. So, I am wondering how we might go about estimating whether or not these doctors are actually serving the population.

MR. LEE: Here is what we do in that case. We subtract the HMO members from the total population of the area and we subtract the number of physicians serving only HMO members from the total number of physicians in the area. From this we come up with a ratio for the non-HMO population.

FROM THE FLOOR: Thank you.

FROM THE FLOOR: I have a specific question about a request we just sent in this October for Madison County, Florida. The community has 16,000 people, four private FPs. We calculated 3.4 FTEs in the private community. They have a tri-county community health center, federally funded (330 funds) located there with FPs on their staff. We sent in a redesignation request excluding the National Health Service Corps obligees from our FTE count.

The president of the county medical society called me yesterday and asked why we did not count the Corps doctors. The community health center is on the HPOL for three more doctors, and I did not have the heart to tell the medical society that fact. I wanted to clear this up and make sure that we made our count properly.

MR. LEE: I think we should hold the specifics of a particular request for either small group sessions or for individual contacts with the designator for the region. In this case it would be Jay.

But I can answer the general question. There is a specific separate amendment to the regulations that says in black and white that we do not count the Corps obligees or practitioners in establishing whether the area is designated or not. But once we have developed the ratio for an area and it is designated, then the National Health Service Corps, to its credit, computes something called "de-designation threshold." In this particular area it would take 2.5 additional physicians to fall below the designation ratio of 3,000 to one or 3,500 to one.

Theoretically, for every designated HMSA there is a maximum number of placeable National Health Service Corps physicians. Offhand, if there was an area with a computed need for two or three physicians and they were scheduled to receive three more, I would question it. But it could be that some of those people are leaving and others are coming in. We will consider more National Service Corps placement questions tomorrow. That is an interesting example.

FROM THE FLOOR: You made reference to Medicaid costs in one of your formulas. Were you talking about actual reimbursement, or bill charges? What is the definition of "cost"?

MR. LEE: The formula that Betty gave you relates to the problem of finding out from physicians the percent of their time spent with Medicaid patients. If you can get data on the number of Medicaid visits by county, we will just accept that. If only the amount of medicaid reimbursement by county is available, then see if the state has the average cost per visit; with this information, we can perform the ratio and calculate the number of Medicaid visits.

FROM THE FLOOR: What we are looking for, obviously, are the primary care Medicaid visits. Some states do separate it out and are able to specify the number of primary care visits. Others keep tract of the total billing and can show the amounts for office visits and primary care visits.

So, it is complicated and it depends on how the data is available in a given state. In a significant number of cases, we were able to get either the total Medicaid billings by county for all patient care office visits or for all primary care visits. (In one instance the data was for all visits but, from a sample survey, it was estimated that x percent of the visits were primary care.) It is basically putting together whatever data is available on either the number of visits or amount of reimbursement, and some estimate of how much of that is primary care, to estimate the number of primary care visits in the county.

FROM THE FLOOR: Thank you. My other question concerns counting the transient or homeless population. Why would you go with the smaller number rather than the larger one?

MR. LEE: Well, if somebody gave me a range of numbers, I would probably take the mid-point. Let me put it that way. It seems as though advocates generally give a very large number, and the skeptics say something else. However, if you have an actual shelter count, that makes a difference. In some cases there may be a very elegant methodology for counting, and the numbers seem reliable. But where the estimates are off the top of the head and there is not much detail on how they were developed, then we just retain a certain skepticism and try to compare different estimates.

Before closing, I would like to make a few comments following up on Betty's presentation. She told you what we need, what we would like to have and what makes it possible for us to do our job. If you can help us by either furnishing information or by adding to a request that you are reviewing, it would be extremely helpful. If it is impossible for you to furnish all the data, then give us what you have and we will struggle.

Now, regarding annual reviews, when we went back in 1983 we reviewed all areas designated in 1978, 1979 and 1980, we had quite a hodge-podge of different types of data of different degrees of specificity. And so we were very insistent that everyone re-review, the sub-county area particularly. The county areas are not as difficult because, if you give us the county data for your whole state and, for each county, provide the data on all the contiguous counties on the same page, our job is much easier. With all the county data we can, theoretically, crank through and recheck the contiguous areas. But when it comes to sub-county data, there can be real problems. And if it is an area that has not been looked at for three or four years, you almost have to re-invent the wheel, because the service area patterns may not be the same as they were.

Between this year and next, we will start re-reviewing all areas that were analyzed in 1984. That year we reviewed all the areas analyzed in 1978, 1979 and 1980 and maybe before that. That is a lot of areas. It is not going to be easy for us or for you to re-invent all those wheels. To simplify, if you are able to say that the service area is still rational, then just fill us in on how the head counts have changed within the service area and in the contiguous areas that were dealt with in the preceding request. In other words, unless you know that there has been a major change, we may be able to make reference to the previous request, with updated numbers, rather than redesign the whole service area.

PANEL DISCUSSION: STATE AGENCY EXPERIENCE/METHODS EMPLOYED IN GEOGRAPHIC HMSA DESIGNATION

Panel Members: Sharon Sowers
Mary Ring

MR. LEE: This afternoon we're going to do several things, first, we have presentations from Pennsylvania and Illinois -- on the state agency experience and methods employed in geographic HMSA designation. Later, we will move to the eighth floor for small group discussions by region, and your agenda will tell you which room you're in according to what region of the country you're from and who the moderators are.

MS. SOWERS: I am not with the SHPDA. I am with the Health Department but in a sister bureau. In our Health Department, the Bureau of Planning is responsible for all SHPDA activities such as CON, writing the state health plan, et cetera. I first worked with the SHPDA but left four years ago. Since I worked on the health manpower shortage areas and just moved across the hall, I took my work with me.

Today, I am talking about the demise of our HSAs. Pennsylvania has nine HSAs; two of the nine have folded, about five or six more may fold. Our current political administration neither appreciates nor cares for health planning; health planning has not received state funding. We do not have the staffing for manpower surveys, and without this information, the need remains. Pennsylvania has roughly 11.9 million people, approximately two million of our people are covered by 70 primary care HMSAs.

When you think of Pennsylvania, you think of Philadelphia and Pittsburgh, however, Pennsylvania is 69 percent rural and most of our HMSAs are in the rural areas. We had to devise some way to meet our responsibility for responding to HMSA designations and also the placement of the Corps doctors into priority health manpower shortage areas.

I have been responsible for developing an "Automated Primary Care Data Base," thanks to funding by the now-defunct Appalachian Region Commission, and the National Health Service Corps Contract. We started out collecting information on doctors in a very manual way, since the last automated survey was done under the Cooperative Health Statistics in 1980. Two years later, we found ourselves needing this information, but the 1980 information was too old, and was not applicable anymore. We started manually compiling information on doctors in each of these HMSA areas, and expanded into collecting data in contiguous areas and areas of need of corps physicians placements.

As we studied more of the state, we realized the need of a formal way to collect and store data. We categorize Pennsylvania into "PCPUs," or "Primary Care Planning Units." The State of Pennsylvania is divided into 260 Primary Care Planning Units, excepting the city of Pittsburgh and the five county areas surrounding Philadelphia, since I am the only person working on HMSAs in Pennsylvania.

These PCPUs are minor civil divisions that comprise a 30-minute travel time service, roughly what HMSA regulations describe as a rational service area. Whenever we collect any kind of data, or manpower information, it is categorized according to primary care planning units. As we received federal funding, we began to develop the data base with resources we had been collecting, and this information is entered by Primary Care Planning Units. We now collect population information, broken down by age, sex cohorts, poverty, infant mortality rates, teenage pregnancy, and low birth rate. We have reviewed all hospitals and other facilities in Pennsylvania and categorized them, into each of these planning units, to determine for each planning unit here the amount of manpower and the number of health facilities available.

Pennsylvania does not have any organized survey mechanism with the licensing application. We have been manually compiling physician lists via phone books, professional directories, and other sources using temporary part-time clerical help. We compile a list of doctors, call them, and get names, practice locations, any satellite clinics, the office hours in each clinic, hospital affiliation and their specialities. A physician can be assigned to as many Primary Care Planning Units (PCPUs) as necessary, since one doctor may have three satellites throughout the county, and each for a different service area; he would be listed three times (not more than one full-time equivalent) based on the number of different office practices.

We thought about using AMA data; but the data could not be as specific as the data we had been collecting. We have worked out an agreement with the Pennsylvania Medical Society to annually mail, with their cooperation, printouts to each county's local medical society listing all the doctors, location of practice, etc. and request an update. The response has been good mostly because they realize that if they do not cooperate, more doctors will be placed.

I have been working on the Automatic Data Base for the past three years, and it will soon be a reality. We have employed a computer contractor to have this system within the next month. It is going to be an on-line system, giving us the capability of getting immediate information on Primary Care Planning Units. This will allow us to manipulate our data base to verify information on, for example, the number of physicians and the infant mortality rate in an area. The data base will automatically calculate physician to population ratios, and develop MUA or IMU scores for each area. We have devised a formula to compare supply and demand. We thought it was very important to include information on Medicaid, since areas of the state have population designations for the Medicaid-eligible population.

The Department of State has this responsibility, but does not license physicians as the Department of State. We had to work with them to get in-

formation, and work with our Department of Public Welfare, for the Medicaid information. The Department of State compiled a printout containing the names of physicians and their license numbers which we are matching against our file of all physician names. Then, we will enter the license number of all physicians on file to have one complete file, which we can match against the printout from the Department of Public Welfare of physician license numbers and Medicaid claims. The Department of Welfare gave us a list of doctors with primary care specialties. Each physician's claims will be counted and converted into Medicaid full-time equivalencies, compiling a physician to population ratio for all 260 Primary Care Planning Units to determine shortage areas for the Medicaid population.

The Department of Welfare also can provide, by county, an estimated percentage of the population that is Medicaid-eligible. Since Primary Care Planning Units are smaller than the county level, and crosscounty borders, we devised a formula for distributing the Medicaid eligible population into each of these Primary Care Planning Units. Any questions?

FROM THE FLOOR: Sharon, have you found any problem with confidentiality limitations either from the physicians or the medical societies on the data you have collected or on how detailed your information can be?

MS. SOWER: No, no problems. Our Department of Welfare has had no problems giving us the number of claims for a physician, as well as the total amount of reimbursement. We are very careful in how we would release this information to the public. We will provide information as needed.

FROM THE FLOOR: I had never used Medicaid components, as a separate category. Why have you developed this and what are some of the uses you have found? Is it to designate the Medicaid population per se, as opposed to the general population in an area.

MS. SOWERS: Whether you are looking at the Medicaid or just a primary care designation, we have to look at the contiguous areas, because in the rural areas we are going to come up with a Primary Care Planning Unit with a ratio of one to 5,000. Right away you know there is a need for doctors there. That may not necessarily be true, since one of the contiguous Primary Care Planning Units may have a hospital and a whole system of doctors surrounding it; and the same applies to Medicaid. This is just a starting point for our additional analysis. Anyone else?

MR. LEE: What criteria did you use for the Primary Care Planning Units?

MS. SOWERS: Thirty minutes travel time. We tried to look at the concentration of physicians or a hospital, although each county was different. We did not stop at a county border. Many times an HSA had started something but would stay with Primary Care Planning Units within their region, and I did not want to do that since people do not stop seeing a doctor if he is two miles over the border.

MR. LEE: The reason I asked that question, was because you said one needs to look at the contiguous areas. If your Primary Care Planning Units were all more than 30 minutes apart, that wouldn't be a problem, would it?

MS. SOWERS: Maybe not.

MR. LEE: Well, you probably have some problems because the de facto centers of care are within 30 minutes.

MS. SOWERS: In some cases there is no particular reason for the way people travel for medical care.

MR. LEE: It appears to be a well developed system. You have utilized the Medicaid data better than any program I have seen. Other states have divided service areas throughout the state and compiled the ratios on computer so you can see the contiguous area ratios. Whenever that can be done, it is going to be good. Our next speaker is Mary Ring, from the Illinois Department of Public Health.

MS. MARY RING: We do most everything in the same fashion, although our focus is a little different in Illinois. We started with health manpower shortage area designations in 1978. Since that time, we have developed a manpower data base for the whole state, the HMSAs being one use of that database. The HMSAs in the state have been identified as a continuing need or when the health manpower has changed to such an extent, we have de-designated the area. Most of the high priority HMSAs have been addressed either by community health centers or in cooperation with family practice residencies throughout the state. Illinois may be one of the best served states in the area, with 25 family practice residencies, many of which have been willing to set up satellite clinics in underserved areas unable to support a community health center.

Six years ago, we started to automate the system and to expand the database to full coverage of the state. In Illinois, there are 102 counties, one being Cook County, the Chicago area. We deal with the HMSAs in there on a case-by-case basis and use the resources within the city. After a year and a half of negotiations, the Chicago Medical Society agreed to give us access to their data tape and we are now going to match it against the addresses of physicians by census tracts in city of Chicago. The Chicago Medical Society assumed a 60 percent membership in their organization, not ideal, but considerably better than what we had. At the 60 percent level, there are almost 4,000 practicing primary care physicians. The surrounding counties are very densely populated and generally very wealthy. If we receive a request from a particular area, predominantly for a population group, we work on a case-by-case basis; otherwise, we cannot deal with these areas.

We concentrate on 95 counties throughout the state. We have gone through the same activities as Pennsylvania over the years, looking through the phone books, and using the AMA directories, to develop the initial preliminary listing of primary care physicians in the area. But we enter all the data, prepare a preliminary run and we send this out on a county basis to a hospital administrator or the person most useful at the hospital level, such as the director of nurses or the head staff nurse. We send the listing to someone associated with the hospital in the area. We also use local public health departments, of which there are 76 in Illinois. The school nurse or nurses make referrals for children who do not have a family physician. They are knowledgeable of the amount of time a physician is actually available.

The only time we actually deal directly with the physician is when there are discrepancies in data reported by several local sources. In that instance, we will call the physician's office directly to determine how much time they are actually spending in practice. We assume full FTE unless there is some very specific information. Our database is relatively simple, maintained by county, town, specialty, approximate age, and up to three separate practice sites per physician. If they are practicing in two other counties or have two other practices within the same county, we split them out by FTE by site.

We have been using the database for our state program more than for the HMSAs. We have a state-funded scholarship program. Our first 42 scholarship recipients (1979-1981), are just finishing their residencies and are being placed in under-served areas of the state. We have another 180 scholarship recipients in training. With the phasing out of the National Health Service Corps and the relatively high ratio required for an HMSA, we are finding out state program needs are greater than the HMSA needs right now. It is very preliminary at this point. Our criteria use a ratio of population to physician of 3,000 to one, and considers areas lacking in a particular specialty, such as OB or pediatrics. Regardless of the ratio, we will allow placement of a scholarship recipient in one of those areas.

We also have been collecting the Medicaid data from 1983, 1984 and 1985. One of the state universities has done some extensive manipulation of the data for 1983, only to discover once we compiled the 1985 data, that the 1983 data was terribly suspect and that the programmer had made a very grave error. We discarded the 1983 data, although we wanted to do a trend analysis. The 1984 and 1985 data, is divided by the primary care physician, by county, office-based and services. We have an unduplicated count of recipients and an account of services provided with the dollar amount billed.

Our biggest problem is that it is an unduplicated recipient count, for the individual physician, but not unduplicated for the recipient, since we do not know how many different physicians that recipient has seen. We know that the data is inflated. We are working with the Department of Public Aid to do further analysis by individual recipient, rather than focusing on the physician providing the services. It will be difficult, but it is the only way to determine the number of people getting served.

Physicians in a particular county have been drawing Medicaid eligibles from all the surrounding counties. If you just review the currently presented data and compare, for example, the number of recipients served in county x with the number of Medicaid eligibles for that county, we might find that it is 80, 90 or 100 percent. People from the other counties are coming in to those physicians, there is a constant migration. One of the big projects in the future is to redefine service areas.

We are trying to combine, with our health manpower database, the data available in other sources, for example, the MCH data on the low birth weights, low care, which are all in separate databases. We are working with our Department of Registration and Education on the physician licensure forms. The Illinois Hospital Association, the Chicago Department of Health, the State Department of Public Health, and the HSAs are all interested in it. We would like to re-design the physician licensure form to include specialty,

date of birth and a business address. The State Medical Society has been the primary sponsor of the scholarship program I mentioned. They were supportive of us during the National Health Service Corps Contract, and did not contest many of the placements of the corps physicians. They see the need for developing the licensure change, particularly since 220 physicians are currently involved in the scholarship program, and approximately another 240 individuals will be in the next four years. We are going to have a problem trying to place them without financial support for their practice.

In summary, our database is a little different from others in that the HMSA is just one component. Are there any questions?

MR. LEE: Thank you very much. Once you have the system automated, it allows you to update it, determine when a designation status changes, and print out the information on contiguous areas. The system's capability makes both our jobs easier.

The Pennsylvania case, excepting Cook County, is probably more complicated because of the primary care analysis areas. Designing those service areas had to be done by hand, but once you computerize that information, it can be printed at need. It is helpful to know what has worked in other states. Tomorrow afternoon we will have presentations oriented towards population groups. If there is anyone present not asked to speak who has some particular phase of their program they would like to share with the group, feel free to inform the person in your panel meeting this afternoon or me and we will fit you in, if it is of general interest. In each discussion group, please nominate a reporter to present the issues discussed to the whole group Friday morning.

The general proceedings were recessed at 2:35 p.m.

PARTICIPANT EXPERIENCES/PROBLEMS WITH
HMSA DESIGNATION (EMPHASIS ON
GEOGRAPHIC DESIGNATIONS)

Small Discussion Group A
Regions III and VII

Moderators: Melba Kokinos
Betty Hambleton

MS. HAMBLETON: A letter from the Commonwealth of Kentucky is available for distribution as a good example of developing a matrix of every county for viewing the contiguous counties. They were able to provide complete data for every single county in the state. It may give you some ideas for the annual review process

MS. KOKINOS: We are going to talk about particular problems.

MR. KAPLAN: What is considered the normal time-frame for receiving a response to an application?

MS. KOKINOS: The time-frame is that while we try to complete review on a request within 60 days after we receive it, that does not always happen. The time span for comments on the annual review is 90 days.

MS. HAMBLETON: For the annual review, we usually wait for all the information to be submitted before reviewing a state, rather than reviewing each piece of information as it comes in. While you get a more complete picture if you review the whole state at one time, this can cause delays, especially when a deadline extension is requested because we tend to wait and there are a lot of phone calls saying: We cannot meet the deadline. And that is the day before the deadline. In addition, we still receive individual designation applications which must be processed.

MS. KOKINOS: On individual requests, much is dependent on the reliability of data received.

MS. HILLEMANN: We have done a computer printout for all of the counties in the state and all of the HMSAs, which is available upon request.

MS. KOKINOS: To date I have received data only on the number of providers.

MS. HILLEMANN: We usually report to you which HMSAs need action, but we can also provide information on each county in the state.

MS. HAMBLETON: This information is at the county level, correct?

MS. HILLEMAN: Yes, in addition to all of the HMSAs.

MS. KOKINOS: Does this include provider names and office hours?

MS. HILLEMANN: We tabulate the FTEs, not office hours or names of the physicians. It does include columns for the adjusted populations and the most recent population estimate, as well as listing the number of FTEs in a county. As separate categories, we include the number of Corps physicians placed and the special needs indicator. It calculates what the designation should be, and keeps track of what the designation is. In addition, we have a need ratio to identify for the HPOL where critical areas are for National Health Service Corps placement. We use that to make our reports to you, but if you would rather have the readout it would be easier for us to just give it to you than to have to do the other paperwork.

MS. HAMBETON This printout will not eliminate the need for additional paperwork as the narrative still needs to be included. We have just input recent fertility and infant mortality data. Whatever information you have received we will feed into our data base to update it nationally.

MS. HILLEMANN: We have information on primary care physicians, psychiatrists and dentists.

MS. HAMBLETON: We would appreciate receiving that information.

MR. LEE: We lost a HMSA designation a couple of years ago, and while today's discussion has been useful, it is a couple of years late for me. Essentially, we lost the designation when we were not able to show that when a new physician office building came into a HMSA area, the physicians were not serving the medically indigent population, for whom this designation was received. This area has fertility and infant mortality rates among the highest in the nation, and the health status indicators are very poor. The area is across the street from the Maryland line and physicians viewed it as being ideally located in the District, erected a building, but did not serve the area's population.

We did surveys, but these physicians saw it as not in their interest to answer, returning two out of 40-50. I am interested in ideas on handling this problem as the area is in need of more doctors, but we are not able to prove this point.

MS. KOKINOS: One possible solution is to apply for a population designation. Determine the doctors serving Medicaid using a provider number issued by the Welfare Department. A Medicaid data cross check will prove that they are not serving the area. This is a good example of when to use the population group designation.

MS. HILLEMANN: We have had a similar problem in St. Louis in poverty population areas where the hospitals, public health department and 330-fun-

ded community health centers are very knowledgeable of area Medicaid doctors. They are willing to do the survey work for us, including contacting doctors' offices, talking to staff people, determining whether or not they accept Medicaid, if they accept new patients, and the number of office hours. With this help, we have done several population group designations.

MS. SOWERS: We get as much information as possible from the Department of Welfare, as the county medical society is unable to compute that data.

MS. KOKINOS: Did you mention being able, through a computer printout, to determine where the patients are coming from?

MS. SOWERS: That is a process we are working on more and more.

MR. BERRY: I have a policy question. One of the major benefits of having an area desigated a Health and Manpower Shortage Area is that the National Health Service Corps physicians can be assigned there, thus meeting their loan obligations. There are 900 possible physicians for assignment this year, and by 1987 there will be 300 physicians for assignment. Given that situation, it is very unlikely that there will be any National Health Service Corps assignees in the future; considering staff time needed to maintain a designation, we are wondering whether or not it is worth the effort.

MS. HAMBLETON: That is a good question to bring up tomorrow when people from the National Health Service Corps will be here to speak on the future of their organization; they are thinking to continuously address health needs.

MS. KOKINOS: It may be worthwhile to try keep the program you have.

MR. BERRY: Our programs have been getting grants from the Federally recognized Robert Wood Johnson Foundation, so we do not have to depend solely on the federal government.

MS. ROONEY: Should we ask that foundation about funding for states not otherwise funded, for data to comply with giving this information? At this time local HSAs help the local individuals wishing to apply. Kansas has not been involved in the application, but we have a data system due to our state scholarship program that could easily supply the information you are currently seeking.

With our HSAs and our whole health planning program in need of funding, only our research people would have necessary funding for computer work. The State of Kansas would not be able to find programs of the local level maintaining only our regional office system. Does every state need to produce information?

MS. KOKINOS: We do need information from each state, and we recognize that you have state programs which have not been very active lately.

MS. ROONEY: We were planning to eliminate our data survey, as there is no other need for it. Presently, it is still active, and we can supply you with those figures.

MS. KOKINOS: Thank you. We can use them.

MS. HAMBLETON: Dave Ober should address the question of state contractors and the funding situation, how to maintain data bases, federal needs and what future funding will be available in particular contract situations.

MR. BERRY: You are making it more difficult to maintain a designation when it may be to your advantage to make it less difficult to maintain a designation.

MR. KOKINOS: We do need to make the information clearer and identify the true shortage areas.

MR. BERRY: Because a lot of the state health planning departments are trying to do that with their research people and trying to do the same amount.

MS. HAMBLETON: The issue of HMSAs is more widely known than it was a few years ago. More interested parties are involved in the process. These people are more aware of the situation at the local level. In many cases there are questions on the validity of the data. We do not intend to make the process more difficult; simply, we are trying to provide substantiation to avoid challenges of our sources.

MR. BERRY: If local medical societies were aware of the number of physicians available for assignment, I think they would not be issuing challenges.

MS. HAMBLETON: We provide them with a copy of the designation request and in many cases you get a letter back from a representative of that local medical society saying there is no need of doctors and everything in the request is untrue.

MS. KOKINOS: On the other hand, even though they may challenge it or not concur, and they do not produce any solid evidence to prove their criticisms, the area will be designated if it meets the criteria, with or without their approval.

MS. HAMBLETON: Their negative comments do not affect the objective analysis of the area, except when they provide hard data.

MR. BERRY: Listen to their comments, weigh them against data you have collected, and, if you think you have ample cause, make the application. On the state level, these groups respond not only to Central Office when they receive notification that an area is under reconsideration or is about to be redesignated, but to local politicians as well.

MR. STAMBLER: Can I add one comment?

MS. HAMBLETON: Go ahead.

MR. STAMBLER: This problem affects the corps placement more than the designation process. The Health Placement Opportunity List is supposed to ensure the cooperation of the state or local community doctors before they place anybody. Placing a doctor in an area where there are real objections creates serious problems; area doctors may not offer any assistance or they may fight him. He may not get hospital privileges.

So, when we get a congressional or senatorial support letter, we have to respond, but it does not enter into any of the decisions we make. If the Corps knows there are real objections, they reconsider placement because that doctor could be there three years without hospital services and having the area doctors fight him.

MS. ROONEY: I wanted to ask Sharon a couple of questions. If I understand correctly, you have a uniform system for analyzing service areas developed. Should an individual area have a different idea of a service area, will you incorporate the two systems? Do you have any local people to redefine this service area? How do you work with that?

MS. SOWERS: A hospital may send us an application on developing a service area different from the service areas we have developed. We will work with them and if their system makes more sense, I will change my service area to reflect their input. My service areas do not always correspond to HMSAs. I put a lot of weight on what local people submit to me.

MS. HILLEMANN: The most recent request we have received is in getting primary care physicians into psychiatric facilities. We can have facilities designated as primary care shortage areas, but not psychiatric hospitals, as they have very special needs not shared with the rest of the community. We're tried to work with our department of mental health. They've had a tremendously difficult time trying to place primary care physicians in the state hospitals. We can get psychiatrists and we have designated shortage areas for psychiatrists. We really need to find a way of getting National Health Service Corps primary care physicians in those institutions which cannot attract other doctors, for many reasons, including the low pay for institutional doctors. It is a critical problem in Missouri.

MS. SOWERS: Do you want to get Corps physicians in there?

MS. HILLEMAN: The institutions rely mostly on foreign doctors, which raised the problem that mental illness is sometimes so culturally defined, it becomes difficult for a foreigner to understand the hallucinations or delusional symptoms in an American psychiatric patient.

MS HAMBLETON: That is a difficult type of designation to define because psychiatric institutions in a state or county are dispersed throughout a wide area.

MS. HILLEMAN: In addition, they are very small population groups.

MS. HAMBLETON: Access problems will exist unless you maintain a consortium having physicians on a contract basis. Your private community of physicians might provide so many hours of care a week or a month. Otherwise, the approach would be difficult and I don't know of any designations done, except for the developmentally disabled, which is a different group altogether.

MS. HILLEMANN: But are there similar types of institutions? These groups have both differences and similarities.

MS. HAMBELTON: Correct. There are many structural barriers with that particular population. There are difficulties in approaching the problem because of the location of the population to actually define the access barriers to the public physicians. Are these patients hospitalized for the long-term, removed from the community or patients who return to the community who do have access to the private sector?

MS. KOKINOS: To date, we can not do anything about the problem.

MS. HAMBLETON: Howard, can your group do anything?

MR. STAMBLER: I wish we could. It is difficult to develop a set of criteria, put them into play after analysis and put them into the Federal Register.

MS. HILLEMANN: Is there some way to distinct the term of the facility, a shortage area, i.e., a hospital?

MR. STAMBLER: We just designated a psychiatric hospital for a prison system.

MS: HAMBLETON: We have means of dealing with those facilities providing psychiatric treatment. I am not sure we can handle primary care physicians for mental institutions on a facility basis.

MR. STAMBLER: It is something to be looked at since there will be an increasing number of the institutional issues coming up as more of the geographic area issues disappear. This problem occurs because of the difficulty in identifying a population group rather than an area. Areas circumscribe very easily and most of the new designations have been population groups. As that is the direction we are taking; it is very difficult to collect population group data and extraordinarily difficult to evaluate it.

MS. HILLEMANN: We recently designated a correctional facility in the St. Louis area.

MR. STAMBLER: We have new criteria in draft form, so I hesitate to put them forward.

MS. LEE: I have heard about the draft regulations. What would the District of Columbia need to do to designate a facility we run in Virginia. Would we have to take into account what is happening in the area of Virginia and what kinds of primary care physicians are available? We operate the Lorton Facility.

MS. KOKINOS: You want to know if you can designate Lorton in Virginia, which is under your jurisdiction?

MS. LEE: It is under our jurisdiction but is in another state.

MS. KOKINOS: We do not define travel time in that case. It would be possible, and we would fuss over who had the jurisdiction.

MR. STAMBLER: Virginia would not argue over having the doctors.

MS. KOKINOS: If it meets the criteria, it is possible, although you may want to look at D.C. to get validation.

MS. HAMBLETON: The Lorton D.C. facility should not be a problem if you consider the whole system. Perhaps you should consider other areas as well.

MS. SOWERS: Printouts for our data base show HMSAs falling in West Virginia, Pennsylvania and New York, and, at the end, the HMSAs are listed in numerical order.

MS. KOKINOS: We do not list tri-country facilities in all three states because it would give us a false reading.

MS. HAMBLETON: We should send you the annual review printouts to look at, if you have included in that all of the data bases for the state that have have those parts.

MS. SOWERS: Yes, we have.

MS. HAMBLETON: We have tried to do that, and will find a better way to make sure that when data is compiled and packaged, you will get the information, perhaps by an HSA identification number.

MR. WILSON: I wish that the printouts were by county and identification number, so that we do not have to double check the entire package to be sure every township is covered.

MS. HAMBLETON: It is a problem for us as well.

MR. WILSON: Two printouts, one by service area, and the other by counties, would be helpful to us.

MS. KOKINOS: One that shows the service area and its parts?

MR. WILSON: Correct.

MS. HAMBLETON: We are developing a system called "BHCDA-net," which will help us automate the designation process to some extent. I am trying to develop a printout system addressing exactly these problems, so that you will have cross-references and will not lose any pieces. You will be able to see exactly where the service areas are, even when located in another state. I have a layout at the office.

MR. WILSON: If the areas are withdrawn, why do they continue to appear on the printouts?

MS. HAMBLETON: There is no way to completely delete any service area because of the administrative problems and the expense of running separate programs to list certain things. Questions in the future regarding a suit brought against the National Health Service Corps by a doctor sent to a previous area can be answered by the historical data in that data base. In rare cases we delete a record when a new service area has been developed with a different I.D. number including some of the same census tracts and towns in that new area. In that case, we would delete the original towns, enter withdrawal dates and enter them under the new number, to avoid an unmanageably large data base.

MR. WILSON: I have a problem with the present printout when going through the annual reviews and seeing designations that were withdrawn.

MR. STAMBLER: Perhaps a designation will be withdrawn and, later, found to have need of redesignation. This would be a reason to maintain old records. Often, in Mississippi, the situation is much worse than we are able to identify. When not dealing with us except for the annual update, it might be worthwhile to review withdrawn areas to ensure the situation has not worsened.

MR. WILSON: If we had more resources, that would be a good policy.

MR. STAMBLER: Is anyone here from a state with a National Health Service Corps contract?

MS. KOKINOS: Sharon Sowers is here.

MR. STAMBLER: Okay. Resources or no resources, one of our objectives is to consider borderline or changing areas in need of designations. The state contractor may need help, and we should offer our information. If possible, involve people other than state health planning agencies and state health departments, such as the office of rural health. There are many people with an interest in particular situations who would love to be involved, and the more people involved, the better the designation will be. Some medical schools are seriously examining the needs. As the SHPDAs, HSAs and others disappear, we will need more help. If you can get assistance from the state medical school or health science center, it will better enable you in providing services to the state. In the next six months, try to involve additional people who have useful information but are not in that strict state health department or SHPDA routine.

MR. WILSON: Iowa works closely with the medical school at the University of Iowa, in getting our physician data; they work with the regional office as well in looking at placement of National Service Corps. The school does a community analysis of most of Iowa, but they probably would not share that information.

MR. STAMBLER: We can not compete with 127 medical schools or 200-plus HSAs, which is why we work with the states and local people with information and insight in the area.

MS. WASHINGTON: This is in the way of a comment. The problem that Maryland faces is that health maintenance organizations (HMOs), preferred provider organizations (PPOs) and others are not willing to share information on the patients served or the type of providers employed. Is this a problem in other states, or have you developed mechanisms for getting information from organized providers?

MR. KAPLAN: The only problem we face is in rural areas where physicians spend one or two days in a town, making it difficult to accurately count.

MR. STAMBLER: The PPO/HMO data problem is nationwide. Have others run into that problem? Major insurers moving into the management of health care are spending millions of dollars developing a data system. We are going to have to deal with them, but so far we have not had much luck. The American Hospital Association and the American Medical Association are facing the same problem. Has anybody had any success in dealing with this?

FROM THE FLOOR: We do not have many HMOs in West Virginia although some of the larger hospitals have HMOs in development stages. So far, HMOs do not cause competition in the rural areas.

MS. WASHINGTON: PPOs are an umbrella organization who employ some doctors in isolated areas. This keeps costs on a more manageable basis, and guarantees the provider a certain patient population. The advantage to the ultimate payer is a fixed cost for medical coverage. It would be more advantageous for doctors to group together to provide a larger service, i.e., a CAT scan or MRI in an area where one provider could not afford it alone.

FROM THE FLOOR: Some of our smaller hospitals are doing that and buying the mobile units, especially physicians in rural areas with a captive Medicaid audience. Medicaid is the largest employer in many counties.

MS. WASHINGTON: These groups are reluctant to share information because they are trying to protect their market share.

MR. WILSON: Our Medicaid program is tending towards HMOs in larger cities and a couple of state-wides.

MS. LEE: We have regulations requiring health providers to supply certain data, but it is difficult in a era of de-regulation, to increase the data. We do receive basic information and we are not a cost-commission state. The new strategy we are employing is to inform HMO heads of data we need while convincing them that it is in their best interest to supply the information. We have collaborated with the home health agency in Washington, a group that does not have to provide any data on a survey. They eliminated some questions, and added others, the final result was a summary giving us needed information which they can use for marketing. First, you must convince them that there is benefit for both in working together, which can be done through meetings with community-based people that are on your boards and who have entry to the group you are trying to get data from.

MS. HAMBLETON: So far we have focused on the activities surrounding primary care designations. Perhaps we could discuss dental designation requests. A dental annual review letter went out to you last July. These have not been completed due to the emphasis on primary care annual reviews for 1985. The results of the annual reviews will be incorporated in the next list. We need to have the psychiatry annual reviews finished and we will be publishing an updated psychiatry list in the Federal Register. There may be some problems with respect to areas having a significant number of dentists saying that they are under-employed. How do you collect information and what is the information that you have on visits? Are there any particular problems you want to address now?

MR. KAPLAN: Every time we submit a request to the dental association, it is opposed. This often happens with the dental requests because dentists maintain they are under-utilized, and do not have enough patients.

MS. HILLEMAN: We have let the dental designations slide because we have so many rural areas, hard-pressed economically, where people are not consulting physicians much less dentists. The dentists are having a tough time, especially in the rural areas. Liability is another issue that's crushing them.

MR. WILSON: How many placements are there for dentists?

MS. HAMBLETON: There are fewer, but I can not give an exact number for this past cycle. There will be a representative from the American Dental Association speaking tomorrow, primarily to address policy issues. It is a lower priority for the Corps in terms of numbers in the past and in scholarships.

MR. WILSON: In Iowa, we pass that information to our dental people or the people at the Department of Human Services but we never receive comments.

MS. KOKINOS: The state of Iowa has redefined the area. We hope to publish that in a couple of months, with the completion of the annual review.

MS. WASHINGTON: In Maryland, we have designations in one very rural part of the state and in an urban area of Baltimore City which has existed for a long time, never opposed. We do have a growing need with the elderly population. Doctors provide medical needs for the elderly but not for their dental needs, which are sometimes very drastic. The institutionalized elderly population has tremendous needs which are not adequately covered. Can this be solved with an HMSA?

MS. HAMBLETON: You need to determine the number of providers available to meet those needs.

MR. NEAL: The dental association needs to work with the insurance industry and the HMOs to get a central component into the coverage plans. If you don't have the money, you are not going to consult a dentist.

MS. HAMBLETON: No, not unless you are in pain.

MS. HILLEMANN: In a recent meeting with a number of health associates, the director of the dental association said that the demand for dentists is not there. He feels that if people would have regular checkups and have work done, rather than postponing it, there would be shortage areas for dentists. Until this happens, the dental association will not be supportive of HMSAs.

MR. NEAL: There is not enough business to create a big problem.

MR. KAPLAN: In Nebraska, the enrollments are down in dental schools.

MR. WILSON: Many dentists are not practicing.

MS. WASHINGTON: Some of the HMOs are not putting on dental components. This is a possible employment opportunity for dentists. Unfortunately, it will again be difficult to track the impact they are having.

MS. KOKINOS: There will be no response to the dental annual review?

MR. KAPLAN: In Region VII, they have designated dental areas outside of St. Louis and Kansas City.

MS. KOKINOS: There are eight designations in Iowa, 11 in Kansas, 44 in Missouri, and two in Nebraska.

MR. WILSON: Has Iowa responded to the annual review?

MS. KOKINOS: I am not sure. We did not request new dental designation updates this year.

MR. WILSON: The emergency medical services have developed a mapping system for micros. Will your system work with that?

MS. HAMBLETON: No, our greatest need is for maps at the local level. When we try to find a city on the Rand-McNally Atlas it is a little dot, with no concept of roads, or distances.

MR. NEAL: The Bureau of Census is developing a mapping system. Depending on the size of the geography represented, it might be available on the census geography.

MS. HILLEMANN: That would be nice if it was based on the Census.

MS. WASHINGTON: Yes. The first constraint is that if the Census doesn't provide the population then you can't develop your services.

MR. NEAL: In West Virginia, we do not have a census of divisions, but of magisterial districts which are politically motivated and politically drawn, making it difficult to draw analysis.

MS. WASHINGTON: Except for the Census, where can you get accurate population data?

MR. NEAL: One possibility is to count houses and multiply by the estimated number of occupants.

MS. KOKINOS: West Virginia usually includes a map.

MR. NEAL: That is because I am a geographer.

MS. KOKINOS: The maps you include are very much like those from the Census Bureau.

MR. NEAL: Perhaps states should hire a geographer.

MS. KOKINOS: People have ignored providing a map, but it makes our job easier if you include one.

MS. HILLEMANN: I have included many maps in the past few years, and roads have not changed.

MS. KOKINOS: We have a book of maps by state, but when we receive a request without a map, we must search though it to find the service area.

MR. WELLES: Are you using the 1977 book?

MS. KOKINOS: No, the book for 1980, with all the counties listed. In the back are the counties and their parts. If a map is not included we must Xerox this map of the service area so Dick will not spend extra time determining the location of the service area.

MS. HILLEMANN: What happens to the maps provided? Are they kept or do they go with the old file?

MS. KOKINOS: They become part of the application.

MS. HAMBLETON: If you have provided some extensive mapping for a previous request, you could just note the date of the application. Sometimes, within two years, an interstate can be built in an area.

MS. HILLEMANN: In Missouri, it takes a lot longer.

MS. HAMBLETON: If you would note that the area has not changed and refer to previous maps it would enable us to trace them.

MS. LEE: Do you have an automated spread sheet to analyze our data?

MS. HAMBLETON: Not all of the material for every request is input. The designator or analyst reviews the material and using a worksheet, compiles the information in finalized form. The other worksheet is used for data base entry of the definition of the area by census tracts, counties, CCD, population of the component parts of the population, FTE, high-needs numbers and poverty.

MS. KOKINOS: All this data is included as part of the analysis.

MS. HAMBLETON: We often refer back to the data base because it holds the records at the county and national levels, as well as the data previously provided to use as a comparison. What goes into the data base is the ratio, population and FTE; often we have computed the ratio and high-needs factors. The computer generates the number of physicians needed. The data sent in is put in a file folder.

MS. LEE: You do not use a data base package or a spread sheet?

MS. HAMBLETON: We use the data entry sheet. Our "Information Systems Branch," does the computer work, entered onto an IBM mainframe computer.

MR. WILSON: Does anyone use micros for their data base?

MS. LEE: We use both Symphony and Lotus, but I was looking for new ideas.

MS. HAMBLETON: BHDA-net has been in the developmental process for over a year. The program will do calculations for us and will provide us with increased file capability, elevating our workload.

MS. HILLEMANN: Do you need our support in promoting the BHDA-net?

MS. HAMBLETON: No, this program is being done under contract although we have been having some problems, i.e., a contractor left mid-project. Although we thought this would be a simple task, converting the analytical process into a program, we have found it is very a complicated project.

MS. HILLEMANN: We have been experimenting with a computer bulletin board called Plan-nette. If we could communicate with your office via computer, we could send our updated data bases on a routine basis, while you could send us information. That would eventually save on paperwork and time, but would require a large investment, in money and time, to get the system working.

MR. NEAL: Have you discussed the high-needs indicators? I have recently had a problem with it, using third world infant mortality rates to qualify areas for high need at one to 3500, and with the poverty rates done in 1979. Much has happened since 1979, especially in West Virginia where many counties are at 35 percent unemployment. Is there any way to put forth an argument using 1979 data for a county with a poverty rate of 19.9?

MS. KOKINOS: Write us an acceptable explanation.

MS. HILLEMANN: How can we update the poverty information aside from using the Medicaid data files?

MR. WILSON: In Iowa, we have a very good economic analysis unit. Can we use such an internal force?

MS. HAMBLETON: Yes, because those are published independent of the census.

MS. WASHINGTON: If a particular area has considerably worsened since the last published Census, mention any verifiable information that is applicable.

MS. HILLEMANN: We also have recommended to the Census Bureau that they publish every five years.

MS. LEE: If we have information on the number of people medically uninsured, could we also submit that?

MS. KOKINOS: I do not think so.

MS. LEE: While not a criteria, it is a target population.

MS. KOKINOS: They would fall into the category of those with some ability to pay. If you had a total poverty population and excluded Medicaid eligibles, what is left is indigent.

MS. LEE: They are medically indigent. That's the closest to it. There are a surprising number of people not covered who are in need.

MR. NEAL: With the current economic situation, there will be a new case for national health insurance, as the middle class is disappearing.

MR. WELLERS: I doubt we will ever see national health insurance, but perhaps 50 state health insurers.

MS. HILLEMANN: We are seeing that already.

MS. HAMBLETON: We will discuss populations and any questions related to BHCDA tomorrow.

The proceedings were recessed at 4:30 p.m.

PARTICIPANT EXPERIENCES/PROBLEMS WITH HMSA DESIGNATION (EMPHASIS ON GEOGRAPHIC DESIGNATIONS)

Small Discussion Group B
Regions IV and VI

Moderators: Jasper Battle
David Brand

Mr. Brand: To begin our discussion of this morning's program, I would like to emphasize the importance of good communication between our office and those of you at the state level. There are a number of states where we only have one contact. Ten years ago there were four; five years ago there were two or three; now, in many places, there is one or zero. Frequently, we receive applications for areas with unfamiliar populations, and we work with the information submitted. Then we look around for additional sources of information because, in these instances, it is really advantageous to have more than one set of data to work with and more than one opinion. In many states, another set of data cannot be found. We need people to supply good information, not just you folks who do it already, but other people in other places. Perhaps you can put us in contact with persons in your state who are compiling similar data, because it always helps to have additional sources.

In some states we need to redesignate areas, but there is no one to put the material together. In other places there are one or two persons struggling to help; they are not working specifically on this anymore but they get involved because there is no one else in the state to do it. (A few of you who help us out in this way are present today.)

We will now turn our attention to geographical designations. Please feel free to pose any questions or problems you may have as we go along.

We talked this morning about putting together a designation and defining a rational area. A geographic area comes in many forms: it can even be a group of census tracts in the middle of a city, and any combination of those can be submitted reasonably. An entire county is probably the easiest rational area to define because a county usually has some degree of homegeneity in its characteristics. This depends, of course, on how much poverty exists, what markets people use and what people do for a living. Areas involving CCDs, singularly or in combinations that function together, can possibly become rational areas for designation.

I have in hand an example we have done, provided by Mark Shapleigh. I telephoned him earlier and asked him to provide us with a good example of a sub-

county area designation. At this time, I would like to ask him to explain why he chose Lead Hill, Arkansas.

MR. SHAPLEIGH: We did this one some time ago, so I will try to remember the background as best I can. As I recall, this service area was put together basically from talking to the community members who were interested in recruiting physicians, building a clinic and encouraging some development.

There are seven distinct little communities in that area, only three of which are actually incorporated. The population does its a gathering primarily in Lead Hill cities, which are very retirement-oriented. There is a lot of recreational activity on that winding lake, called Bull Shoals, just north of the service area. In other words, there were things that we could see that pull that area together, and they focused on Lead Hill as the center of activities.

In my report, I mentioned commerce patterns, community input and then I go into a little bit about rugged mountainous areas. Now our interpretation of mountains in Arkansas may differ from New Mexico or other places. Nonetheless, you cannot attain a lot of speed on the highways, especially with an elderly population, so the area qualifies as hard to get around in.

I also talk about the distance to the contiguous resources and about roadway access. In this particular case, you combine commerce paths with a geographic variable, which is Bull Shoals Lake. This lake is really like a wide river, but it is so wide that it effectively cuts that whole area off from any resources on the other side of the Missouri border -- at least, anything that could be considered accessible within an hour.

So the lake is the natural border that hems people in on the northern side, and you cannot even begin to consider them crossing it. There are no ferries to speak of, and not many of those retired folks own boats.

I think I over-refined the proportion of the townships that I took in, at least with the database. As I understand, Jay, the database is set up in your office to consider either all, or half, of a township. So we edited that a little bit. I have, for instance, Omaha Township, 25 percent. How did I arrive at that? Well, you basically look at the area that the community has described as their service area and you try and match that against the townships, and you are probably just cutting a line from a quarter of that township that includes a community. It is probably splitting hairs a little bit there.

So we talked about the high needs and the poverty level and then a little bit about contiguous resources. This particular area had no physicians in it, and many community members said that they received no help from Harrison, which was the center of the county, in terms of medical resources of any type. There were no physicians who visited or spent time operating clinics up there, nothing. The area was effectively isolated, by the population being mostly elderly, by the patterns that they used, and by the lake.

It is hard to illustrate what I am saying with this map.

MR. LEICHT: It looks like we omitted the page with the township boundaries.

MR. SHAPLEIGH: We do have those types of maps available. Unfortunately, the types of maps that we have available that show townships do not show anything else, or very rarely show highways. If we could find one that would clearly show the highway system, the geographic boundaries and the municipality, it would be extremely useful.

MR. BRAND: We are discussing a service area involving subcounties, and the original application included at least six townships. Notice that there are two counties involved and the rationality is established by something other than county-wide districts.

MS. RAEL: It is a pretty small population.

MR. BRAND: We did not say that.

MS. RAEL: Indirectly.

MR. SHAPLEIGH: I recall asking Jay about that on another point. I don't think it is still like this, but he said you could designate a township with 20 people in it; however, it is up to the core branch to decide what size service area you would be allowed.

MR. LEE: A township of 100 people, isolated and with no physicians, is now designatable.

MR. SHAPLEIGH: The key is no physicians, because you cannot produce a ratio.

MR. LEE: But then, if they come around to placing somebody, they are probably going to rotate a physician through there one day a week, or something like that.

MR. BRAND: There are lots of small areas in Arizona that are like this. There will be 120 people in a town and it is 25 miles in any direction to the next. They may take four of five or those towns and put a clinic in the middle, and then assign one doctor to each of those towns one day a week.

MR. LEE: And that is why they came up with the Rural Health Consortiums, and so forth, which you will hear more about tomorrow.

MR. BRAND: I wanted to ask if Sue Ellen could perhaps remember the background to that.

MS. RAEL: Harvey will know about that.

MR. LICHT: Thoreau is interesting. You would have to know New Mexico. On your way to Gallup and Albuquerque along Route 66, they never mention Thoreau, with good reason. There is a Tasty Freeze there and a private church school which is designed to serve the southern parts of the Navajo reservation; other than that there is a Navajo chapter house, and there used to be a

refinery, a mine processing plant. The population center is a couple of hundred people, but it does serve an area that is substantially larger and is a center of commerce, such as it is, for that area.

MR. BRAND: What was it you remember? What was there about the area that made it designatable?

MR. LICHT: The reason in your mind, or our mind?

MR. BRAND: In your mind.

MR. LICHT: In our mind it was the hub of an area. It was a commercial center, even though it encompassed perhaps 59 people total. It was its own CCD area, which came in different varieties. Distance is actually the factor that made it separate. Even though it has a small population, it takes sometimes four hours in bad weather to go from the northern part to the southern part, which is only 20 miles away. The roads are terrible.

MR. BRAND: We were interested in the fact that there is a major highway, an interstate, that goes from Gallup to Grant and passes right through the area.

MR. LEICHT: It is 30 miles in either direction. Unfortunately, the state road map makers skipped one section and forgot to put in one of those tiny little numbers. It was physically there, but not noted. The area has a small population, and at the physical center of it are clustered only 300 or 400 people in one of the townships; but it draws in probably 1,500 people from the service area, which is also small, but very definable.

MR. LEE: A population designation is appropriate there, is it not?

MR. LICHT: Yes, because of the school and the mining category, among other factors.

MR. BRAND: Do the Indians have more than half the population?

MR. LEE: Easily more than half. Another, subjective reason, I must admit, was that New Mexico is a very rural state with lots of wide open spaces and so forth. The major population centers include Gallup and Grant. And here you have carved out this HMSA, in between two major population centers in a sparsely populated state. My original thinking was that one would want to put doctors in New Mexico in the places that were 100 miles from Gallup, not the places that were barely over 30 minutes from Gallup. I was ready to believe the map that had the low mileage because of the super highway and the fact that it was near a population center.

However, the criteria are very specific, and when you write back to us and say, "By the book you must give it to us," you are right, so we gave it to you; but by just looking at the data, a designation area was not self-evident.

MR. LICHT: One of the things it points out is the whole question of frontier areas; when you go far enough west, you get into very different types of areas with very different types of needs. Even though on the map

it may look like it is so far between here and there, perhaps the distance from Washington to Hagerstown, in fact, that far on our scale of the map is the distance from Washington to New York. This changes our perspective in the state, as to the need for designations.

These areas are usually discrete and we usually do not go in unless there is a local request to set something up. In the future, there may be some additional requirements for frontier-type areas. Why have that designation if you are not going to be using it in one way or another? Those areas, even with lower priority, need to be worked into the formula.

MR. BRAND: Another point brought out by the authors of that application for New Mexico is that this area is up on top of the continental divide, about 4,000 feet in the air. There are a hundred people living up there and it snows a lot; and the road, albeit a superhighway, is either snowed in or closed from November to April.

In response we measured the distance, and we turned down the request because the distance was less than 30 miles. I am not saying that I particularly ascribe to this approach, but that is the way we do business. It has been proposed that when we evaluate these applications, we should make some kind of an allowance for the fact that there are special local conditions involved. I don't know.

MR. LEE: The difficulty is that you cannot make a site visit to every requestor.

MR. BRAND: I would like to ask Eloise Hatmaker from Tennessee to talk about some of the areas in the eastern and northern portions of her state in relation to what we are talking about now.

MS. HATMAKER: We have one place, which is a mining area. It takes two hours to go 12 miles across the mountain. The area is highly populated along the interstate, but then you have to go up a road that is run by Augie Wentworth Coal Trucks--all in the same county.

MR. SHAPLEIGH: I have a problem which can arise when you designate an area that is 30 minutes away, supposedly, from an area that is being considered for designation. A state senator wrote us about one of our proposals, saying, "How in heaven's name can you designate an area which looks like it is sitting on top of a large city?"

MR. DEMAREST: In our case, this area was remote. It had no physicians and about 2,300 people. Thirty minutes driving time would put you right in the middle of Greenville, South Carolina, which is a city of about 70,000 people. The problem was that all the medical facilities in the city were located in the southern quadrant, between Greenville and Anderson. There is no doctor located from the central city towards greater Tigerville, and we made that point known. However, we were turned down because the maps indicated that the area was proximite to a large city. Are there any considerations given to where the physicians and the health facilities are located?

MR. BRAND: In an instance like the one you describe, it would be very difficult for us to designate an ordinary population, unless you can show tremendous poverty.

MS. PEASE: One of my questions goes along with his. People in the outlying towns around Atlanta do not go into Atlanta for health care. They would rather die, and we are talking seriously here. You do not go there unless you die. Many people will not utilize services which might be within 30 minutes and, when an entire community feels that way, I think we need to start looking at that kind of consideration. We should try to document the attitudes of these people. They are poor and rural, with an average of maybe 25 percent of the adults being high school graduates. They are not middle class.

MR. BRAND: How close are these towns to Atlanta?

MS. PEASE: Slightly bordering. I am talking about Barstow County. The southern half of Lake Altoona is definitely a land of B.M.W.s. To the north, we are talking a whole different population that is separated by the lake.

That is the kind of split personality you find in Georgia, and it is something that I find very difficult to communicate to you.

MR. BRAND: I know you do.

MR. LEE: In the case that you just described, you might be able to do it by simply saying, "This county has a split personality and if you are north it is such-and-such." You might also be able to show, once you have drawn the line, that the people to the north are more than 30 minutes away.

MS. PEASE: NO.

MR. LEE: Then you are in trouble, assuming there are limited positions to allocate. In the last couple of years the National Health Service Corps has had a lot of positions to allocate, but the number is going to be dwindling.

Basically you cannot make a logical argument that you should send more physicians to some place within 30 minutes of Atlanta because the residents, for whatever their own personal and cultural reasons, do not want to drive into Atlanta.

MS. PEASE: Another problem we ha' is that it is longer than 30 minutes to the medical care facilities and the doctors, but it is no more than 30 minutes to the city limit from Marietta. The hospitals and the medical community are located along one section of the perimeter and they are located downtown. Rush hour traffic adds to the problem.

MR. LEE: Those two we can deal with. If in a particular city, the medical care resources are located in a particular place, you must send us a map of the city which shows (with dots) where the hospitals, etc. are located. If you can further show that the area is on the other side of the city, and that more than 30 minutes travel time is involved, then we can proceed.

Rush hour traffic or high traffic does contribute to travel time; we have guidelines within the criteria that we follow unless you give us specific time variations.

MR. BRAND: As I remember, in Kentucky we went through the same sort of situation in Carter County, where Covington borders the Ohio River south of Cincinnati. We ended up having to compromise because there were some counties that were fairly close to Covington that probably were similar to what you were describing in Georgia. There were plenty of doctors in Covington and another town just south of there, in Hinton County, I believe it was. Some of the counties that bordered Hinton County were as you described: There were people there who were not willing to go into the big city of Covington. Those same people may have responded to a county mental health center, with perhaps a social worker or a nurse practitioner and someone to refer people. But still, because of the distances and the access by highway, there was a tremendous problem with some of those counties.

MS. PEASE: I have heard a little bit about it.

MR. BRAND: The same thing happened with the counties in between Louisville and Lexington. There is a superhighway running down there. When you started getting too close to one of the other cities, we had some problems.

MR. SHAPLEIGH: We have a city in southeastern Arkansas, Pine Bluff, which is in a high minority and high poverty region. We were able to show that all the medical resources, primarily the hospital and the physicians, were way down at the bottom in the affluent part of town. Most of the minorities lived on the northern edge, and there was a considerable number of people.

By documenting the public transportation system and other major routes, we were able to demonstrate that the minority population could not get from one side of the city to the other, consistently, in 30 minutes. This is a city of only 60,000 people, but they just could not do it.

MR. BRAND: In northern Arkansas there was this small CCD in the northeastern portion and, on the southeastern portion of the same county, there was a designated area that was another CCD in that county and a county below. In all, there was a distance of perhaps 25 or 30 miles between the northeastern CCD and the southeastern CCD.

In this case, I really had to take a look at what was going on in between, because the entire county, which consisted of nine CCDs, had a ratio of less than 2,000 to one, however, there was one designated CCD, because of its particular, separate characteristics, and Arkansas came back and asked for another one. We had to consider, first of all, the location of the population center and the number of doctors in this entire county. An aspect of this is that the rest of the county was not overutilized, to the extent that the ratio within that entire county was less than 2,000 to one.

A subcounty area usually stands a much better chance of not being as carefully scrutinized if there is a ratio more than 2,000. In this particular

case there was a population center that was about 29 or 30 miles from the new area and about 29 or 30 miles going the other way. It was right in between.

MR. LEE: Just a general comment on the population of CCDs, and whether a community is a township or minor civil division. A township is a census designated division which reflects some sort of unity. We assume that a township is either in or out of the XYZ service area; and that applies to most of the places that the Census Bureau calls minor civil divisions.

The Census Bureau also has CCDs, Census Counting Divisions, particularly in the west, which are arbitrary pieces of real estate, but they simply had to draw a line some place for the purpose of taking census. In those cases, where the distances are too great or they have no real relationship to the rational service area, you have to split up the CCD in order to make sense of the designation.

The only thing we can do is to follow your guidance and say, O.K., if half of this CCD is part of this service area, we will take the population and cut it in half. We would like to avoid this wherever possible, but if that is the only way to go, that is what we will do.

MR. SHAPLEIGH: I think Arkansas is going to change in the 1990 Census. Right now, we are stuck with townships that make absolutely no sense.

MR. LEE: Townships?

MR. SHAPLEIGH: Yes. We have subcounty divisions which are called townships. They serve, in many cases, as boundaries for political subdivisions, but they do not make any sense. We have, for example, senatorial districts that are like a T: they go out in both directions and down the middle.

MR. LEE: But if somebody says "township," you assume that there is a town government that has jurisdiction over that unit and is providing services to it.

MR. SHAPLEIGH: That is what you assume, but it does not always apply. Now we had a discussion last year, back when the Census Bureau came to town, and they were going to consider more sensible boundaries, things that would last over time, such as roads. I do not know if that is going to help. Some of our counties are pretty small and, to get useful sample data, they are going to break them down into two or three sections, and that will be worse.

MR. LEE: Basically, what we need to know is why you are asking us to do a half of this or a quarter of that; we need to be sure that the population numbers are accurate for each designation.

MR. LICHT: One more thing; I have a rural area, and I guess because of the brilliance and foresight of the New Mexico planners, the CCDs in our area actually are good. Is there anyone else who runs into situations where the count in these census divisions are pretty good borders? We have towns

which draw from an area, and for some reason somebody has drawn lines that actually have some resemblance to physical features. As a matter of fact, they are so good that for subcounty use the Health Department decided to start trying to collect some epidemiologic data in the CCD as a unit outside the city.

MR. BRAND: Are there any other points that we need to make today? Are there any questions about subcounty areas? Fine. The next subject at hand is geographic designations for urban areas. One of the difficulties with those is that we are not talking about the whole city of Dallas or the whole city of Miami or the whole city of Montgomery or the whole city of New York. We are talking about a small portion of those cities, and usually it is a fairly well-defined, circumscribed area the Census finds rational in some way.

One of the things that I would like to see is a homogeneity or uniformity in the area. There are 50 census tracts in the area that have been defined. Of that number, 15 have a poverty rate of under 15, 15 are between 15 and 25, and the remaining 20 are between 25 and 35. To my way of thinking, that is not rational.

Other examples would be: if the area is unwieldly in terms of there being two or three forms of marketplace patterns, or if there are two or three groups of people that are really different side by side (such as high income groups, the lower middle class and people with incomes below the poverty level).

MS. RAEL: You can have a five-acre parcel of land with a $200,000 to $300,000 house on it, and right across the street is another acre with an old adobe that has two or three rooms and a low income person. Parts of Albuquerque have a real mixture of people. You can have a $500,000 house and a $10,000 house right next door to each other.

MR. LICHT: Ultimately, the regulations we were talking about in defining areas have to be mixed with certain indicators. An area is either geographically distinct, or it is homogenous because of some social characteristic, which moves us toward population designation.

MR. BRAND: What makes a geographic area rational?

MR. BATTLE: A whole county, a subcounty.

MR. BRAND: No, we are talking in cities.

MR. BATTLE: According to the criteria, any neighborhood that has a population base of 40,000 qualifies, but this number generally relies on contiguous census tracts. As long as the census tracts involved are contiguous.

MR. BRAND: Right, but you do not have to have a homogenous population.

MS. RAEL: That is not what I am hearing. If you are going for strict geographic areas, the tracts have to be a group of tracts. If they are, then you must have a homogenous community.

MR. BRAND: When you submitted your designations for dental designations you had a series of neighborhoods that ran almost in a straight line, for a portion of the city. What was the thing about them that made them separate? We eventually accepted the fact that each of them was a specific neighborhood, identifiable by families.

MR. BATTLE: The bottom line is that you want to have a rational service area. So you need the correct population conventional ratio, 3,000 to more than 3,500 and continuous area resources. These things you generally have to have.

How you prove that you have them is up to you, because he is going to change it. He will take an urban designation like Memphis, which is No. 60th census tract. He will go to the map and draw a circle to make sure the census tracts are contiguous. Then he will go to the files and start checking the status to see if they will qualify for poverty. That is exactly what he does. Then he will look at the contiguous land, if necessary. In the case of Memphis, the area was already too big to start with.

MR. BRAND: What do you mean, too big?

MR. BATTLE: Greater than 30 minutes. The population of a geographic area should be within 30 minutes of a medical resource.

DR. MARSHALL: Is that 30 minutes by public transportation?

MR. BATTLE: In an urban area, yes. In a county or rural area, no. The population centers of your services areas should be within 30 minutes of each other to constitute a rational area. For example, I ringed Atlanta. I have Atlanta Northwest, Southwest, South Side, West Atlanta -- all separate service centers. All the population is within 30 minutes of the CAC's service.

MS. RAEL: How did you determine the 30 minutes?

MR. BATTLE: The time it took by public transportation.

MR. BRAND: What do we need in this kind of application? As far as I am concerned, we need a good picture of the area. I need census tracts, sometimes even three. Certainly two levels around the entire periphery, with bordering roads. Also, if there is any question of distance and travel time, I need information on busses, subways, highways, whatever is relevant. It would also help if, in the contiguous areas, you could color in the specific tracts all the way around which are actually of value to people in terms of their accessibility.

A lot of this is determined by what the ratio is in a specific census tract. One of the things I do is to draw a map from the data which shows the contiguous census tracts, maybe two or three deep, and I color in the ones that are immediately contiguous that can perhaps provide critical or primary health care to people in the area. I do that in the second level, and I start to see what the pattern is, if perhaps there is a pocket in the northwestern portion of the area in question where there is a group of doctors.

In Dallas, for example, there was a dental school which was two census tracts outside one of the designated area and was accessible by public transportation; it was, however, outside the 30 minute time travel limit from the center of these two areas that were contiguous to it.

But I need to know that, because I am going to be asking for this kind of information if it is not in the initial application. You do not have to do the coloring; I will do that. But at least give me the data, which tracts are accessible to the population in terms of time and distance, and which ones are not over-utilized, because that information is very important to us.

MR. BATTLE: I like to take the path of least resistance. If you have three contiguous areas of consideration, remember that all you need is one. Use the area that provides the best data and forget the others.

MR. NICHOLS: In dealing with census tracts and the contiguous census tracts, which would you prefer us to give you, the statistics for all the contiguous census tracts as a total, or for each individual census tract?

MR. BRAND: I think ultimately we have got to have it all. Sometimes data is available, sometimes it is not. Then we just go somewhere else. What we are looking for is the ratio, how many doctors are there, how many people are there and what is the distance of the census tracts to the center of the area. Poverty ratios pose some special problems, in my opinion.

MR. BATTLE: I have a problem with that.

MR. BRAND: When the poverty percentage and ratios in a whole series of contiguous tracts all the way around the perimeter of a designated area are roughly the same as those inside, I have a great deal of difficulty in establishing that the area that we chose is more rational than half of it here and half there.

MR. BATTLE: He will add them in and completely redefine such a service area. And likewise, he will take them away. He will take away a whole CCD or similar census in a county contiguous to your service area because he feels that it is eight miles from Greenville, South Carolina and it should not be in there.

MR. BRAND: An example comes to mind that involved a hospital across the street from the Desire Project in Louisiana. I recall that there was a major medical center sitting right here, across the street, in the outer limits of what in New Orleans is called the project areas.

The point is that we did not refuse to designate the areas in question because the hospital was there. The folks in Louisiana showed us that this hospital provides the only care for the people in these neighborhoods, and that without this hospital there really is nothing else within view. Therefore, it does not really function as a contiguous source even though it is technically across the street from the boundary.

Does anybody have any questions or other examples?

MR. LICHT: Expiration not based on the situation can happen in the reviews, if we have a CHC. One of the things the CHCs do as part of their annual needs assessment is a population census, where they actually sit down and survey records, either on a 100 per cent basis or a sample basis, and make note of census tracts.

Can we use that information for the purpose of the review? Can we say, for example, "Oh, look, there is this whole other census tract over here, and we have 20 per cent of the population. This is new. They knocked down all the houses over here and they moved everyone over to this side and people are continuing to use the CHC as the center of the service area"? Is it reasonable to use such facts as a basis for defining a new rational service area when it comes time to do the review?

MR. BATTLE: Moving the people from that CHC. Right?

MR. LICHT: Yes. Let the CHC stand where it is.

MR. BATTLE: What is going to be between the CHC and the people?

MR. LICHT: I was thinking of the city of El Paso where many years ago they knocked down the whole south side on the way to Juarez and moved everyone to the east end of the town. However, they did not move the CHC.

They may have opened up a satellite or wanted to open up a satellite at some point but, essentially, they just added on a couple of census tracts on the east end of town and maybe dropped out a section where there are hotels now. I was just wondering whether the case analysis they do every year would be useful to you if we wanted to rationalize this slightly redefined service area. Is that a good way to approach it?

MR. BRAND: If it is reasonable to the state, there is a chance it will be reasonable to us. You just need to explain to us what it is that is done and why.

MR. BATTLE: What you say is true as long as the population has reasonable access to this CHC within 30 minutes travel.

MR. GLASS: Should we redefine your service area likewise?

MR. BRAND: As long as it remains rational, sure.

MR. BATTLE: In Florida, we had a CHC that was in a census tract that was just on the northern edge of a designated area; they wanted to put core positions in a CHC, so we redefined the service area and pulled that census tract into the designated service area. It was right on 30 minutes, and there were no problems.

MR. BRAND: That is an example of what we meant when we talked about an annual review needing to be complete. You can go ahead and change it any way you want, as long as you tell us exactly what you are doing and why you are doing it.

MR. BATTLE: Right. Many people have sent in a request where they have a pocket of people here, a medical complex right here, and another pocket of people over here, and they want to designate both pockets of people and ignore the medical complex in the center.

MR. BRAND: Do I recall a case like that in Nashville?

MR. BATTLE: Yes, but we eliminated all of the geographics in Nashville and did a population group for the whole county.

MR. BRAND: The characteristics of the census tracts included would be fairly consistent. They ran through the city like this, with fingers going in all directions. It is not only Nashville. It happens in other places.

MR. BATTLE: Of course, you have medical schools there like Vanderbilt, with many doctors and interns.

MR. BRAND: What do you do about medical schools that are in cities and close to areas that are poverty pockets with few doctors? Does anybody have anything to say about that?

MR. DEMAREST: We tried to get some of the teaching hospitals to come there, for example, Richland Memorial Hospital School of Medicine. They are beginning to provide services either through the free medical clinic that has been set up there, or through the hospital that is located nearby so that that area can be served. So we do have residents, second- and third-year residents, as well as full physicians traveling into the area, charting the referral parties and utilization.

MR. BRAND: In places where there is a community hospital, as opposed to a teaching hospital, those doctors are, in many instances, primarily available to serve the medical needs of people that can afford to pay the prices.

You can show that a lot of those doctors are not serving the people in the geographic area that really require their care, but then you border on the need for a population count.

MR. BRAND: What about sliding scales?

MR. DEMAREST: We have a nursing care center in one of the worst areas of the city that works on a sliding scale, but they will do a payment schedule. It might be for the full price, but they will do a payment schedule.

MR. BATTLE: Well, what are we talking about, a geographic or population designation?

MR. DEMAREST: We do not always know how to define these areas.

MR. BRAND: In a county in California, there was a big controversy recently concerning a doctor who really made the difference in terms of whether this place was designated or not. The folks in the clinic who were applying for the designation were able to show that this doctor was not serving all the people of the county and did not even have a sliding scale.

Mostly what they were doing was bringing people in for initial workup, running a whole bunch of lab tests and then referring them someplace else for care.

That is what this particular place was doing, among many others. If they are providing primary care to the entire population, we have to count them as one extra unit; but it is on the shoulders of the people applying, sending in the application, to tell us that they are there and what they are doing, and to give us some background to justify a decision about whether to count them or whatever. That is not easy.

MR. DEMAREST: What tools can you use to provide proof?

MR. BRAND: In the particular instance that I am talking about in California, the head of the county medical society told us what they were doing. This was backed up by the physician's clinic and several other people, so that we knew it was going on.

Use anything that will work in an instance like that. If you can provide information, such as Medicaid data, to show it, fine. It is also fine if you can provide the opinion of a responsible official, like the head of the medical society.

MR. BATTLE: The Medicaid reimbursements are different and physicians cannot file across borders. But if you can prove that the primary trade pattern of that particular service area crosses that line and those people are utilizing those physicians in another state, then you have to take a look at it.

MR. BRAND: What about a place like Texarkana, Arkansas and Texarkana, Texas; or Kansas City, Missouri and Kansas City, Kansas? What do we do with that?

Mark, do you have any comments on that?

MR. SHAPLEIGH: I have a very similar case, on a much smaller basis, one on the northern Arkansas border, Mammoth Spring. As I recall, one-half of the population was right up in the northeastern corner of the county, in a place called Mammoth Spring. From Mammoth Spring you can practically see the Missouri border, and just a mile on the other side of the Missouri border is the town of Bayer, Missouri, which is the largest population center for that county in Missouri (already a manpower shortage area).

So what you have, then, is a population center of your subcounty area three miles from the population center of a designated area, and the question is, how do you consider those?

I really provided more information than I had to, but I wanted to detail the fact that all the doctors in the Missouri County were in Bayer, whereas in the whole town of Mammonth Spring, in what I considered a rational service area of this county in Arkansas, there was barely one doctor. It just so happened that the population centers of both counties were right next to each other; it seemed as though they had to be part of the same service area because they were only three miles apart. It was a very unusual situation.

MR. BRAND: How do you distinguish that from a subcounty area that is contiguous to another subcounty area that has applied for designation?

MR. SHAPLEIGH: In this case, I did not distinguish it from that. You know, Bayer-Mammoth Spring is almost considered one town, they are that close.

MR. BRAND: By way of positioning tomorrow's work, will somebody please define for us the characteristics of a set of census tracts that might more reasonably be submitted as a population designation? What kind of characteristics does this group have that might lead one to think that we are better off dealing with populations than geographic areas?

MR. DEMAREST: We will hear some more about that.

MR. SHAPLEIGH: Are you speaking in terms of an urban area?

MR. BRAND: Yes. You say, "Well, this is a geographic area, but it does not fit precisely the definitions that are in the book, and there are so many population characteristics." What kinds of things have to be true about this area of poor that would lead one to consider it as a population designation rather than a geographic one, or a least question the idea behind it.

For example, where the ratio is too low, where there are doctors in the contiguous areas, they are going to have a ha time with a geographic designation. This is true, even though the doctors are really serving a whole different source of population. In these cases, a population designation become more feasible.

MR. BRAND: The question was, where are the psychiatric designations? Well, there are some.

MR. LEE: Who is complaining? I will check them out when I get back.

MR. BRAND: New Mexico.

We have a problem with Louisiana. They have been logged in, but they are not in the pending file. That does not happen often.

MR. LEE: Well, did you come up with any unanswerable questions about urban designations?

MR. BRAND: The last thing we got into was, at what point do you begin to think about a population, as opposed to a geographic, designation when you are considering a group of census tracts that are rational? Two factors were mentioned: ratios that are too low and the presence of doctors in a contiguous area, even though the ratio is high enough in the particular area.

MR. LEE: When we look at urban designations, we tend to start by evaluating the tracts in terms of the poverty rates. If a portion of the city that you are trying to designate is made up tracts that are, 30 percent poverty or worse, the chances are that it is a total poverty area.

If you have an area with a mixture, perhaps some over 20 percent, some 15 to 20 percent and maybe some down as low as 12 percent, then there may be some other reason why that is a shortage area. Chances are that it may be more appropriate to pull out the population group in this area that is experiencing a problem, because it does not look like the whole population is likely to be experiencing a problem. Use any other indicator that you can find, but poverty is the one that is readily available by census tract.

MR. HAGLER: Using 1980 data, I presume?

MR. BRAND: Right.

MR. LEE: I do not know what other means are possible. People have asked: "Can we take our unemployment rate and assume that poverty moves in sync with the unemployment rate?" We said no. However, we are open to suggestions on how to adjust because we are aware of the fact that our poverty situation has changed dramatically since 1980. What do we do?

MS. PEASE: Take the metropolitan area of Albany, Georgia, which has experienced major employers closing down and moving out, and the loss of 2,000 jobs. The result is that the poverty rate within the census tract of Albany is greatly different than it was in 1980. How should this be adjusted?

MR. LEE: You address it with that information. If you can identify where the people are that were affected and say, "Here is the 1980 data but it does not tell the full story. Here is what has happened since 1980," then at least we know that not all the census tracts according to 1980 data were high poverty. This does not mean that they are not part of the area that is having extensive problems now.

If you do not tell us these things, we look at the 1980 data because it is the best we have, and question why they selected this area as an urban designation. It basically comes down to explaining why this is the area, not just naming the tracts, getting your ratio and expecting it to work automatically.

MR. HAGLER: I have a suggestion to make that may lend more weight to this kind of application. If you can go back and get your unemployment rate for an earlier period, say 1980, when the poverty rate was X, and then show a dramatic change in the unemployment figures, it should give a lot of credibility to a higher poverty rate.

MR. LEE: If you show a persistent major change, it could be helpful. One thing that I would like to see more often is a map that shows the census tracts involved. We have the SMSA maps for all metropolitan areas, but it takes some effort to find them and use them effectively. On the other hand, a photocopy of a map that actually shows the boundaries of the tracts under consideration makes the job much easier.

It is also helpful to show where the hospitals and major care services are located relative to the area. A census tract map can show roads and poverty areas, but we need to know whether there is a charity hospital across the street, and that is not always obvious from submissions.

Let me respond to the person who was complaining about his site designation. We do have a lot of cases pending, as well as many letters and drafts in progress.

MR. BATTLE: The system is that there are five people reviewing designation requests and it does get a little bit slowed down.

MR. LEE: However, if there are particular cases that are giving you problems because they are not resolved, you can either call or send a follow-up letter. Keep us informed of your needs and we will do our best to respond.

MR. BRAND: Anything else? If there are no more questions, we will adjourn for today.

PARTICIPANT EXPERIENCES/PROBLEMS WITH
HMSA DESIGNATIONS (EMPHASIS ON
GEOGRAPHIC DESIGNATIONS)

Small Discussion Group C
Region V

Moderator: Philip Salladay

MR. SALLADAY: This is the Small Discussion Group for Region V. We have a representative from each state with us. I am Phil Salladay, an economist in the Distribution and Shortage Analysis Branch, and the Project Officer on the contract for this workshop. We will begin with the discussion of any points raised in the morning session that you would like further comment on. Secondly, we will review sample designation requests included in your conference packets. We will look at geographic areas - the sub-county request from Arkansas and the annual review submission from Texas today. Tomorrow we will look at the population group sample requests. And thirdly, if you want to ask me about any particular cases or anything pending, please feel free. First, did you find this morning's session informative or useful?

MS. SINGER: Will there be some new programs and criteria?

MR. SALLADAY: There will be a further discussion of efforts to revise the criteria and guidelines on Friday morning in the main session. In the past there have been efforts to develop criteria, although the current Administration is not keen on expanding Federal Regulations. One of President Reagan's stated goals was to reduce the size of the Federal Register. To some degree, he has been successful.

We have developed a draft proposal for revising the correctional facility criteria. The intent of the revision was to develop an improved methodology for counting the number of internees. There were several correctional facilities designated in major metropolitan areas which, through the existing criteria, were designated with extraordinarily high numbers needed. It is sort of a distortion to the data base. Riker's Island in New York with a number needed around 60, and Cook County Correctional Facility with a number needed of 58 or 52, are two examples. The change involves a computation for length of stay which effectively reduce the number needed. A particular type of facility may have people stay for a week. If we count them as one whole internee, the same as staying for a year or two, it is a distortion of the data. By factoring in the length of stay, several of the designations seem more reasonable.

Another interest is in expanding or developing criteria for obstetrical shortage areas as a sub-set of primary care, prompted by the malpractice insurance crisis. In many states, obstetricians will no longer do deliveries

because of the inordinately high cost of malpractice insurance, particularly when serving low-income mothers. That problem goes beyond the scope of HMSA criteria. We do not have the ability under the existing criteria to disaggregate the primary care health resources amongst the various groupings of family practitioners, general practitioners, general internists, pediatricians and obstetricians. Any other comments on this morning's presentation? Did you all agree with everything presented?

MR. HEINZ: I was surprised to find that most states are experiencing similar problems. Wisconsin has traditionally been active in HMSA development, but, in the last year and-a-half, they have been replacing corps doctors in the existing HMSAs because of CHC turnover due to emphasis from the regional office. The Governor's Health Policy Consult established a subcommittee to study manpower shortages throughout the state, gather data and compile it so we can look at contiguous areas and new areas. We get requests for assistance from physicians with active clientele in areas that are not designated. We are often unable to help them due to our lack of data. One of our new priorities is to assemble a data base similar to those of other states.

Regarding Medicaid population designations, I interpreted the contiguous areas as being 30 miles from the border, rather than 30 miles from the center of the service area. I would like to hear more discussion on this point.

MS. FOSTER: When studying Medicaid-eligibles, I look at the number of services and recipients by physician to get an average number of services per recipient. What is the average number of services per recipient?

MR. SALLADAY: What type of data are you getting from the Illinois Department of Public Aid?

MS. FOSTER: They give the number of services and recipients by physician. When looking at accounting, for the doctors in that area, see how many provided public-aid services. When I try to work out the number of services per client, it might be five services per client. I do not know whether that is a high or low figure.

MR. SALLADAY: The billing period is for a year or a month?

MS. RING: The data is aggregated on a yearly basis.

MR. SALLADAY: There is no breakdown of that?

MS. RING: We can not determine the number of physicians each of these recipients consults. They might have received five services from each of five different physicians. One possibility, using the National Health Survey, is to project the average number of primary care physician visits, by gender and age group, and calculate the expected number of visits for a particular county.

MR. SALLADAY: For Lorrain, Ohio, in designating the Medicaid-eligible population, we equated one invoice to one visit. That information came from

the Ohio Department of Human Services. In some cases, an assumption had to be made regarding the percentage of the invoices representing primary care.

MS. FOSTER: Sometimes I come out with 8.8 number of visits per Medicaid-eligible person. Is that the average, a low or a high count for the Medicaid person?

MR. SALLADAY: The Robert Wood Johnson 1982 study of Access to Medical Care covered the average number of visits to a physician each year for different groups, including Medicaid-eligible or the indigent.

MR. DARGA: Do you have a statewide figure comparative?

MS. FOSTER: No, that might be worth looking into.

MR. HEINZ: She still does not know if she should include her figure in the data report since she does not know what level for an area is high or low.

MR. DARGA: If a patient sees more than one doctor, and is counted as more than one patient, the figure they arrive at for the state is not going to match the federal standard. If they could have a statewide figure using the same methodology they could compare their local data.

MS. RING: How did you do the arrangements with the population?

MR. JOHNSON: We worked with the Department of Human Services and the Department of Welfare at the local site.

MS. RING: What kind of data did you get from them?

MR. JOHNSON: They used their criteria for Medicaid-eligible. They worked with the hospitals in the area to get a profile of the physicians and started determining the age category, by-sex and by-service delivery units.

MS. RING: Your service is by physician or bu services received by Medicaid-eligibles?

MR. JOHNSON: We studied both.

MS. RING: The figure we are missing is that of actual services received by recipient.

MR. JOHNSON: This was done at the local level. The state does not use that definition.

MS. RING: They obtained data through the local public outlets?

MR. JOHNSON: The data was gathered through the associations of the health system. My office asked specifically for that information, since we knew the regular HMSA criteria would not show the significant needs. In order to show this need, we involved the community in information collection. The medical community worked alongside, and were able to supply much necessary information.

MS. RING: The medical staff or societies are generally more supportive of community involvement when they have a Medicaid population. Perhaps they view it as a possibility of getting additional, particularly Federal, obligated physicians. While they probably now must serve everyone regardless of ability to pay, they could send the Medicaid patients to obligated physicians.

MR. JOHNSON: We have got some good, neat dynamics in Ohio. We have 87 different medical societies. We also have the growing interest in HMO development. We have experimental projects in the Medicaid HMO development which is led by the Ohio Department of Community Services In some areas of Ohio they have a lock-in population for Medicaid HMO, and others do not. You can see that that creates some very interesting dynamics in monthly physician stat reports. We are now having a lot, not all, of our HMSAs challenged by the medical societies. We turned the table by taking it back into the community and telling them you work with the health service agencies and the local providers of HCH programs as well as community health centers and clean data. But we find that it is very important that the medical society have some role of involvement, though we are not allowed to take over the totality. Some of our counties have tried to do so.

MR. SALLADAY: Richard had a question about contiguous area considerations. Let us look at the example in your packet of a geographic area designation. This particular case was submitted through the Arkansas Department of Health. Mark Shapleigh, one of the attendees at this workshop, was the person who initiated it. This is a request for designation of the Lead Hill service area, in Boone and Marion Counties, as a primary care service area. Mark Shapleigh worked through the West Arkansas HSA, which sent him a submission. He also received comments from other interested parties, including the medical society. This is a case where the medical society actively supported the request.

We did find it helpful to hear from all the interested parties during the process rather than after the fact. We have had cases where a determination was made and several weeks later the local medical society writes, vehemently opposing the request. If you are the lead person developing a request, perhaps, in the future, a state agency person can provide technical assistance to the local health center or facility seeking the designation. It is best to contact the medical associations and societies to explain the process and the benefits of designation. In many cases, the medical society's opposition to a request is based upon a lack of information.

I want to comment on several points in this particular case, starting with the June 27th, 1984, submission from West Arkansas Health Systems Agency to Mark Shapleigh. We chose this one as we thought it a good example. They provided a detailed break-out of the service area by county and sub-parts with the population. They noted that the percent of the population with incomes below the poverty level were 20.8%, qualifying for high-needs. They give a useful narrative on the service area, and discuss the topographic features. They give the highways which service this area in detail, and proceed to mention the contiguous area resource, Yellville, more than 30 minutes travel time from the requested area, Lead Hill.

They provided a road map which also shows some of the topographic features. In addition to this map, we would look at the sub-county township

map, (the best source for that is the 1980 Census publication by state using the number of inhabitants series with maps in at the end) and do an overlay between the road map and the census division map to get the full picture of the sub-county area.

The number of physicians practicing in the area was zero, leaving no contention in that regard. The submission included a letter of support from the medical center in the contiguous area. We reviewed the application proceeded to designate the area.

MR. HEINZ: How does the 30-minute driving time affect the projected HMSA?

MR. SALLADAY: In this case, the distance would be measured from Lead Hill. If you have two towns five miles apart, both having a population of 1,200, we would view the population center as a point in between the two in terms of looking for 30 minutes travel time.

MR. HEINZ: But it is from that point within the HMSA, not from the boundaries, correct?

MR. SALLADAY: Correct.

MR. HEINZ: Theoretically, we could draw a 30-minute radius from all medium-sized cities in Wisconsin in which the ratio is below the threshold, and develop HMSAs.

MR. SALLADAY: Yes. From my experience in dealing with Wisconsin, many parts of the state have a small town every 10, 12 or 14 miles down the road from another the same size. In many cases, each town has a 20-bed hospital, which complicates the analysis. Many small hospitals are merging or closing. Yet, we have situations where two towns close to each other, in the same service area, both have 20-bed hospitals, sometimes under different religious auspices. Since the two towns do not interact, the situation gets complicated, and it does not map out easily with 30 minute radii on a computer program. You have to make a decision to group them as appropriately as possible. We will collect as much input and narrative on local conditions or local characteristics and try to define the areas. When we review one area, we are in effect, viewing three or four contiguous areas at the same time. When you designate one rational service area, you are making a statement about the other rational services areas surrounding it. It is difficult to do one area at a time. Northern Michigan Health Systems Agency did a computerized rational area analysis for all of the counties in their area.

MR. DARGA: That analysis was done in the western, the northeastern and the northwestern lower peninsula.

MR. SALLADAY: Similar problems came up in Pennsylvania and Illinois, which holds true for Michigan. You can use this rational service area in mapping the primary care service area delineation on more rural areas. But it is a very different analysis in metropolitan areas.

Ken, you may recall the considerable effort to designate Detroit. We have pending requests for further evaluation of areas in Detroit. In urban

areas, we tend to study recognized neighborhoods, although they may have changed over time. In Cleveland, social planning areas were delineated in the 1940's, some of which still remain and are recognized as neighborhoods, while others have changed considerably. We try to take that into account. In summation on the contiguous area question, you must also consider the surrounding rational service areas as part of the contiguous area consideration.

MR. HEINZ: We had a request from an area 50 miles west of Eau Claire, that would have qualified in the HMSA analysis. But 30 miles from the radius of this area included the city of Eau Claire, which totally destroyed the ratio. If we use the population center of that projected area it will not encompass the city of of Eau Claire, but people have developed physician referral patterns to the city of Eau Claire. Consequently, even though the number of doctors per population designates a shortage, people may be going into Eau Claire.

MR. SALLADAY: If you have a small town, located 50 miles from a larger municipality with a large number of primary care physicians, the smaller service area further from the urban area may also be smaller.

If someone is located equidistant between Shell Lake and Eau Claire, they probably will go to Eau Claire in consideration of the magnitude of primary care resources available. If the midpoint is 30 minutes from Eau Claire, then those people at the midpoint will probably go to Eau Claire.

If a primary care designation request is submitted by a hospital administrator, invariably it will be larger than what we consider rational, because their consideration is usually based upon the farthest point from which a person comes to utilize their inpatient facility or out-patient clinic. We review each particular township in a proposed and consider where the majority of the people in the township are going for primary care.

MR. HEINZ: In Wisconsin many small hospitals are now being purchased by the larger majors. Sacred Heart in Eau Claire, is purchasing many of these hospitals, who are asking for designation to bring in corps physicians to staff these primary clinics.

MR. SALLADAY: In a similar case, two hospitals were both seeking a designation in Houston County, Minnesota: LaCrosse Lutheran and St. Francis, both located across the river in LaCrosse, Wisconsin.

MR. HEINZ: LaCrosse Lutheran was the one having to buy the hospital, which makes it much easier for Blue Cross Lutheran. In five years, in Wisconsin, we will probably have just five major health care networks, the smaller hospitals will be owned by somebody else, or become ambulatory clinics.

MR. SALLADAY: Was there anything in the packet you had a question about in terms of the handouts?

MR. JOHNSON: I am interested in the updated guidance for calculating primary care physicians full time where only office hours were known.

MR. SALLADAY: That was recently developed in our office to reflect the more recent AMA publications on socio-economic characteristics of

medical practice. There was one small error on the table, at the bottom of the second column under all primary care, 47.09 should be 47.9.

MR. JOHNSON: Are there any contingents to look further into the OB shortage designations?

MR. SALLADAY: We did investigate the possibility of developing a population group approach to low-income mothers, since there is a severe shortage of obstetrical care for them. We have had a very difficult time in trying to develop and get approval for any new criteria. One of the previous efforts dealt with facilities for the developmentally disabled, an area of severe need. We developed a notice of proposed rule-making back in 1981, but it never got through the department. Concerns have been raised over the severe shortage of obstetrical care in many areas in the county. The National Health Service Corps has been trying to strategically place the obstetricians available. You may want to raise that question to David Ober tomorrow morning when he gives the presentation on the National Health Service Corps.

MR. JOHNSON: In Ohio, we are trying to strategically place the National Health Service Corps, since we can not give them enough support, they are reaching the point of burn-out.

MR. HEINZ: We had two sets of OB/GYN and pediatricians in six months leave on default together.

MR. JOHNSON: The Maternal Child Health Program Chief is trying to set up a circuit rider to provide some relief.

MR. SALLADAY: We will now turn our attention to the other sample designation request, an annual review submission by the Texas Department of Health in 1984. This particular submission dealt with whole county designations, sub-county designations as well as some correctional facilities.

On the Hale County migrant case, the letter of determination stated a need for further information. The application was approved later when the necessary information was received. I do not know if migrant health is a major problem throughout Region V, although I am aware of the presence of migrants in Michigan and Ohio. In western Michigan, there are several migrant streams. In both Michigan and Ohio, migrants were factored in as a population adjustment in the geographic area request, and we did not have a separate migrant designation in the state.

In the Texas submission, they have defined Delta County as a whole county rational service area, and proceeded to give the most recent population count along with detail on the number of primary care physicians practicing in the county with information on the particular data sources.

The same was done for Dimmitt and Frio Counties. In Dimmitt County, we noted that Crystal City in Zavala County was just nine miles from the population center of Carrizo Springs, Dimmitt County. Thus, we defined a different rational service area than was submitted, and based on that combined area, we did not designate the Dimmitt County/Crystal City area. Dimmitt County received a rejection in the letter of determination, with the reason being that the service area was not rational when contiguous resources were considered.

MS. FOSTER: I have a question about migrants. You said that we calculate a population adjustment when considering an area based on migrant populations, correct?

MR. SALLADAY: Yes, that is one approach to factoring in migrants. You can, if working on a geographic area, take into consideration the impact of migrant population. In Ohio, there may have been 500, 800 or 1,000 migrants in a particular county. In contrast, counties in the state of Washington may have 24,000 to 36,000 migrants present in a two or three county area. In the case of Washington, we did separate population group designation for migrants.

MS. FOSTER: In southern Illinois there are migrant workers seasonally. How would you designate an area if those migrants are not there permanently?

MR. SALLADAY: Is the county already designated?

MS. FOSTER: This is just a theoretical question.

MR. SALLADAY: Many of the counties in southern Illinois have very high poverty levels and have geographic area designations.

MS. FOSTER: Correct. But, if a migrant population came in for just a few months, how could you designate it based on the fluctuating population?

MR. SALLADAY: Using the criteria, we follow the stated formula for the portion of the year which migrants are present. In southern Illinois, first, check to see if the county already has a geographic HMSA designation and, if it does, in your next review you can include a factor for the migrants.

MS. FOSTER: Mary said that the migrant counsel is involved with providing medical physician services to that area.

MR. SALLADAY: Are there separate clinics which serve the migrants?

MS. RING: They have developed several on their own in the southern part. Almost all of which are located in the area of the medical centers, since there are only four areas in the state with a migrant population. The migrants in Illinois are becoming settled in the area, moving from the northern to the southern part of the state depending on the corps.

MR. SALLADAY: As you suggested, Mary, some of the migrants are becoming settled, and may now be classified as seasonal farm workers. By definition, seasonal farm workers are included in the resident population, whereas, the migrants, by definition, are not.

But even amongst the seasonal farmers, studies have suggested that the economic status of the majority of seasonal workers is be pretty poor. In Washington, Idaho and Oregon, a number of studies have been conducted primarily for the Bureau of Health Care Assistance, and we have studies to get any data useful to the HMSA process on migrants.

Getting back to the review at hand, we selected this as an example because it is thorough and well done. On pages six, seven and eight, you can see that they have a computerized system and this is a print-out from their data base. It will be tied into a system which includes BHCDA and BHCDA NET.

MR. JOHNSON: Has any thought been given to lowering the ratio from 3,500 down to 1,800 - 2,000?

MR. SALLADAY: You suggest 1,000 to 2,000 as a threshold for designations?

MR. JOHNSON: AMA suggested it about four to five years ago.

MR. SALLADAY: While 1,800 to 2,000 is a desired goal as a level of adequacy, it is probably low as a threshold for severe need. The range of 1,800 to 2,000 is generally considered level of adequacy. There has been an effort to develop recognition for rural, isolated areas where one practitioner may be serving 2,200 or 2,500 people, and these have been coined "frontier areas." They have a population density of six or less persons per square mile, and are usually distant from any contiguous resources.

This effort comes from the Primary Care Branch of BHCDA, and is directed towards reducing sole practitioner burn-out in rural areas. It is not going to qualify by our criteria, but in practice, there may be one physician who is overworked and very far away from any back-up help. John Hisle is scheduled to be here tomorrow morning from the Primary Care Branch, BHCDA.

MR. JOHNSON: That is a growing problem for us in rural areas as well as in contiguous areas.

MR. SALLADAY: This would be more applicable to most isolated type of rural areas.

MR. JOHNSON: A significant volume of primary care is provided to urban populations while rural areas are experiencing shortage.

MR. SALLADAY: True. In urban areas, that would involve the accessibility factor in terms of physicians present but not serving. We have a mechanism to deal with that - the population group criteria. You can identify the barriers and make a determination about the amount of primary care available to the medically indigent, Medicaid-eligible or the poverty population.

MR. HEINZ: What about the ages of physicians?

MR. SALLADAY: Under the primary care criteria we do not make an automatic discount for age. We do have that type of provision in the criteria for dental practitioners because of specific studies that showed productivity of dentists declines with age. We have several steps: under 55 year; 55 to 59 or 64 year, which are detailed in the criteria.

For physicians, we will make discounts based on reduction of practice hours with inclusion of specifics surrounding the case. We have one rather

memorable case where a physician wrote to us to comment on designation requests, rather upset that we sought to discount him merely because he was 70 years old. We examine them case-by-case, and there is no automatic discounting for over 60 or 70. We recognize that it is a very useful consideration in terms of future physician needs. If you know of a pending retirement, we will not count a physician if we know that he or she has unequivocably indicated in writing a retirement date in the very near future. We need specific information.

MR. HEINZ: We get the situation where the physician is too proud to admit he is not working full-time. When we try and define it to him, he wrestles with the definition. We just have to present more data.

MR. SALLADAY: There are two questions to ask when collecting additional information in those circumstances: Does the physician have any hospital privileges? And what else is he doing with this time?

MR. HEINZ: It certainly is locally censored.

MR. SALLADAY: True. It is often difficult for someone to put in writing that they are going to retire. Announced publicly, they may lose their patients to another doctor when they may be negotiating the sale of their practice.

MS. FOSTER: I had insufficient data on a particular case and called the doctor to talk to him. One of my sources in the county told me that he had two practices; one in the county up for designation, and one in the county next door. When I talked to him about it, he told me he had a full-time practice in that office, and denied having a second office location. Directory assistance supplied a phone number, and the receptionist gave me office hours. It is frustrating to deal with doctors who lie to you.

MR. SALLADAY: In that case, document and give a narrative on that particular case in your request to indicate this problem. We will analyze it and assign an appropriate FTE.

MS. RING: Phil, on this Texas designation, they totally discounted the FMG's.

MR. SALLADAY: We do count FMG's with permanent resident status.

MS. RING: It states that FMG's are not U.S. citizens. If we discount FMG's in many of our counties, we would suddenly have a 100% increase in the process.

MR. SALLADAY: The appropriate treatment as specified in the criteria is to determine whether or not they are permanent residents.

MR. HEINZ: Is there any way of knowing who is an FMG without actually going into the community? Is there any other source of data?

MR. DARGA: Licensing would know that.

MR. HEINZ: That is part of the annual licensing survey?

MR. DARGA: To get that information, unless you do your own survey, you would have to look at their individual file folder to see their application for a license.

MR. SALLADAY: The criteria states: "Graduates of foreign medical schools who are not citizens or lawful permanent residents of the United States will be excluded from physician counts." "Those graduates of foreign medical schools who are citizens or lawful permanent residents of the United States, but do not have an unrestricted license to practice medicine will be as .5 FTE." So you can discount the physician entirely if they are neither a citizen nor a lawful permanent resident. Karen, do you have any foreign medical graduates in Indiana?

MS. DARWISH: Surprisingly, we do. With the School of Medicine, we get quite a few.

MR. SALLADAY: Another source of information is INS.

MS. DARWISH: I do not recommend that source, but it is one way to check.

MR. SALLADAY: Do you have any questions about specific pending cases?

MR. HEINZ: Has there been an annual review of the facility designations?

MR. SALLADAY: That is a part of the annual review. We do not do a separate review for facilities. In Wisconsin, we have done a number of state correctional and mental health facilities. Were there other types of facilities you were thinking of?

MR. HEINZ: In 1981, we tried to designate Milwaukee County's Children's Psychiatric Institute, but from our records, no one was ever placed. We have an aggressive administrator now who wants a couple of court child psychologists. The regional office has not yet heard from your office if that is a currently designated facility.

MR. SALLADAY: I believe that we previously designated the Milwaukee Mental Health Complex.

MR. DARGA: Will there be much impetus for shortage area designations?

MR. SALLADAY: The National Health Service Corps placements will be falling off considerably in the coming years. Over the next year or two, we will probably see more designation requests coming from the CHC's themselves as they will not have HSAs to work up the request. I think there will still be an interest in the designations. There are a number of state programs piggy-backed onto the Federal HMSA designations. In that regard, Joan Singer is involved in the state loan program in Minnesota. Do you want to tell us a little bit about what you do in that area, Joan?

MS. SINGER: The Minnesota Medical and Osteopathy Loan Program was established by the State Legislature in 1973. It grants loans to eligible medical students with the stipulation that, should they practice in an area of need in the State of Minnesota, their loan would be forgiven. At that time a task force was formed to develop our own criteria and list eligible areas in the State of Minnesota. In 1983, it was determined that this list, established by the original task force, was out of date. As I am the only staff member on this program, I could not review every area requested to see whether or not it would be considered eligible to service funding. It was decided at that time that we should use the Federal list. We now use the Federal Shortage Area List in placing our physicians.

MR. JOHNSON: How is that working out?

MS. SINGER: The program is now being phased out. The legislature has reviewed it and has determined that the intent of the program is not being served, as not many people are practicing in a rural area. About 21% of the participants have either practiced in a rural area and had all of their loan forgiven or are currently practicing in one of the eligible rural areas. We had hoped to be placing a higher percentage but, I am satisfied.

MR. SALLADAY: Any other concerns?

MR. HEINZ: Tomorrow can we discuss physician counting?

MR. SALLADAY: Our focus for today was geographic, although we touched on a few physician counting problems in terms of elderly and foreign physicians. Are there other problems that you have encountered in doing the FTE calculation?

MR. HEINZ: I am interested in new ideas on innovative ways of verifying data. After subcontracting with the HSAs, they have sent data back which is bad as far as FTEs. The only data base we have comes from the licensing data which does not have office locations and multi-county practice. How do you verify license information without knocking on doors or calling offices on a statewide basis?

MS. FOSTER: Do you deal with hospitals?

MR. HEINZ: That is going to be phase two. They are going to reverify the HSAs verification.

MS. RING: Do they have local health departments?

MR. HEINZ: That is something to check as well as with the head nurse at hospitals.

MS. RING: The director of nurses at the hospital or the school nurse or health agencies.

MR. JOHNSON: In some areas, the United Way or the Cancer Society will offer assistance in validating physician data.

MR. HEINZ: The next problem is confronting the physician and having him deny the data.

MS. RING: We use other sources to get a consensus from two or three health-related individuals. I do not take the word of one individual, usually seeking out two or three, sometimes four. It is more time consuming, but you collect more accurate information.

MS. FOSTER: Make a data print-out of information for the previous year.

MR. HEINZ: We introduced legislation to get some data put on licensing information. The Wisconsin State Medical Society has gone on record as opposing, since the legislation includes increasing the physicians fees $2 a year to pay for the automation. That is presenting a real problem.

MR. DARGA: In Michigan, most doctors get an annual Controlled Substance License. The Licensing Department printed a separate card perforated to the license renewal card including questions on the specialty practiced, the specialty trained in and the zip codes of their hospital or non-hospital practice. We are doing a separate survey for the physicians without a Controlled Substance License, and are still in the process of compiling the data.

MR. HEINZ: The Controlled Substance License is issued by the Federal Government?

MR. DARGA: This particular license is a State Controlled Substance License.

MS. SINGER: Regarding the involvement of the AMA in the development of the area shortage, are there any other state agencies besides the Health Planning Agency? Would the State Board of Medical Examiners be involved in any recommendations?

MR. SALLADAY: Usually, our contacts are with the State Health Planning Agency which, in some states, is within the Department of Health while separate in others. We do not usually have direct contact with the Board of Medical Examiners, but the State health agency can and often does turn to that source for information.

MR. DARGA: Does this concern the availability of Federal funding for state and local efforts involving designations of HMSAs?

MR. SALLADAY: The funding previously came through the Health Planning Act, and the likelihood of future funding is somewhat uncertain.

MS. FOSTER: Should we write letters of support for this meeting?

MR. SALLADAY: Yes, please do. Many SHPDAs had two or more people working on HMSA designation. Now, we may get 25% of one SHPDA person's time devoted toward HMSA reviews.

One of the purposes of this workshop is to develop better ways of dealing with HMSA designations. In terms of the regulations and the

legislation, in cases where the SHPDA folds, we turn to the governor and ask for a contact person on health policy or statistics. We have not yet reached that point in too many states. We think the majority of the state health agencies will continue functioning. Tomorrow, we will be able to discuss population groups in more detail.

The session was adjourned.

PRESENTATION: FEDERAL PROGRAMS RELATED TO HMSA DESIGNATION (INTRODUCTION)

Richard C. Lee
Chief, Distribution Shortage Analysis Branch
Bureau of Health Professions

MR. LEE: Good morning and welcome to Day Two of the Health Manpower Shortage Area Workshop. Today, we will focus on the federal programs using HMSA designation, the role of the professional societies in HMSA designation and concentrate on population group designations.

The original program for designation was loan repayment. That program, from 1971 to 1977, involved repayment of loans for all health profession training if the person was willing to serve in a shortage area. From 1978 to 1980, a smaller program forgave federal health profession student loans. The loan repayment program dissappeared with a lack of funding in 1981. There is an authorization for loan repayment under the HEAL Loan Program, not yet implemented.

The National Health Service Corps is the largest and most important program involved with HMSAs. As mentioned yesterday, that program began in 1971 placing federal doctors in critical health manpower shortage areas, and was significantly expanded, particularly with the Health Professional Education Act of 1976, to the NHSC Scholarship Program. We face a decline in the future in the number of people available through that program to serve in HMSAs.

There are a number of programs in the Bureau of Health Professions' Division of Medicine, including family medicine, general internal medicine, general pediatrics, with funding priorities for those grantees with practice sites or residencies in HMSAs.

We have the AHEC Program, with linkages with HMSAs. There is a program administered through HCFA for Medicaid and Medicare reimbursement to nurse practitioners and physician assistants at rural health clinics in HMSAS. Another designation activity was originally developed for the HMO grant program in 1973 and became the first step in qualifying for Urban and Rural Health Initiative grants.

The methodology for medically underserved area designation involves an "Index of Medical Underservice," developed with four indicators: infant mortality, percent aged, practitioner/population ratio and poverty level. Recent legislation, PL-99-280, requires that criteria for designation of medically underserved populations be published as regulations in connection with the Primary Care programs, requires that the medically underserved population designation process consider comments of governors, local officials and state organizations representing community health centers.

In the National Health Service Corps, practitioners are used in the Primary Care Programs to a large degree. Medical and dental societies are involved in both the HMSA designation process and the National Health Service Placement Process. HMSA designation requests are submitted to the State medical and dental society for comment. In the NHSC placement process, the local medical and dental societies are contacted prior to placement and asked for a "Needs Demand Assessment," confirming the need and demand for practitioners within the HMSA.

In the development of the HPOL, the HMSA Placement Opportunity List is developed by the National Health Service Corps indicating vacancies in those HMSAs that in any particular year they plan to serve. We have had questions, about the criteria for the HPOL. One that was raised yesterday, was whether the population group designation would be playing a larger role in the years ahead. As the number NHSCs available become smaller, and you must concentrate on the most needy areas, certain population groups will become more significant than some of the geographic areas.

We will now hear about the activities of the National Health Service Corps from David Ober.

PRESENTATION: NATIONAL HEALTH SERVICE CORPS

David Ober
National Health Service Corps
Bureau of Health Care Delivery Service

MR. DAVID OBER: Thank you, and good morning. I am going to give you both a brief overview, as well as address, in some level of detail, the issues that have been outlined on the agenda.

The National Health Service Corps was created in 1970 with the basic mission to provide health manpower resources to those communities, populations and facilities that could not otherwise recruit and retain health care professionals.

From 1970 to 1986, this mission has really not changed; however, what has changed significantly is the nature and the number of resources available to the National Health Service Corps so that we have been forced to meet our mission in different ways over the years.

In 1972, we made the first placement of 20 volunteers who were federally salaried members of the National Health Service corps, assigned to under-served communities. The number of volunteers available to the National Health Service Corps increased to 200 by 1974, but in 1972, the numbers of volunteers interested in National Health Service Corps were not enough to adequately serve the needs of the under-served communities.

Congress authorized the National Health Service Corps Scholarship Program, designed to award scholarship to health profession students whose applications reflected a philosophical commitment to the under-served. Every year, the pool of scholarship applicants was far greater than the number of awards authorized by Congress. Therefore, one of the critical determinations in considering scholarship applications was an individual's stated commitment to practicing in an under-served area.

These scholarship recipients incurred a service obligation in return for support during their medical education, the length of the obligation based on the number of years they were supported. For each year they were supported, they incurred a one year service obligation; with a minimum obligation of two years. Due to the duration of medical school, we could then expect obligated scholarship recipients with a two to four-year service commitment.

Upon completion of medical school, each physician was required to complete at least one year of post-graduate medical education. Deferments of service obligation were given for up to three years if the physician was

interested in pursuing an approved residency program. The three-year limitation was designed to direct physicians into residency program which would allow them to become board eligible in their specialty at the completion of three years. We tried to direct physicians into one of the primary care specialty programs, such as family practice, general and internal medicine, pediatrics.

Most physicians elected to pursue one of the residency training programs rather than declare themselves eligible to begin their service obligation upon completion of one year of post-graduate training.

The breakdown amongst primary care specialties has been relatively constant. Each year, approximately 30 percent elect family practice and 30 percent elect general internal medicine. Pediatricians and OB/GYNs account for 15 percent each with the remaining 10 percent psychiatrists.

The Scholarship Program increased in size until 1979, when the number of first year awards began decreasing. However, because of the seven year pipeline between the day of the initial award and the scholarship recipient's service commitment commencement date, the largest groups of scholarship placements was not made until just these past two summers. In each of these years, 1985 and 1986, about 1600 providers were placed in shortage areas throughout the country. These placements were in all types of shortage areas, in Indian Health Service Hospitals, in designated federal correctional institutions, and in health care facilities in Puerto Rico and the Pacific Basin.

The current placement activities of the National Health Service Corps involve practitioners due to complete their residency training program in June of 1987, and therefore eligible for placement next July, August and September. For the 1987 placement cycle, there will be approximately 900 providers.

The National Health Service Corps legislation requires that all scholarship recipients fulfill their service obligation in currently designated shortage areas. The number of shortage areas currently designated throughout the country is quite substantial, and far exceeds the number of providers the Corps has available for placement. Because of this and because we understand that we can only meet part of the need in any given year, we have had to develop various policies which we use to direct National Health Service Corps scholarship obligated physicians into what we consider to be the most needy of the designated shortage areas.

This involved process begins each year with an evaluation by the Corps of the number of designated shortage areas and the needs within those areas. We also rely on information from state agencies, federal assignees in certain states, state contractors (we have contracts with some states to assist us in the placement of corps personnel), and also from our staff in the various regional offices.

The list of opportunities we decide upon for each given year is called the HPOL. Some of the guidelines used in developing the HPOL are basic measures of health status, such as infant mortality. Other measures, such as the poverty rate, are factors that tell us which designated shortage areas have the greatest need for physicians independent of either the physician to

population ratio, or the absolute need for physicians required to bring that area below the level where it could continue to be designated.

Another consideration in our development of the HPOL is what specialty provider or provider mix could best meet the needs of a particular community or a particular population. Factors that influence our decision here are whether the shortage area is urban, a low income inner city population; or whether it is a rural area with a small number of under-served residents dispersed over a large geographic area. Other inportant considerations are: What past success has that area demonstrated in recruiting non-obligated providers? What types of support systems are in place to suggest that that area is more attractive than another area? What number of physicians are already present to provide coverage or other professional support?

Associated with these considerations is the type of site listed on the HPOL for physicians of those specialties. Will it be a solo site, a large community health center, a hospital-based practice or other?

We next identify which specialty could best meet the needs of a particular shortage area. The list of opportunities we provide to family physicians is entirely different from the list of opportunities provided for specialists in internal medicine or pediatrics, for example. Because physicians trained in family practice are most capable of providing the broadest range of medical care services, with a relatively minimal degree of support from other providers, they are obviously best suited to practice in isolated rural sites, as opposed to physicians trained in internal medicine, pediatrics and OB/GYN.

Family practice physicians in small isolated rural areas are likely to admit and follow their patients into the hospital and do not require the medically sophisticated facilities needed by OB/GYNs or pediatricians. Thus, the preponderance of opportunities available to family physicians in the National Health Service Corps are in rural areas; likewise, the major portion of opportunities available to specialists in the other three primary care specialties are either in large rural systems of care or in urban areas. OB/GYN sites, for example, are only located in areas where adequate support and cross-coverage are available and where there is a hospital of sufficient sophistication such that deliveries can be made and emergency surgical procedures can be accommodated.

Psychiatrists' placement opportunities are limited to rural, designated, psychiatric catchment areas because, should you compare a designated urban area and a designated rural area, most non-obligated physicians will locate in the urban area. The opportunity for continuing education, professional support, professional interaction, and the like, are very important to physicians when they are determining a practice location. Therefore, we feel the need to especially target rural areas for placement of psychiatrists because those areas have little opportunity to recruit providers. The National Health Service Corps has similar criteria for the placement of emergency medicine physicians.

The regional offices in the National Health Service Corps utilize these criteria in conjunction with state agencies, contractors, primary care associations, and health systems agencies, and then make their recommendations

to the central office for sites to be included on the Health Manpower Shortage Area Practice Opportunity List, or the HPOL. At the beginning of each placement cycle, we try to provide guidelines to the various regions regarding the absolute number of providers we expect to be placing in their region. Those numbers are a direct function of the physicians need in health manpower shortage areas in that particular region. The regional offices, in conjunction with these other associations, make their recommendations to us and, within the broad constraints of the targets we nave given them, we will approve vacancies for inclusion on each year's HPOL.

The HPOLs that will be mailed to scholars in July include one further notation. Not only are the highest minority shortage areas listed, but also listed is a specific opportunity associated with that shortage area. Each site will have associated with it the type of payment system the provider can expect.

The providers can be placed through one of several payment mechanisms. They can be federal employees, either members of the Commission Corps of the Public Health Service, or general scheduled civil servants. The types of position we identify as appropriate for federally salaried providers are those most rural solo-sites without an established community health center or other medical facility already providing care to the population and where the income level of the population, is such to make it unreasonable to expect a provider to earn a decent living on a fee-for-service type of practice. Approximately 10 percent of our vacancies each year are federal placements.

The next type is private practice assignments, opportunities at community health centers. These are located across the country, in urban and rural areas, and account for approximately 75 percent of placements each year. One of the reasons they account for such a significant percentage of our placement is because we know that that community health center provide the type of care to the populations we want to serve. We know they are serving the under-served and are providing the primary care services the program has intended.

We also recognize that CHCsare not everywhere, which is the reason we allow for federal placement in rural areas and a selected number of pure, private practice opportunities in areas where no health center or other facility is providing care, but where the income level of the population is such to expect a provider can earn sufficient income from billings.

The final type of placement is a salaried private practice associated with a local hospital an ambulatory care center, or an out-patient clinic providing care to the under-served residents of that area. The combination of salaried private practices and pure private practices accounts for the remaining 15 percent of the placements each year.

In order to give each community or population identified on each HPOL a reasonable opportunity to obtain a provider during the placement cycle, we have limited the number of HPOL vacancies per speciality to a number equal to the number of those specialists in that placement year. We have made this commitment to sites on the HPOL because prior to this commitment, when we have identified more opportunities than scholars available, it was obvious that the scholars were gravitating to the more attractive of the opportunities and more needy areas continued to remain unstaffed year after year.

With all these considerations, we print the HPOL and mail it to scholars in July of the final year of their residency training. The individuals completing their training in June of 1987 received their first HPOL this July, along with which they are sent an entire placement package which explains the placement process and how it affects them. The placement cycle is broken into three time periods.

The first is known as the "Early Decision Period." We offer all the providers in a given specialty the opportunity to match any of the vacancies identified for their specialty across the country. They have the maximum choice and selection in identifying a site to best meet their personal and professional needs, as well as any other considerations, geographic or otherwise, they may feel important.

Over the last several years, approximately 65 percent of the scholars were successfully matched during this period, which ends in October. At the end of October, we identify the areas on the HPOL not yet filled, and prepare the "State or Regional Assignments." The remaining unmatched providers which still equal the number of remaining vacancies receive assignment letters, stating, "Since you did not find a match during the early decision period, and we have remaining needs in these states or regions, and you have indicated in a site selection questionnaire that you have interests or preferences in this state and region, you have now been assigned to this particular state or this particular region to continue the placement process and compete for the remaining vacancies in that state or region."

This still provides some opportunity for geographic selection and the opportunity to choose from amongst the various sites, while giving sites in those unpopular states or regions another opportunity to aggressively compete for scholars who have not previously expressed an interest in their particular position. This opportunity is available to those scholarship recipients through the 15th of April, when we enter the final phase of the placement process, the site specific assignment phase. Again, we identify the number and location of those sites that remain unfilled. We re-examine the providers remaining unmatched. Taking into consideration their interests and preferences, we will make site specific assignments to each of those scholarship recipients, notifying them of the particular site where they are expected to fulfill their National Health Service Corps commitment.

During the whole placement process, the government provides for, at government expense, travel to interview at the site the scholars are interested in or to which they have been assigned. There is an opportunity for them to meet with the community representatives, the hospital staff, and the local community to decide whether they can successfully make a commitment to that community during the course of their obligation.

That is how the placement cycle runs. Now that you understand how we choose the site and how this affects the scholars, one of the remaining interests you may have is the number of scholars or recipients available in the forthcoming years. The number is declining quite dramatically. In 1986, we placed roughly 1600 providers. In 1987, it will be roughly 900; in 1988, approximately 550; and in 1989, about 250; and in 1990, it will drop to 150.

Unless we can expect the number of designated shortage areas across the country to drop at an equally precipitous rate, we should begin looking for another source of providers to meet the needs of the designated shortage areas. We are anticipating this in two different ways. We have recently instituted a reorganization of the National Health Service Corps which will create an entirely new branch within the structure of the central office, devoted exclusively to the recruitment of non-obligated physicians and other health care providers. This new branch will be working actively with the Indian Health Service in their recruitment activities and our expectation is that they can create a broad appeal to physicians who lack a clear understanding of the National Health Service Corps program, or who are uninformed about either the Indian Health Service or the National Health Service Corps. Because the two programs may be linked very closely, we are trying to portray this recruitment as an effort to get physicians and other clinical specialists involved or interested in the Public Health Service.

The goal for the 1987, placement cycle for the volunteer branch, is on the order of 200 primary care providers. If that goal is achieved, we will be making not 900 placements in 1987, but 1100. If this goal is exceeded, it would not be unreasonable to expect the National Health Service Corps to shift more of its focus and its resources from the placement of obligated scholars to the recruitment of non-obligated providers. However, it would be unrealistic to expect we could ever hope to recruit enough providers to meet the needs of all shortage areas, much less to even approach the level of the number of obligated scholars available for placement.

The other method that we are going to be pursuing, is through a small group, of about 400 to 500 careerists in the Public Health Service, primarily physicians, but also dentists, nurse practitioners and other health care professionals who are interested in a career of public health service and in a career spent rotating from one critically needed shortage area to another, depending on both their specialty and the need for providers of their specialty. This career cadre, will only be able to meet the needs of the absolute needy areas, and will be a function of the designated areas or populations existing at that time. Any questions at this point?

MR. STAMBLER: What will be the payment mechanism for the volunteers and will it have the same choices or be part of the Corps?

MR. OBER: The recruitment branch, will identify vacancies for volunteers much as we have done for the obligated scholars. We expect to be able to inform the volunteers not only of the particular shortage areas in need of a physician of their specialty, but also the type of site serving that particular population and the type of payment mechanism is associated with that type of site. If it is a community health center serving a designated population, we will be informing the volunteers that there is a system in place where they will be competing for a slaried position. If the shortage area is served by a hospital, the hospital may provide certain benefits, but not a salary. They may provide a guaranteed minimum salary for one or more years or may want to bring the individual on as a salaried member of their staff. Whatever opportunities are available in shortage areas is what we are going to tell the volunteers about.

MS. SOWERS: Dave, each HMSA has a de-designation threshold. In the past years we have always adhered to those de-designation thresholds. Why is it now, when we are placing corps physicians in areas with a 330 center, we do not adhere to those thresholds?

MR. OBER: We recognize, because of our close association with the Division of Primary Care Services which funds the community health centers, that the under-served populations being seen at the community health centers or within the community health center service area, may not coincide exactly with the designated area. For instance, while a designation might exist for a small geographic area, the community health center may be seeing, not only the residents of that geographic area, but also indigent patients from a much larger area. If we can be convinced by this particular center that their needs are greater than what is represented by the de-designated threshold, we will consider permitting assignments that exceed the threshold.

MS. SOWER: It is difficult for the state people to explain to the county medical society why an area which requires two physicians is receiving four. I can understand the local medical society's standpoint.

MR. OBER: It is difficult. And I think it is appropriate that I mention one part of the placement process I did not mention earlier, the needs/demand assessment.

During the placement process, we ask our staff in the regional offices to contact the professional societies prior to finalizing a match in any given area to get their opinions on this matter. Sometimes the reaction we get from state or local professional associations is a disagreement in fact, take that into consideration. Sometimes they may clearly agree with us that the de-designation threshold for that particular shortage area does not adequately represent the needs, whether it be the need for the area or the need for a particular facility serving that area. We recognize that there are going to be disagreements. Rarely is there any complete agreement.

MR. LEE: Could I comment on expanding the threshold because they are serving poverty populations of other areas? In that case, you are expanding the designation because your mission is to serve, with the National Health Service Corps, the people in health manpower shortage areas. It is a contradiction to say that we will increase the threshold unless you also have us increase the designation.

MR. OBER: In many of those cases, there may be a designation for, an indigent population, that simply has not been designated.

MR. HISLE: Dave, can I answer also?

This is a very good question. Many times when those cases come up and are investigated it is a very serious charge, that we are putting too many National Health Service Corps physicians in a community health center. Many of the physicians in the county who are complaining are not seeing the poor people. They complain because they think that there is competition, which, in fact, the competition is not there for paying patients. We are concerned with assuring the non-paying patients and the poor patients receive equal care as the paying patients.

FROM THE FLOOR: I would like to know the status of these state contracts. As I understand it, this year no new states could receive state contracts for oversight of the National Health Service Corps placement?

MR. OBER: Although they are National Health Service Corps Contracts, there is a separate office within the bureau handling the administration of those contracts. Unfortunately, a representative from that office could not be here. I think, though, that Mr. Hisle may be able to help address that question.

MR. HISLE: I'll address that in my presentation.

FROM THE FLOOR: Dave, I have one question about the National Health Service Corps placement.

When someone is assigned to an area, how long must they serve in that area, and what recourse does that area have when a National Health Service Corps physician either leaves the area or finishes his obligation? We have had many leave recently and those areas are without doctors.

MR. OBER: We do not have enough obligated physicians to restaff every position ever occupied by a National Health Service Corps physician. Their legal obligation to the government will not exceed four years. If we place a National Health Service Corps physician in an under-served community for a period of four years, we have done what we could. We place him and put him in a position where hopefully, he will establish roots and received an idea about the practice of medicine in that community. It is up to the community to try to retain the services of that provider beyond the completion of his obligation. That is something a number of communities have not worked on because, when the supply of providers was increasing, it was fairly easy to restaff and, if you could make a case for the continuing demand, there was a good chance you would get a physician approved on that HPOL. Clearly, that is not the case anymore.

MR. LEE: Dave, do you have any figures on the extent of retention after obligated service is completed?

MR. OBER: No, I do not. One study done early in the 1980s showed a retention rate in HMSAs on the order of under 50 percent.

FROM THE FLOOR: Can communities receive assistance in keeping physicians in a community?

MR. OBER: I do not know of any system or component of the bureau with either the manpower or the money to provide that sort of technical assistance to communities. But I agree with you, it is a legitimate need.

MR. HISLE: When you ask that, you also have to ask what kinds of things in a physician's practice, solo or group, and in the community, are needed to retain a physician. It is not a question of having technical assistance, but something you must ask yourself and the physician now in your community: What would he or she be looking for in your community in order to make it a decision to say there?

MR. OBER: That is a place to start. With a physician already there or finishing his commitment in a year, a legitimate question is: What would it take to get you to stay?

FROM THE FLOOR: After several years of developing the PPO procedure, it is virtually impossible to get a PPO on an HPOL. When non-designated areas have appeared on the HPOL, the state people, are in a position where they must attempt to get a designation.

MR. OBER: If a non-designated area has appeared on the HPOL it has been an error.

The pure private practice opportunities (PPOs), are functions of the level of income of the under-served residents of that area. If a population is economically well off, many physicians will find it a financially productive place to locate. We will be left with shortage areas where the income level of the residents is not such that a provider could expect to make a decent living. That is why you will see so few pure private practice opportunities listed on any given HPOL.

FROM THE FLOOR: Can emergency medical physicians be placed in areas not designated as health manpower shortage areas?

MR. OBER: We look, in the placement of emergency medicine physicians, for a hospital with an emergency room located in a shortage area and serving primarily residents from that and adjacent shortage areas. As you can well imagine, there are not very many of those. We have tried to limit our placements to that type of situation.

FROM THE FLOOR: Are there any other criteria involved in placing (emergency medical) experts? Being so far from a tertiary care center? Are those criteria still being honored and, if so, what are they?

MR. OBER: Yes. they are. The specific criteria you are referring to is that all placements must be at least 50 miles from a tertiary care facility. There are three particular components to our policy for identifying emergency medicine HPOL vacancies, that being one of them. The other two are designed to ensure that the opportunities exist primarily in rural areas that, although they may be in need of specialists in emergency medicine, they have had difficulty in recruiting emergency medicine physicians because of the low level of sophistication of their emergency room facilities or because of the relatively less frequent occurrence of traumas that make the utilization of the emergency room less varied than that of a tertiary care facility of any inner-city urban emergency room.

FROM THE FLOOR: You mentioned the possibility of having 400 to 500 careerists with the Public Health Service stationed in shortage areas. What type of position will they be taken from to be sent into the shortage areas?

MR. OBER: They will not be. We already have a number of providers that are members of the Commission Corps of the Public Health Service actively practicing in the shortage areas. What we are trying to do is enlarge those numbers, through recruitment of additional providers into the ranks of the Commission Corps.

PRESENTATION: OTHER HRSA PRIMARY CARE PROGRAMS

John Hisle
Deputy Director
Rural Health Branch
Division of Primary Care Services

MR. LEE: The next gentleman that will be speaking is a present and former member of the primary care part of the Bureau of Health Care Delivery and Assistance, but in between that is the former Branch Chief of the National Health Service Corps; he is also well-acquainted with both programs. We are very happy to have John Hisle with us.

MR. HISLE: Thank you, Dick. I am the Deputy Director of the Rural Health Branch in the Division of Primary Care.

As of December, 1985 there were 600 community health centers serving 5.1 million people, recording 14.6 million visits, for a total expenditure, including grant dollars, of $775 million. If you add the National Service Corps expenditures, this becomes a billion-dollar operation. Sixty percent of the patients seen by community health centers are female, 40 percent male, 64 percent minority, 31 percent black, 28 percent Hispanic, five percent other. Sixty percent of the users of community health centers are below the poverty line and another 25 percent are between 100 and 200 percent of poverty. In summary, community and migrant health centers provide services to people without access to care. (A point that David made just a few minutes ago.)

The National Health Service Corps, over the last four or five years, has made an incredible difference in the shape, form, quality and quantity of community and migrant health centers, especially in their ability to deliver high quality managed care.

I am going to talk in general terms about urban, rural, migrant, frontier expansion activities. Back in 1983 or 1984, the Bureau of Community Health Services recognized the need to deal with a number of factors. First, we needed to place, 1500 physicians in 1985 and, another 1200 physicians in 1986. We would not be able to accomplish that using the same standards, criteria, and mechanisms used in previous years. Second, we recognized that given the politics and general trends in the country, people were looking less to the federal government for answers to their problems, and more to themselves, private industry and the states to solve their problems. People were much more interested in their local environments than in who, for example, was elected the senator from their state to represent them in Washington.

There was also a recognition that community health centers and migrant health centers had finally come of age. They started out in the mid-sixties as anti-poverty programs, with philosophy that if the establishment would not reach out and care for poor, black, Hispanic, urban and rural people, and if private industry, the counties, and the states were also not going to provide care, then perhaps the federal government could do it.

The community health centers now have a resource with which they could become part of a very viable, and leading part of the existing health care system in many communities. They had physicians, dollars and systems, and were able leverage for better systems of care in many communities, not only for the poor and the minorities, but for the rest of the community as well. I am a bit prejudiced because I work in rural health now, but I spent eight years in New York City, and know a bit about urban health. Many rural areas in this country are struggling, primarily because of economics. They are losing their doctors, their people, their hospitals, their health departments, their dollars, and are all struggling to retain the little they have.

We could not afford to have two, three or four systems of care in many places in this country, and were fortunate to have one system of care. That is why we have a rural, urban migrant, and a frontier strategy.

The focus still is state-based, recognizing that often, states know more about their needs and demands than the federal government. Counties and towns know more about their needs than does the state. Our focus is the state for a number of reasons, primarily it is where the resources lie, through Medicaid, private insurance, and, in some states, indigent care pools, health departments, and bloc grants. Increasingly the federal and state governments, the counties and local people have to cooperate rather than compile.

If we integrated resources, including private hospitals, we would be able to retain and perhaps improve on a system of care.

We also talked about investment. Investment, not necessarily in the Wall Street sense of the word, but using physicians and dollars the federal government, the state or the county had to integrate them and make the system work for everybody. It was a different attitude and approach.

We also talked about sharing services, pooling resources, joint purchasing and a general interaction at the state level.

The most important part of the strategy is the development of a concept of a system of care, which starts with primary care, the local doctor, whom we trust to manage our care. No longer the concept of: We will hold this clinic this morning and that clinic this afternoon and we will see 20 patients. But: Hey, do you realize that Mrs. Smith is coming in at 9:00 o'clock this morning and Mrs. Smith's child just got hit by a car last week and she's really in trauma and she may have trouble delivering that child. The concept of personal involvement in managing people's care makes the system work. There are the kind of activities and practices which are attractive to physicians and enable us to retain physicians.

In this larger system of care, doctors have become inter-dependent. They are now fully admitting to the hospital, following their patients, caring for their patients, regardless of "office hours". They have some stake in the community.

Another part of that activity is the actual creation of, and dependence on, the state to develop state-wide plans for the next two to five years. We have evolved in terms of a relationship between the federal and state governments, and a local group of providers, called state primary care associations. We started with corps contracts, which were let to an entity of the state to manage the National Health Service Corps activity.

These activities have developed into "cooperative agreements." Cooperative agreements are an agreement between the federal government, the Public Health Service, the state entity, and the state primary care association, (an association of community and migrant health centers), health departments, private practitioners, interested hospitals, all of whom are moving toward developing a system of care for that state's set of communities.

In 1985 and 1986, most of our investment was in urban, rural and migrant expansions, placing 420 physicians into 84 urban centers in 47 cities at a cost of $31-1/2 million. We placed 270 new expanded capacity physicians in 197 rural centers in 36 states at a cost of $34 million.

What are we going to do in the future, in 1987? We currently have 30 cooperative agreements signed with states and the state primary care associations. We intend to spend another $10-15 million in expansion activities; investment in communities to build systems of care (be it further expansion of existing systems or developing new ones which will care for the needs of newly identified populations.)

We are also concentrating this year on the interaction with traditional maternal and child health programs, primarily at the county level. Often, in rural counties, primary care centers and private doctors in maternal and child health programs are seeing the same people, especially in pre-natal and perinatal systems. We want to capitalize on the successes out there, let others know it is not difficult to expand that network.

In 1987, between 150 to 200 physicians will go into expanding capacity primarily community and migrant health centers, but some larger systems which incorporate hospitals, private practices and health departments.

Now, let me talk a little bit about MUAs and designations of MUAs, but in the context of what I just said as a logical extension of what I just talked about.

The "chief executive officer," defined as the governor of a state, recommends certain areas within his or her state as medically under-served areas. The regulation states that the secretary of Health and Human Services may agree with that recommendation made by the governor. This is a further extension of federal/state cooperative agreements and understanding, moving more towards a realization that states do have a very important role in defining their needs and helping the federal government identify areas most in need of resources.

Our time-table for publishing regulations is the first of the year.

There is one proviso in that new set of regulations which states that no more than five percent of the dollars being spent by community and migrant health centers in any given year be spent on activities so recommended and approved by a state. For your information, there is a similar proviso in the law for expenditures to public agencies, and a similar stipulation in reference to hospital systems.

The whole question of designation, is becoming one of identifying populations in need rather than geographic areas in need. The populations of high need that once existed in ghettos, now reside in smaller concentrations dispersed throughout the country.

One of my earlier experiences was working in the south Bronx, a borough once having a population of one to 1.5 million which is now down to 500,000 people. Over the last 10-15 years, the Federal/state and local governments have invested most resources here yet have evaluations of health status, e.g., infant mortality remain high and continue to rise.

We are now looking for ways of designating an area as under-served and applying our collective resources towards solving problems, in terms of population, and in terms of what happens with that population, i.e., what is affecting morbidity and mortality? What is the best way that we can all begin to address that specific kind of a problem? I think part of that thinking certainly comes about when you start discussing the possibilities of how you may want to begin to look at and utilize the drug treatment dollars that may become available.

Is primary care the best way to address the problems of the South Bronx? Is an internal medicine physician the best person available to help a population deal with alcoholism?

FROM THE FLOOR: Will the regulations contain the new criteria for MUA designation?

MR. HISLE: I do not think so. We are not close enough to re-defining how you look at under-served populations.

FROM THE FLOOR: My recommendation is that you allow the state to define their own categorizations for MUAs to target a 200 percent of poverty and below.

MR. HISLE: To some extent, a HMSA designation, a MUA designation or any other designation is a tool. We are all providing the best access to care possible at the local level. We are involved in primary care. We are not hospitals, we are not emergency medical systems. We are trying to assure people across the country a minimal level of access to care.

The only constraint I would put on any definition is that there are no answers, there are just a lot of questions. Where do you stop saying that a group of people are in need and start asking maybe they are not in need?

FROM THE FLOOR: Are there any specific plans for making available a resource to the frontier areas?

MR. HISLE: Yes, in the broad context of my statement. The first year that the frontier regulations were available, we set a base line. The national base line of expenditures by BHCDA in frontier areas is about $5 million, and that base line is determined by the amount of money we are spending for community health centers in frontier areas, how many National Health Service Corps providers we had and the market value for those providers.

Last year in terms of planning and development dollars, we added another three or four hundred thousand. We have informed the regions and the state people that we are very serious about developing viable proposals and applications for frontier areas, and we will accomplish this by 1987. We will probably fund another ten or 15 frontier operations and activities, and continue to do so as long as we have funding and there are truly needy areas, areas that people are looking at as access questions that can be addressed with the available resources.

FROM THE FLOOR: I have a question on the status on the corps contracts and the cooperative agreements. Are you allowing states which did not receive contracts on the initial review to reapply, and to get contracts? Is there new funding to allow that?

MR. HISLE: You are referring to next year?

FROM THE FLOOR: Correct.

MR. HISLE: It is not necessarily a question of new funding. Realistically the money comes from the same budget, in a sense, and in another sense it does not. The trend is not to have specific corps contracts activities, but to do more than just deal with National Health Service Corps. It concerns the issues of investment strategy, federal, state and local cooperation, and an agreement between the federal and state governments and the primary care associations. We will spend the next year agreeing to identify areas of need, areas without access to care, and who is going to commit resources to solving those problems.

FROM THE FLOOR: The states, over the last years, have gotten involved in planning and resources, and have tried to assist, state or federal organizations.

Now that federal monies are gone for health planning, we have to recognize that resources are cut back on the state level. Unless the federal government recognizes the cutback and tries to fund, through other programs, to assist the states in planning, this program is also going to be cut back. We will be in the same situation as when the program first started, when the National Health Service Corps was placing physicians without state involvement and cooperation in getting the appropriate placements. Physicians will be placed for a year or two years and then be gone, which creates a real problem. Communities cannot rely on those services. They do not see those as resources. People will not use those services as much. It creates a real problem if we cannot get those services to work with the communities.

MR. HISLE: The National Health Service Corps is not going to be the resource in the next three, four or five years that it once was. We have plans to recruit doctors, and there are people studying various ways to obligate or deobiligate physicians and put them in the service of the federal and the state government over the next three, four, five, six years. In actual fact, we are not going to have 1500 physicians as in 1985, regardless of the source.

In terms of looking at how you, as a community, or a group of people relies on a system of care, doctors, hospitals and health departments, convince your current doctors this is a good place for them to stay, or you can convince a new doctor that this is the place he or she wants to set up practice.

Next year there will be a surplus of 33,000 primary care physicians in the system, in toto. That does not address the issue of a physician in a frontier area. Managed systems of care, managed practices, with a salary, a full participation of physicians at a professional level, are the kinds of things we are hoping physicians will look at and begin to decide is a good lifestyle, since not all physicians can practice in downtown New Orleans, earning $250,000. More and more are going to be looking at the systems we develop as viable places to spend the rest of their lives.

There is a need for planning, and we are going to feel the cutbacks, but we are not talking about planning when we talk about cooperative agreements between the federal and state governments. Identifying areas of need and areas that lack access, is not difficult.

MR. LEE: That you very much, John, for a very interesting overview of the whole situation with primary care and the approach that is being followed.

PRESENTATIONS: PROFESSIONAL ASSOCIATION INVOLVEMENT IN HMSA REVIEW PROCESS

James Marshall
American Dental Association

Norbert Budde, Ph.D.
American Medical Association

MR. STAMBLER: I am Howard Stambler. Well, we have a couple of people here who I think are going to shed some light on where we are and, particularly, where we are going and to give us some ideas from the professional association viewpoint. We heard a little bit yesterday from Bud Baldwin on many of the issues the AMA is dealing with. Today we are going to hear from the American Dental Association and, again, from the American Medical Association from a different point of view.

The first person I would like to introduce is James "Jim" Marshall, who is the Secretary of the Council on Dental Health and Health Planning. He has been heavily involved in a great many of the things relative to the Council's interest in planning, the Council's interest in dental health. And, Jim, we are very glad you could make it.

MR. JAMES MARSHALL: Thank you very much, Howard. I appreciate this opportunity, as always, to meet the people who really do the work with this program. It has been, as you know, the better part of a decade or more, actually, that we have been at this with the current criteria and designation process. It seems like just yesterday we started all this and we are still at it.

I have been listening carefully to the discussions yesterday and today. I am impressed with the level of dedication and effort that this process has been dealt with. I say that up front because I know that, as we have discussed the issues of designation and Corps placement for one reason or another, whether it is convenience or from a practical standpoint, the issue of dentistry has rarely surfaced. And I take that as, possibly, "no news is good news," or just the practical fact of the matter that the Corps output for dentistry is down to practically nothing. I think the numbers are around 50 or so dental students in the pipeline for this year, and dwindling at the same ratio as they are for physicians. You will recall that when the regs were published in 1978, there was a fairly strong and concerned response on the part of organized dentistry. I hope to give some perspective as to why that was and how it has evolved to where we are today.

I believe the early designation listing for dentistry, totalled in the 900s, 900- and some at that time. The impression of some of our membership,

was that within six months an army of Corps dentists was going to march out of Washington into those 900 areas and begin practicing. It took a while for us to understand the process and then convey it to them, through the state associations and to individual members. The designated areas were there administratively. The response to their existence, however, was to be through the National Health Service Corps placement process, which had many fewer candidates to serve in that capacity. So, our initial responsibility was to cut through all of this and understand the regs ourselves and the placement process and then convey that to the dental societies who were concerned. Some of the concern was a bit hysterical, some of it was based on fact, some of it was not. And we wanted them to understand what this program was and what it was not. Our role, therefore, was convey as much clarification as we could so they could respond.

I would say not by way of defense, but by way of explanation that, the concern of the profession was particulary high at that time. Many areas were still in a recessionary period at that point in time, and the concept of the economic well-being of dentists was clearly on their minds. Many dentists were seeing a downturn in patient loads and at the same time hearing of more bankruptcies and the like. This spread like wildfire through an organization of 140,000 members. It does not take long for that to catch on.

At the same time, we were aware that the production level of dentists was at an all-time high. This, coupled with the notion that the government was programmed to provide salaried dentists in shortage areas, came together at a time when the profession was a bit on edge anyway. Dentists are people, too. They are steadfastly conservative. Though I must say that a decade has passed and we have a whole new generation of practitioners coming out. So, like in all disciplines, the average age of our members is going down, the number of women is going up, the old guard is moving on and the profession as a whole, is looking at these kinds of issues, problems and concerns with a different perspective than they did before. And I think this is all for our benefit.

But early on -- those were the circumstances, the characteristics that the ADA was looking at, and much of our activity was aimed at alleviating those problems. So, we had, on the one hand, an understanding at the national level, that much of what we were hearing from our members and from state associations was based on a misunderstanding of the regs and a misunderstanding of the process. At the same time we recognized that even with a clear understanding they still had a complaint about it. So, we worked with Howard and others in Washington to educate ourselves.

We developed a strategy manual which, in essence, was a primer for dentists to understand, first off, the distinction between the designation process and the placement process. But, by the same token, when it gets down to the local level, when the designation process is underway, what that really means to any provider organization is that it is possible or likely that another provider is coming into the community. It is very hard to separate the two. But we tried to do that in this manual. It was published and put in layman's terms. Actually, the manual is still fairly accurate, I believe, as far as most of the criteria. And it is available to you, if any of you would like it. You know these criteria and their applications better than

we do. But what we wanted to get out to our individual members was the process for designation and de-designation because, quite frankly, that is what most of them were interested in.

What this manual was intended to do was to spell out the process of de-designation and what kind of data you needed to support and document the designation and, conversely, what kind of data they are going to need to prove their case.

I have to say that after several go-arounds and exchanges, we succeeded, I think, in upgrading their ability to do that. I do not know what the total number of states represented here is, but I am sure you are seeing a varying degree of response now in sophistication in the state association local offices. We felt very obligated to let them know what the process was, so if they so chose to challenge a designation, that they did it in a reasonable way so that no one was wasting time going to Congressmen, writing letters, that fell on deaf ears.

We tried to change the criteria where we felt that that was the problem but had less success. We did administratively however and, again, I have to offer a tip of the hat to the federal people who acknowledge things like the inadequate review time. Once we finally got plugged into the system, so we knew what was going on, you had ten minutes to respond to it. And they were not geared to do it in a year's time, let alone 30 days or 60 days. But we got that extended. And that puts the onus back on the professions to find out where their members are and find out how they are practicing and how often they are seeing under-served patients and are they, in fact, where they thought they were ten years ago as far as practice location. Get that information together and put your case together. And we saw many state associations gear up to do just that.

Going on, then, into the 1980s, we geared our Department of Economic Behavioral Research, which is more akin to Dr. Budde's area here, to provide data resources. And we now have a capability of surveying our membership and providing information on a timely basis to them. It is offered to Howard, but not free of charge anymore. I think we used to give it away just for the heck of it and then realized that that was not making any sense from our standpoint. We provide it for our members and it is available to the public quite readily as well. Quite frankly, I do not think the whole process is all that sinister, it is just that we work at varying levels of currently data and that is always a problem. So, I wanted to mention that we are now providing that kind of information to our states. It is distribution data of dentists by county. It does not go all the way down to census tracts and that, of course is where much of the problem lies. But we are not at that level.

DR. MARSHALL: What concerned us more recently was what appeared to be kind of a shift in emphasis, a subtle, seemingly unannounced shift away from serving critical shortage areas with salaried dentists, which is very hard to argue against and we really did not. Where the areas were the high-need areas, the 01s, the 02s, we did not argue about those kinds of placements. We acknowledged that there will always be under-served areas for whatever reasons you have heard and they are fairly obvious. Place Corps dentists in those areas with our blessing.

What started to happen was -- and I will not go through all of the different impressions that were coming out of this -- was a shift to: Let's get these people placed anywhere. We have a problem; they are backing up in the dental schools and we have to get them out there. Get them out there anywhere you can.

That was the concern. That there was support for getting them into any area. I recognize that the designated areas needed to apply, and that those that did were not always in the high-need areas. So, we had the added problem of: where are the requests coming from? And if they are coming from rural 03 and 04 areas, or inner-city areas for that matter, that is where these placement people are going to end up.

At the same time, there was an apparent shift in willingness on the part of the federal government to maintain a budget to provide salaries for these people. There was an interest in getting them placed where the salaries would not come out of the Corps budget, but community health centers and the like, where someone else's budget could pay for that dentist.

Then we had the private practice concept starting to evolve as well. Well, by inference, you can tell that the private practice concept is obviously not going to work at all in a high-degree area. Where it would work and the individual might succeed is in the marginal area where there might be an economic base to support a dental practice, at least to some extent.

Another area that seemed to shift was the concept of serving a need and getting an individual into an area and hopefully having them stay, that is, the retention question after their service obligation. To get them there, there were incentives of loans and equipment support. Of course, dental offices differ from medical practices for the most part in the expense of establishing a dental office. Hanging up the shingle is the cheapest thing they do. You do not provide any care without investing quite a bit of money. So, those incentives were provided. But as they started to dry up, the placements started to go to the marginal areas, where there was a possibility of a financial base. And there, again, was generated a renewed concern on the part of the professions, particularly dentistry. And that is what concerned us, that from Washington there was a shift of emphasis. And we were concerned about placing Corps dentists into these areas and rotating them out because there were not new requests in other areas. Here's a viable spot that has been requested, there is an office there, the Corps dentist served his or her two years, rotate them out -- so you have a spot and can fill it right away because it is a live one. That is the impression we were given. I do not have numbers of how often that really happened, but that was the impression that came out.

Also, our concern was for creating shortage areas, chronic hard-core shortage areas, which might otherwise have been marginal. If you have a Corps dentist in the area who can see a full range of patients, the law required that anyone could walk in and opt for a sliding fee scale down to zero. The potential then was for this -- to siphon off those marginal patients of practitioners who were trying to make a go of it in that area. Now they are faced with the competition of a Federally-subsidized practice which did not have to rely entirely on patient fees. You then, drive out those private practicing dentists, trying to make a go of it there, and you have, a shortage area for sure.

So, we were concerned that the original intent of producing more manpower was not necessary. As Dr. Baldwin pointed out, we over-shot that projected need. Early on we were supportive of the concept of expanding dental schools and of getting more manpower but it has exceeded the demand. But we were supportive of a program to serve the hard-core shortage areas and that government should respond. At the same time, we were hoping that the government, and society in general, would support adding dental to Medicare and expand Medicaid dental benefits which 30-some states have but they are very marginal benifits, as you know.

The issue has quieted down, again, as I said, because the numbers of Corps placement are not triggering the kinds of responses you used to see. I polled about half of the states that are represented in the districts here and uniformly the dental association said: We have got the old problems if it comes up. For example, we still object to designating a place across the river where there are three bridges, but the river is there and it got designated anyway, and people go across every day except for dentistry. Apparently they cannot drive across the bridge for dentistry. Why is that? Well, those problems exist and they still exist, but because the placements are not as frequent as they have been, we are not hearing it as much.

In talking with Howard, I see that the plans for the Corps are possibly evolving into a voluntary system. Selecting volunteers out of the existing pool, or providing funds for loan paybacks of existing pre-doctoral candidates. That, I think, is a more viable approach and may be a useful thing. And I hope we come to that.

I will conclude by saying I am impressed with the dedication and the sincerity that you people expressed here. I wish more of our state association officers and staff could realize that the effort is very sincere to designate or not designate an area based upon the criteria and the needs.

I hope that the communication continues to improve at your level with these people. I know that you are all understaffed. The SHPDA and HSA people are no longer resources for the process, and it has gotten more complicated. But I hope that you understand their level of concern and that you minimize any abuse of the criteria as best you can, minimize the subjective designations as much as you can, be willing to provide the information as readily as you can to document those designations and consider the dental associations first. I hope that we can get to that. Give them a chance to serve these populations. If they cannot do it or they do not do it, then there is no recourse left. But I do want to reiterate that offer and opportunity to serve.

As I said, we have a generation of dentists that is responsive to the needs of the elderly, the handicapped, remote area residents, the under-served populations. We have some chronic problems that haven't changed, but I think the age to come will be a more productive and cooperative one. And I, again, thank Howard and all of you for your kindness and courtesy.

MR. STAMBLER: Thank you very much, Jim.

I would like to avoid quarreling or disagreeing with Jim on some of these things. And, fortunately, I can in all honesty avoid arguing, because

we have recognized some of the same problems and issues. We have been able to do more work internally, as have others as well, on the question of physician diffusion and metropolitan and non-metropolitan shortage areas. We know very well that there is a diffusion of dentists taking place. We have not been able to identify it as readily. We do know that many dentists are physically located in an area, but that their calendars very often are not filled and the activities are there to provide care for a lot of people.

I would just like to appeal to all of you to take a better look at dental data, the dental shortage areas, both in terms of the annual review and on any other occasions. We very often do not get much from the state dental societies and when we do it is usually not anything that can help us to make a rational kind of decision. But I think that the states and you here can really help by taking a closer look and not ignoring the whole area of dentistry, even though there may be only 50 dentists coming out next July. Programs can change and even those 50 dentists who are coming out have to be placed, or should be placed, in the most needy places. And, of course, that is why the Corps has the HPOL. They have understood this kind of thing, the PPOs that you mentioned almost disappearing now because of the Corps' understanding of same issues.

So, I think that on this particular issue I would like very much for you all to, spend some time looking at the data, looking at the distribution, looking at the things that can help us do the shortage area designation and, in many respects, reduce the number of shortage areas because we know this is happening. But we need the information ourselves to be able to do it rationally and to justify a de-designation or redesignation.

Now, to conclude this morning's session, we have another gentleman from the American Medical Assocation who is going to deal much more with the data, data resources, and the services that the American Medical Association can provide. Our speaker is Dr. Norbert Budde, who is the Director of the Division of Survey and Data Resources of the American Medical Association and is, like Jim, a long-time friend and of real significant assistance to us, and I hope he will be to you as well. He will be talking about all the data AMA has.

DR. NORBERT BUDDE: First thing, good morning.

FROM THE FLOOR: Good morning.

DR. BUDDE: Thanks. We are within a few moments of not being able to say that. I am here to participate in a discussion; it just happens that I am on the podium. I think that we have to take the approach that Ted Kennedy took when he came to the AMA and told a variation of this story. He said the three least credible things you are ever going to hear are: I will respect you in the morning; the check is in the mail; and I am from the AMA and I am here to help you.

But that's the fact, Jack. AMA is here to help. What we have, in the AMA, is a AMA Physician Masterfile that has been a building for about 80 years, it is good, and it is there to be used. And not unlike the work that you do, our job consists of planning, execution and then dissemination of information.

What I want to do is take you through, as quickly as we can, the process of planning, managing and disseminating that information, and appeal to you at all three steps: we need your cooperation because we cannot provide information that we do not know you need.

Now, Howard and the Bureau have been extremely helpful in that. That help goes back quite a while. We had that information and we could not get it published; they were able to help us do that. We have been changing what we do, we are continuing to change and, again, we need your help to figure out what things you would like us to be able to provide.

We are going to try to take you through a slide show about the AMA Physician Masterfile. I hope that you ask questions as we go along. So, please, just stick your hand up. It is a small enough group that we can spot it, and I think we can do it where you sit.

(Whereupon, there was a slide presentation accompanied by the following remarks.)

DR. BUDDE: The AMA Masterfile has been around, as I said, about 80 years and it has the who, what, where, and why of what we know about physicians. We have it on all physicians. We get that information from both the physicians and from about 2100 other primary source data providers. I cannot state that enough. We need that information for our very existence. Obviously, we are a membership organization so we need to develop members and we need to know who they are.

Our division also provides survey support. We completed about 65 different surveys last year in the division. We also distribute 37 million journals. We have done a lot of manpower research, and we have provided the information for manpower research. We put out our American Medical Directory as a sort of 'ultimate verification.' Doctor can look up their names and see what we have on them. We also provide information to pharmaceutical and other companies who are interested in marketing to physicians.

And then, of course, we have to manage the Association and try to provide some of the services that the members want. We have three basic databases to do that. One is a medical student masterfile, which starts the day the student enters medical school; we get that information from the U.S. medical school. We have the physician masterfile, which is physician-related information. And the third is a group practice file, which is becoming increasingly complex, and with the PPOs and the IPOs and the OWOs, it is getting real tricky to keep up with that. It is going to get even more difficult to keep up. We just get 'traditional' groups done, and then another form of practice emerges.

There are over 546,000 physicians in the United States. There are probably a few hundred other foreign dignitaries in the country that are not licensed and some number of people trained as physicians but not eligible to practice medicine in the country.

This slide demonstrates why my budget had to be raised this year. The number of physicians and the physician to population ratio is rising. The job is getting bigger and we are continuing to work on it.

This is the information base that we have. The first part is the basic identification of the physician. We have a medical education number that we assign when an individual enters school or the country and we learn of it; and that number stays with the individual. We are very, very proprietary about that. We will help you with what you need, but we guard the ME number carefully.

We have the preferred mailing address, the alternate address, and we are now collecting telephone numbers. The demographic information on the left, obviously, is pretty stable. However, we do change sex on about half a dozen people a year. The current professional characteristics are a bear to maintain. They are constantly changing and we are constantly working to keep the data current. The historical information on the right is, again, relatively stable.

Now, you planners are familiar with the beginning of all this. It starts with planning. You have to identify the information needs. I am here to listen, I am here to find out what it is you need, because we live in the same world. You know, the problems and the challenges that you see coming are the problems and challenges that will affect us also. You all know how hard it is to get information together. You have to start before people know they need it. Obviously, the purpose of gathering information is to make productive use of the information. That is what we want to do.

As I mentioned, we do some 65 surveys a year, for the Association, for other Associations, and for a just-started nor-profit subsidiary. This allows us to do work that AMA would not normally do but work that is relevant to medicine.

As people ask these questions, we begin to put together a pattern, we find out what is coming, we search out what people are interested in. To do this, we have expanded our telephone surveying operation. We just added a CATI system, which is computer-assisted telephone interviewing to assist us in collecting information. Physicians, like everyone else, are more cautious about answering questionnaires and we have to work harder than ever to get information.

We began a project in 1981, to look at the general requirements for data. We are now into the second year of a $3 million rewrite of our software that will allow us to do sensibly the things we have been shoehorning into the system and putting in sub-systems, trying to keep the data processing capabilities up to the need for the growth and the need for information. We are one year from completion, if all goes approximately on schedule, and it will allow us to be much more responsive to the requests we get now from organizations like yours.

Here is an example of a validation survey. We do a one percent sample once a year. We send the physician a copy of the data we have on the physician and ask the physicians if he or she agrees with the data. And, strangely enough, we disagree with a certain percentage of them. For example, it is not uncommon for us to classify a physician as a general practitioner with a secondary specialty of brain surgery, because the physician tells us he is a brain surgeon two hours a week and in his spare time he does general practice about 40 hours a week. Well, you know, I think of myself as an econo-

mist sometimes, but I have been a manager for years. So, there is this gap. We may also decide that the physician is right, and then we go ahead and adjust it.

The collection of data is a major job and we have about 100 people working on it. This slide illustrates our Physicians' Professional Activity questionnaire. This is where we get information on hours worked, on specialty, on address. We have added hospital affiliation, we have added group practice affiliation, we have added race at the request of the Bureau of Health Professions and the Bureau of the Census and the Division of Medicine. AMA did not have a need or a particular interest in that, and we had all kinds of legal counsel cautioning us, but, you know, we collected it because there is a need for it in the government.

We also have hours worked in hospital. A variety of new information has been added to match this new, more complex world.

Here is our group practice survey. We found there are about 16,000 group practices out there and about 120 - 130,000 physicians who work within group practices. Now, when you take out the residents, the fellows, the academics and so forth, we are getting up near a quarter of physicians associated, one way or another, part-time or full, with group practices. This is a radical change from just six years ago.

We are able to link the physician masterfile and the group practice file. This is, quite frankly, one of those shoehorn systems that I talked about earlier. With a crowbar and a sledge hammer, we can drag the numbers out and we can use them. Much of this information is published.

Again, 2100 different data providers provide all kinds of information from the time the physician is a medical student, through the very dynamic period of residency, and eventually a physician. So, that is sort of a reminder before we plunge into the different data sources.

The medical schools in the U.S. tell the AMA when a student enters the school. We put the student on the file. Not all students move through in a normal one, two, three, four-year progression, they may shift around. As those changes occur, we are informed, again, by the medical school. Eventually most of them graduate and we are informed by the medical schools. If they don't graduate, we know that, too.

The primary source for everything we have on students is the source that provides, that confers the facts, the school. We make a major effort to keep up with the whereabouts of each student because many of the schools do not want to receive their mail. So, we keep their addresses current so that we can reach them, for recruiting, for whatnot. We can get very good delivery on mailings to the students; if we didn't we would mail them out and they would not come back, but that just meant that somebody was just throwing them in the trash can in the student mailroom. We have all been there and you might remember what those mailrooms are like. The same thing with residents.

The national resident matching program matches about 70 percent of the students that go on to residency programs. We get that information before

residents begin, so we are able to locate where the physicians intend to go to residency. The first step is our Census of Graduate Medical Trainees Program -- this is probably the most complicated single survey on the face of the earth. We fill it out, with the information we have and we mail it to the approximately 7,000 different residency programs. We also ask, "Is there anyone there that we don't know about, that we do not have correct?" We get back the corrections, the revisions, the update and we frequently get information on the same person from two different places. For example, we may have the resident at Rush, and Rush will write back and say, "No, the person is no longer here, they moved to St. Luke's." And St. Luke's will say, "Ah, we have somebody here that you did not know about."

We also verify the completion of residency. So there is a whole series of: Where do you think you are going? Where are you really? And then: Did you really stay? So, it is very complex and it keeps moving.

The Educational Commission on Foreign Medical Graduates provides information on all the foreign medical graduates who are eligible to practice medicine in the United States. We pick up the FMGs as they enter the country, primarily through the residency program. There are a few other routes to licensure and we pick them up there as well.

Some of the other variables that we have include licensure. We get that information from the licensing boards annually. We may be behind on physicians. We will never show one as licensed that is not, but a physician may have recently got a licence in a state and we will not know it for a few months.

The American Specialty Board provides us with a board certification of physicians. Again, this is a primary source. We never take a physician's word for it. If they come through and show us, and say: Oh, no, I am board certified in this or that. We will write it down politely and we will thank them, and then we will check with the board.

We get licensure infromation from the National Board of Medical Examiners. Each year we get an update on who is still in the Army, Navy, Air Force, Public Health Service or VA from the Surgeons General.

We get current practice information from the Physicians' Professional Activity Questionnaire, which we looked at previously. This one actually goes to the doctors. This year and last year we mailed out almost two million of these. In a year when we are not doing much, we will get about 180,000 responses. And we target those carefully. There are times when you expect a physician to move, such as after a residency. We get an address change, and then a hospital will ask us to verify the credentials of a physician. We will note that hospital is not near his current address, and out goes the questionnaire.

We also do over 200,000 address changes a year. Now, that does not mean that 200,000 physicians moved; it may mean that one physician moved more than once. We also have changes where mail is coming to the home and the physician wants it sent to the school. And we've improved our data so we can locate the office. About eight to 12 percent of physicians with a primary other than the office. We are now getting that office information.

We get a lot of requests for change. We get a lot of reported address changes, not only from the physicians, but from the state societies, the licensing boards, the hospitals.

We also put out a "Physician Movement Report," which we are now sharing with the state and county medical societies to help recruit members. We report records that we have added to the Masterfile, name changes, and moves in or out of the state.

Eventually, the physician dies and we verify that. In fact, we usually get the death certificate. We verify it all and we actually have a flag we call "presumed dead." But like Mark Twain's story, "The rumors of my death have been greatly exaggerated," we have to verify a death before we move the physician off the file.

Twenty-one hundred different data providers. Two million changes in the course of a year. Not all these changes are dramatic and some of them are multiples.

How is the data used, the point of the whole thing, as I like to say. One that has a lot of new visibility is licensure action alert letters. When a state pulls the license on a physician or limits it or restricts it, and has come to a final decision, they inform us. We then write a letter to all the other states in which that physician is licensed and say: By the way, Georgia pulled Iggie's license and you ought to know that. We have no enforcement authority, but we think the information ought to be shared.

We are in the process of adding hospital privilege revocation information. That should be up and running early next year. We had some problems getting cooperation because of liability concerns, but there is legislation that the President may sign that will provide immunity. We expect to be designated the clearinghouse for that information.

We also provide credential information to a number of federal agencies and last year we completed around a quarter of a million credential verifications. And, of course, we also provide address changes. This year we will probably provide half a million.

Much of the information is available on an "as requested" basis. You can call us, or write us and we will probably provide the information you need.

Here are some of the things we publish, and we are just about to come out with a Physician Characteristics and Distribution in the U.S. for December 31, 1985, data.

We havve Foreign Medical Graduates, and Medical Group Practice. I brought a packet of things, some order forms and descriptions of some of the books.

We publish the American Medical Directory, an excellent and the only comprehensive Directory of American Physicians. It is copyrighted and cannot be compiled. It changes so fast that by the time we get it to press, there are 30,000 changes in the data, but it is still the best published source of information.

Here is a slide of a contract that Howard pioneered with the Bureau of Health Professions. We had a basic problem: we wanted to get information to you people and it would cost us two to three thousand dollars to put out a book, a la carte, for one case, for one state, for one area. Of course, the first one you could sell at a handsome price because people are desperate for it. You could not sell a second one at above the price of xeroxing, and you did not want to provide it for just one person. You wanted everybody that was interested to have it. So, we got a federal contract and then we were able to produce it. We have an ongoing relationship -- we printed less this time because of the budget problems, but it is available.

This is our profile service which we provide the licensing boards and hospitals. They can request information on physicians and we verify their credentials. We also provide the information to list houses which are commercial companies that can manufacture labels much better, quicker and less expensively than we can. They are not allowed to do certain kinds of things and we supervise those contracts very carefully, because we want only things that relate to the practice of medicine.

So, the purpose of this, again, is, to have a plan, figure it out, do it, and make it available. Our Physician Masterfile Booklet is in the back of the room. And now it is question time.

FROM THE FLOOR: Do you have office hours?

DR. BUDDE: The question was: Do we have office hours? The answer is: No, we do not have office hours. We have hours worked. But we do not make it available. There is a contract we have, with John Drabek and the Bureau of Health Professions, and we are going to look at some of that hours worked data. You know, again, it is a question of "busy-ness," as one of the things that we can look at. We did it about eight years ago and it was very difficult because: What was the standard hour? What can you measure? A brain surgeon and a general practitioner have different notions of an hour's work and we found that there really were very different practice patterns.

We put a brochure together that tries to answer questions. We can do tabulations, we can do data tapes, and we are a little -- we are slow. The intent to cooperate is there, the spirit is willing but the flesh is weak. We just cannot do all the work and it takes us a while. So, please begin discussions. Be real clear on what you need, be able to come to that, and then be prepared to wait because it will take us a while. We keep growing, but we still can't keep up with the demand. Our basic operating scheme is that we will give you information and we try not to identify physicians.

The other thing is that if you find a problem with the data you are already in a contract with us to tell us what the problem is so we can work on it together. You get yourself plugged into the system and then the next thing you know we are asking you: Okay, if it is wrong, how do we fix it? We know it is not perfect. It is real good, but it sure is not perfect.

One of the joys of working with this kind of a group is that anybody that has worked with data knows what it is like. And, people that have not always had these crazy expectations are shocked when there is "a" doctor that is out of place on the thing.

FROM THE FLOOR: I am on the staff here and I want to make a quick comment that there are three things that happen that are negative in relation to applications that we get and responses from the dental or the medical society, and I want to point them out to you because I think you probably know about them, but I want to make the point again.

One is we get form letters, categorical comments where the entire state has decided that they are going to oppose any effort to designate anything in the state and they send us a letter every time there is a proposed designation that says: The blank medical or dental society is categorically opposed to any effort to designate anything in this state and we do not want you to do this. That is number one.

Number two is the one that I call "The pronouncement from on-high," which comes down from a doctor, usually an older fellow in a county or a state or something that says: I have practiced here for a period of years and we do not need any more doctors, period. No facts to back it up or anything else like that.

And number three, and most serious, is when I find instances of medical associations, of doctors, of county and state medical associations or dental associations, what I call, "speaking out of both sides of their mouths." Simply not telling the truth.

There was a recent instance where, in a Spanish-speaking population I received something from the county, a very glossy brochure that indicated all the doctors that have been specifically trained to speak Spanish to deal with Spanish-speaking populations. We then had the applicant agency do a survey of those doctors, called them in Spanish to see if they could get an appointment. And what happened? They got two responses. One was there is no one here that speaks Spanish; the other is, if you speak Spanish you need to go back to the applicant agency for your care. Called all the doctors that supposedly spoke Spanish, and those were the two responses.

DR. BUDDE: I am sure you are getting more grief on the opposition to designation even though there are less corpsmen available. I do not know what a shortage looks like. I do not know what a surplus looks like. I am an economist, and we say, there is no right, there are just a lot of different ways to do it wrong. You keep looking for a new set of problems by changing the program.

I will tell you, though, that we are picking up from physicians, a tremendous sense of disquiet, a real nervousness about their ability to have discretion in treating patients, whether it is IPAs, PPOs or HMOs. There is a whole sense of a reluctance to pay for the quality of care and the style of care that the country has been gearing up for. In the 1960s we said: We want it; we want everybody to have it no matter what it costs. There is real anxiety out there. Everybody knows some physician that is working for $8 an hour. I do not know if that person exists, but everybody has heard it. It could be the same person and it might have been a misquote, who knows?

I am sure you get the idea that you do not need doctors in some areas. We get a lot of comments from doctors, but that is not the AMA, not the part that I do. We try to be the Bureau of Census. We are not the bureau of policy and interpretation.

MR. LEE: I just want to follow up on Dave's comments and Howard's comment earlier, as having looked at the designation comments from medical and dental societies over the past ten to 12 years, it is my perspective that, for example, in the dental societies we used to get that kind of comment a lot. We do not want any federal dentists in this area. We still get that from some places, but for the most part we are now getting very helpful submissions that give actual data, from the dental societies.

With regard to the medical societies, I do not think -- I have not seen what David mentioned, at least very often, in terms of a blanket condemnation. We have had individual cases where the medical society lists lots of different positions and you go back and check and, in fact, they do not all serve whatever population group it is. But at least that by providing the names of all the physicians that they regard as serving the group, you are able to check it out, that is what we need. We have got to have their perspective and they we can compare the two things and get the real answer.

So, as far as I am concerned, we are getting the data from the medical and dental societies and we need it.

FROM THE FLOOR: This is a question in relation to your description of the Masterfile. You were saying that sometimes you have different types of addresses, the physician's personal address versus his professional address. When the summary data is actually compiled, say, for the State of Maryland, which is where I am from, does this list all the doctors that actually practice in Maryland or is there the doctor that lives in Washington and he practices in Maryland? Which file would he go into? That makes a big difference in the supply.

DR. BUDDE: When we talk about the problem we always use Maryland and the D.C. area as an example because it is so severe there.

What we have had, historically, and what the 1985 data book will show, is physicians by their preferred professional mailing address. Our studies have found that that means about 90 percent of the time that is their office. So, there is ten percent difference there. And in D.C., Maryland, Virginia, you know, there is a lot of crossing over the lines. We could be 5 - 6% off, particularly with all of the civil service and the government employed non-practicing physicians.

The system that we have started now and are collecting data for and will be able to provide once we get all our software in place, will be able to distinguish between those. So for manpower studies we can use the office and when we want to communicate with the physicians we can use wherever they want the mail to go. So, you are right, we are off. I think we have cleaned up or expanded the write-ups on that so that it is real clear.

FROM THE FLOOR: Along that same vein, do you make some attempt to try to cross-check, say, with the state licensure files to see how -- when you get your total for the state, how close are those to what the total licensed physicians are for that particular state?

DR. BUDDE: We have not done it in that way because we found that in most -- well, I do not know what the average is, but there might be physicians

who are licensed in two states, so the licensure information just is not a reliable.

FROM THE FLOOR: In terms of trying to determine what is an accurate supply, and this is what comes up from time-to-time, whether or not to use the AMA data versus the state licensure data and there are problems with each of the data sources, as to which is more truly representative of it. When you get to large metropolitan area, it is very difficult to have adequate resources to do a definitive survey, so it would be good to have something like either AMA or the licensure file as fairly accurate.

DR. BUDDE: I was invited to Wisconsin by one of the state society guys because he wanted to get me and the lady that ran the state licensing data to fight. He kept trying to whip us into a fight and we kept saying: Well, hell, use hers; and they kept saying, use his.

They are different and they have different strengths and weaknesses. Ours is more current and it includes licensure information. So you have to look at your problem and look at the data and see which one is better for your purpose.

FROM THE FLOOR: What is the lag time, by the way? What is your most recent publication, a set of figures. I should say?

DR. BUDDE: We skipped year end 1984 and have not published that, but we are about three weeks away from publishing December 31, 1985 data. And there is a form in the back so you can order that one if you would like.

Actually, that brings a question up that I have been toying with, as my management is always whipping me for being behind schedule. With closing the file and creating an historic file for December 31 of a year, it is not available until the next year so we are always a year behind.

Would anybody be offended if we called that January 1 of the next year? Would that be really a dumb idea? It sure would make it look like a lot more -- before you editorialize, can we take a vote?

MR. STAMBLER: Sure, go ahead.

DR. BUDDE: How many think it should be December 31, and how many think it should be January 1? December 31?

(Whereupon, there was a show of hands of a 15 count.)

DR. BUDDE: January 1?

(Whereupon, there was a show of hands.)

DR. BUDDE: It's close.

MR. STAMBLER: It is like the football tape replays, it is very inconclusive. Part of that, just to mention in response to the licensure question and your question, the same kinds of problems exist in a much worse way in the licensure data for other health professions, nursing statistics,

optometrists, pharmacists, and in many cases we have found. There was a survey that we did five or six years ago -- I guess it was pharmacists, where you have as many as ten licenses for one individual pharmacist, and that can create havoc in dealing with them. Quite often the licensure agencies do not have any information on that person. They just have the name, address and licensed or not. And very often they are also on card files, which is not easy to deal with.

If I can add my vote, it took us five years in the Bureau of Health Professions to persuade our Division of Nursing and other divisions to use December 31st as the date. I would hate to have to face them again, but we recognize that kind of problem. And, of course, do not forget to talk to Jim later because they use December 31st for the dentists, as well.

DR. BUDDE: It would solve problems for me, but it seems kind of substantively unimportant. But, packaging-wise, well -- okay.

MR. STAMBLER: Well, Norbert, thank you very much for a very informative presentation, including some things I was unaware of.

Jim, I would like to thank you, also, for helping us out and helping us understand a good bit more about what is going on in the world of dentistry and, of course, the world of medicine.

PANEL DISCUSSION:
STATE AGENCY EXPERIENCES/METHODS
EMPLOYED IN POPULATION
GROUP HMSA DESIGNATION

Moderators: Marcia Collins
Mark Shapliegh

MR. LEE: This afternoon we have asked several state agencies to comment on their efforts with emphasis on the designation of population groups. This will be the topic for this afternoon's small group sessions since the population group requests are complex and difficult. Worksheets developed for use with some specific types of population group designations were developed for the small group sessions. These are a demonstration of how to make calculations when you have the Medicaid data that was mentioned in Betty's presentation yesterday morning. These are step-by-step procedures for doing the calculations. These have not received OMB clearance, they are just an in-house worksheet that we use in our analysis.

This form used a narrative description and notes access barriers and the resources in the contiguous areas. This worksheet is just an aid to arrive at specific calculations to get a ratio to use in connection with the rest of the report. I would like to introduce Marcia Collins from the Texas SHPDA.

MS. COLLINS: Good afternoon. I am with the Bureau of State Health Planning with the Texas Department of Health. I have had limited experience in getting designations for population groups, but I'll share my experience with you. I hope you will share your experiences with the group.

Population group designations are more difficult than geographic area, which is why they are not often done. There were two designation requests for Texas population groups that I wanted to share with you. One request was interesting in that it was an unsuccessful one. The reason it was unsuccessful was that it was determined that the area had a sufficient number of physicians to provide services to the indigent population. What I want to describe is the process by which we arrived at that result.

The initial request was submitted to ODAM and a restricted time frame was determined for providing input. It was a non-330 funded public health clinic that had provided the request. They requested that the poverty population of nine census tracts be designated in a major metropolitan area in Texas. This was one of the worst applications that we had ever seen. The application made no mention of the number of doctors, only of other health status indicators which were largely irrelevant. The applicant identified a

high concentration of Southeast Asian population in the area. This may have been the under-served population.

First, we attempted to quantify that population group. The 1980 Census did not reflect the influx that was described to us. Evidently, this increase occurred after the census, as we were only able to provide counts of about 1,000 Southeast Asians in the area, representing roughly two percent of the total population.

Next we studied the poverty population, which was fairly large, representing about 24 percent of the total population of about 10,000. Once we identified the population group, we identified the physicians providing services to the poor. Thirty-eight physicians were practicing in the service area. Since we were attempting a poverty population designation, we had to identify the number that accepted Medicaid, provided services on an ability to pay, or provided a sliding fee scale, as well as the percentage of patients that were indigent but not eligible for Medicaid. Because of the considerable increase in HMO activity in urban areas, we also inquired whether or not the physicians was exclusively employed with an HMO.

During the course of the survey, when I contacted individuals who were particularly helpful, I asked for any anecdotal information about the area and they provided a great deal of insight. I was told that there is a large Southeast Asian population in the area; they were not treating them as they did not come in.

We found that often the physicians offices were the most helpful to us. They could identify initial doctors shown in our licensure data, and could tell us of physicians who had left the area. I make an effort to collaborate with as many sources as possible when I am collecting physician information. If a community health center is in the area, I contact them, as well as hospital administrators, public health departments, the state NHSC contractor, and other sources, depending on the locality.

I have copies of the entire application that we submitted, and can provide copies later for those interested. In making the survey, we found that there were sufficient physicians accepting Medicaid patients and indigent patients, that we did not have a designatable population group. I used this just as an example of the process of designation.

The second example was of a migrant farm worker population group, a very difficult designation attempt. It had been designatable for several years and had come up for review. The situation was of a community health center located in an extremely conservative region, with a private sector that was very hostile towards the community health center. These problems date back several years. They viewed the center as direct government intervention, work by competition with private enterprise, and similar views.

The center is fairly large. It has roughly a $3 million operating budget, about 60 percent of which is in federal grants. They serve a ten county service area covering approximately 8,000 miles, treating about 45,000 migrants, seasonal farm workers and their families. The central clinic for this agency is located in the county that has a designation. To review that designation we first attempted a telephone survey. The results

of the evaluation were really critical since this area must be renewed for designation or be eliminated from the list. Already there was a good number of NHSC placements at the site, which was also on the HPOL to receive additional placements.

To complicate matters, the NHSC physician specializing in OB/GYN was leaving the area. The community health center was unable to contract with a local physician for the OB services, leaving them a population with a very high birth rate without an OB/GYN to provide services. There was a great deal of pressure in getting this designation reviewed.

As expected, the phone survey was not favorable. Most physicians said they accepted migrants and provided services to them. We arrived at a ratio of far below 1,000 to one. Nowhere close. The community health center took exception to the survey results, stating that their needs demand assessment by their own physician survey indicated that physicians were not accepting migrants. At that time it was determined that a follow-up written survey be done. When we drafted the survey instrument, we decided to include all types of migrants, instead of limiting it to migrant farm workers. We would inquire about poverty, Medicaid eligibles and the medically indigent population. This was done to gain information on several eligible groups, allowing alternatives in follow-up in case the migrant farm worker group again was not designatable.

We went to the site and met with the local medical society president and with prominent physicians in the area. It was imperative that we be able to assure having an adequate response rate to our survey. We provided a draft copy to the physicians and to the medical society president asking that it be discussed at their next meeting and asked for input on the survey instrument itself. It was presented and endorsed by the group and we conducted the survey.

I strongly stress the need to communicate with local medical society authorities. My experience has been that the more you inform your local contacts, the more successful you will be in achieving your designation and placement attempts. Although the survey was distributed to only 24 physicians, we received responses from 22 of the 24. The result was that we did have a designatable population group.

We provided copies of the completed surveys and our summary to ODAM. We had asked the physicians to sign the last page of the survey, thus assuring verifiable data for our report. With a telephone survey a physician could at any time deny any of the information provided to us, making it a matter of our word against theirs. When the needs demand letter went out for the National Health Service Corps placement, we held recorded evidence of a designatable population group.

MR. LEE: Marcia picked the case I would have wanted her to pick, as I remember it well. The reason we asked her to cover this topic is because of the tremendous amount of work involved in gathering verifiable evidence. A written survey takes work and coordination and requires involvement of the local people. Once they are involved it is difficult for them to disagree with concrete data. The Texas SHPDA has been noted for solving cases with surveys as necessary. And I'm just always amazed.

I want to introduce Mark M. Shapleigh, from Arkansas, from the Office of Rural Health. Mark is another person who has been working with us for quite some time. In Arkansas the situation is different. It is not the SHPDA, it is the office of Rural Health and they do quite a careful job.

MR. SHAPLEIGH: Marcia's presentation was very good. In front of you should be a packet I put together. I know that there are a lot of situations that other states encounter that are more complex with more unusual circumstances than in Arkansas. I have discovered that our situations are referred to as "child's play." And it is probably true.

I would like to hold a discussion using the material I have distributed. Page one summarizes the types of information expected. Page two identifies the name of the population group, the way that it is defined for a HMSA designation and the definition of accessible practitioners. We are going to address number three, the medically indigent, and the definitions listed.

The specific case involves a full county in Arkansas -- Mississippi County. We studied the county at the request of local officials. We examined the numbers and found that geographically it would not qualify. The area was, despite high poverty, 2600-2700 to one. We studied poverty, Medicaid and other categories and found that the ratio was essentially not sufficient.

One group we have difficulty with is the "medically indigent." The definition used here is a very conservative one, used for HMSA designation. Roughly, two-thirds of those individuals below the poverty level in Arkansas do not qualify for Medicaid. With a rural poverty rate of 21 percent, one out of seven members of the general population fall into this medically indigent category. Arkansas is not a big state, but we do have 300,000 to 400,000 thousand individuals in this category, the poorest of the poor, who can not afford medical care. Unfortunately, when you try to identify specifically those physicians who see patients regardless of their ability to pay or with a sliding fee scale, it becomes difficult to obtain verifiable data.

I should back up a little bit and say a little bit about our office. We are not only doing the HMSAs but also a variety of community development and physician recruitment items. As a relatively small state our information is pretty easy to collect. Our data base is about six weeks old. We are just starting out, so, once again, this is mostly a discussion topic. On pages three, four and five is the specific telephone survey that we use. We are now at the stage in using a telephone survey and a written survey will probably be the next step in our growth.

Essentially, from many sources, we tracked down a list of names and phone numbers of primary care physicians in Mississippi County, hospital administrators, and medical society roster using yellow pages and notes that we have assembled. We divided up the physicians and county administrators amongst members of the staff and made our survey. We have made changes in this survey since that time. We found that we receive the best estimates and information from the office managers regarding the number of patients seen with Medicaid and other business information.

Question two pertains to the number of office hours and ties in with our discussion yesterday of full-time equivalency of office hours. We asked

our respondents to comment on time in a sub-specialty, trying to obtain concrete figures and a few other items regarding Medicare.

Question six is: Do you accept Medicaid patients? I think there may be new ways we can come up with this information. Number seven concerns what is acceptable as solid data. To date, are the questions we have developed include Do you provide services for patients regardless of their ability to pay? As we are really talking about people on Medicaid, we probably should specify that in the question.

The arrangement for reduced fees is the sliding fee scale. We get such comments as: Yes, we do have an arrangement. But should they elaborate, we find it does not even resemble a sliding fee scale. There are no formal arrangements. Our office is trying to eliminate the subjectivity. Any other arrangements for receiving pay from poor patients? Often, comments consist of: "Well, whatever they can pay and put them on a monthly payment plan." We ask for the estimate of the percentage of time and often we hear: "Well, we really do not want to see any of those. We really try to see them." Or: "Well, we see, you know, about five or ten percent, but we really try to see as few of those as possible." Again, subjective data At some point a decision must be made, and it is difficult to do. I think the written survey is a good idea.

The last page of our survey is other information regarding hospital privileges and obstetrics. We found that getting as much information as possible while on the phone proves useful. We do tell them what we're doing this for, specifically, that we're trying to evaluate resources.

Page six is the summary of all the information gathered for Mississippi County. including the doctor's names, specialties and their hours. The question numbers are given across the top should you wish to refer back to this later, you can match the question number with the particular column. In the first column, questions one and two, we have got the physician's speciality and hours of week devoted to the practice of primary care. Forty hours is the standard answer To get exact figures we changed the question to office hours.

Sub-speciality, column five, for instance, is the answer to the Medicare question. Dr. Colomb was asked if he saw Medicare patients. He told us no, but he said that 28 represents an estimate of 25 to 30 percent. We just rounded it off. So, already our figures are not concrete. But that's what an N/.28 figure would mean. Some physicians, not listed as a Medicare participant, do see a certain component of Medicaid patients. Another weakness in our first survey was that the form was illegible. When we made the phone calls we actually would forget to ask a question, or might miss a percentage. Again, we are learning. We have made the form easier to read.

The two key questions for the medically indigent are the numbers eight and nine regarding fees and other payment arrangements. Based on the answer to question number two, we have figured the full-time equivalency for primary care. Except one physician, all were determined full-time, 1.0. The FTE Medicaid column takes the estimate given in column six times the primary care full-time equivalency. It determines the size of a practice and the percentage within the practice of Medicaid recipients.

The third column, FTE for the medically indigent, is essentially the same process utilizing column seven. Multiply figures in column 7 by the full-time equivalency. We found that in Arkansas, while not every physician accepts Medicaid, there is a sufficient number to negate a Medicaid designation.

The summary, on the next page is a compilation of our data. We talk about rational service area, we define the population group in question, discuss access barriers and the fact that two-thirds of the primary care physicians in Mississippi County do accept Medicaid. The number of practices devoted to Medicaid are about three and a half full-time equivalents. That was too many for a designation. Medicaid is not the problem, it's the 300,000 - 400,000 individuals ineligible for Medicaid.

We have got all the relevant statistics. In point four, I discuss the various information, and then on the final page, how we arrived at that. The telephone survey, the assumptions used, where necessary data was unavailable, why we thought these were generous estimates, and finally the summary as to our ratio, and how it compared with necessary ratio for designation.

I think there is one particular type of designation and it is very difficult to get reliable information to substantiate a claim. I would be open to any ideas that you may have. Our state is trying to wrestle with the problem of addressing the medically indigent. To date, my office has found no easy way to get information regarding people who do not have a means of paying and are without coverage, despite the significant population in this situation.

MR. LEE: Thank you, Mark. I don't want to comment too much on this since it is an existing request. From our conversations, I gather that Arkansas is so small that people know everyone, as well as that Mark has a strong office with a core of good workers. I think in this situation telephone surveys may work out fine. There are benefits to both the telephone and the written, depending on the situation.

Dave Ober and John Hisle will be available all day for discussions. We all appreciate their involvement here today. At this point we will break out into small groups.

The proceedings were recessed at approximately 2:45 p.m.

PARTICIPANT EXPERIENCES/PROBLEMS WITH
HMSA DESIGNATION (EMPHASIS ON
POPULATION GROUP DESIGNATIONS)

Small Discussion Group A
Regions III and VII

Moderators: Melba Kokinos
Betty Hambleton

MS. KOKINOS: In your copy of the Pennsylvania request, please note the letter at the end, regarding an area denied a designation and suggesting a reapplication as a population designation. Sharon Sowers was very helpful to Stephan Pascal in getting the population group designation; it is included as an example of a strong application. They provided a total reimbursement dollar figure for all primary care visits to physicians serving that area, and the average cost per visit. Using those two figures, and the figure of 5,000, from the "Profiles of Medical Practice," we divided the total reimbursement dollar for primary care, by the average cost per visit, and then divided that number by 5,000 to arrive at an actual FTE. That information made the need relatively clear without estimated surveys. Any questions? As David Ober was on the staff at the time he will answer any questions you might have.

MR. OBER: One of the problems that kept occurring was finding an accurate and acceptable method of measuring the amount of services provided in Medicaid eligible populations in any given community. Due to the difficulty in obtaining accurate figures on office hours from providers, health centers or hospitals, we decided to use actual billings on an approximate measure to the amount of services provided to Medicaid eligibles as a starting point for estimating the number of FTE physicians available to the Medicaid-eligible population.

MS. KOKINOS: Are there any questions on population designations?

(NO RESPONSE)

MS. KOKINOS: An annual review is pending for an area in Baltimore City where an organized out-patient department with quite a few physicians is located next to the hospital service area. Perhaps the information should be provided for doing a population group, as it is difficult to maintain an area designation in metropolitan areas where ample hospitals and doctors are located. Does anyone plan to submit requests for population group designations?

MS. WASHINGTON: I am interested in this.

MS. KOKINOS: While it would be different in each state, this group was able to use a provider number with other variables.

MS. WASHINGTON: I am not sure how difficult it would be to get the individual data versus the summary data.

MS. HAMBLETON: Any questions on these worksheets?

MR. KAPLAN: Our migrant population fluctuates greatly over the course of the year. What time period should you use?

MS. KOKINOS: If you can document the actual time they are present, that data can be used.

MR. NEAL: Aside from Medicaid, what other sources of care are we discussing? Our medical process does not distinguish between primary care visits versus office visits.

MS. KOKINOS: All sources of care are indistinguishable.

MS. HAMBLETON: Do they have a percentage of the total?

MS. HILLEMANN: Anything about the ethnic code?

MR. NEAL: No. It is just all one big dollar amount. We have a total dollar figure per physician in that particular county.

MS. KOKINOS: Does that only apply to the primary care physicians?

MR. NEAL: In our rural areas, that is all we have. Physicians cover everything from surgery to basic primary care.

MS. KOKINOS: Well, I would imagine that would still be useful, but then you would have to go a little further and probably do a survey in terms of the amount of time the second speciality is used. When we accept an FTE for a primary care physician with a second speciality, we make adjustments.

MS. LEE: Does your state licensing bureau maintain information on the specialities of licensed physicians and the percentage of time spent in that speciality?

MR. NEAL: We just started collecting the amount of time spent in office hours for indirect patient care.

MS. SOWERS: One difficulty I encounter is sub-specialists claiming they do primary care, whether or not they treat people. We do not count doctors whose speciality is other than primary care.

MS. KOKINOS: What if the situation is reverse, involving family practice and cardiology?

MS. SOWERS: In that situation, if their main speciality is primary care or family practice and they specialize in cardiology, we determine the number of hours actually devoted to primary care versus cardiology.

MS. KOKINOS: If they insist on being counted, and spend time on primary care, I would accept that. It has been accepted.

MS. HAMBLETON: Perhaps their primary care is in conjunction with the treatment of a surgical patient.

MS. SOWERS: This is a problem in the rural areas of Pennsylvania where the sub-specialists are not busy and are accepting other types of patients than just surgical. You would have to assess the number of hours they are providing care only to primary care patients, and not as follow-up on a surgical patient.

MS. HAMBLETON: Often, in rural areas, a specialist does not find a lucrative practice, so they practice primary care medicine to make a living.

MS. SOWERS: While "Surgeons" is a bad example, there are many sub-speciality doctors claiming to do primary care.

MS. ROONEY: For example, dermatology.

MS. KOKINOS: Mostly, it depends on the number of hours the doctor is spending on primary care.

MS. SOWERS: For example, when you get this information on a Medicaid case, it is listed by primary care specialty, and we might delete a physicians name because he is listed as an ENT specialist on other records.

MS. KOKINOS: Any questions about annual reviews?

MS. SOWERS: We do not do those. What is on the agenda for the coming year? Is it just dental?

MS. KOKINOS: Yes. We have not quite finished dental.

MS. HAMBLETON: It is near to completion.

FROM THE FLOOR: And next year, will there be another primary care physician review?

MS. KOKINOS: Yes, we will be doing those every year.

MS. HILLEMANN: Will it be like this year, doing one year and the next year's HPOL?

MS. KOKINOS: Yes.

MS. HILLEMANN: Do you work on the MUA designations at all?

MS. HAMBLETON: Joan Holloway is, in BHCDA.

MS. HILLEMANN: Will we have annual reviews on the MUAs?

MR. OBER: I am not sure. You should ask John Hisle.

MS. WASHINGTON: In your speech this morning, you discussed new and different ways to get personnel with the National Health Service Corps.

MR. OBER: Part of the obligated dollars, correct. Community health care centers already have pledged the number of providers, but they need a supply of services for the current demands. The grant dollars pledged to physicians will continue to exist. Eventually the community health centers in designated areas, who already are connected with the National Health Service Corps, will have to actively recruit new volunteers. In addition, they will find themselves paying salaries in excess of those given to obligated Corps scholars.

MR. BERRY: The MUA designation might become more important than the HMSA designation?

MR. OBER: It could very well.

MS. WASHINGTON: A HMSA will always be an MUA, but not necessary vice-versa. Some areas have a real need for increasing capacity, but do not have the financial capability. Although you will be using more innovative ways of attracting personnel, I do not see any help with that problem?

MR. OBER: One way is placing a federally-salaried doctor in those areas. This would be limited by the number of doctors in the cadre at that time.

MS. WASHINGTON: What is the supply, in terms of doctors?

MR. OBER: There is no real supply. Currently, over 100 physicians and nurse practitioners and 60 dentists are in the cadre. Not only do they service the shortage areas, but several are pursuing opportunities in the Centers for Disease Control or in educational MPH programs. They are not limited to clinical activities in shortage areas.

MS. WASHINGTON: Their obligations are different?

MR. OBER: They do not have an obligation per se, instead they have voluntarily joined the Commission Corps of the Public Health Service, knowing it entailed rotations through research, training and administration.

MS. HAMBLETON: Dave, how are nurse practitioners placed?

MR. OBER: Their placements are based on the requests of community health centers utilizing nurse practitioners that are having difficulty recruiting them. We limit their placement to primary care shortage areas.

MS. WASHINGTON: One of the questions I wanted to ask was if placement was always proprietary?

MR. STAMBLER: It is proprietary to the extent that, if possible, they will provide it. Often states can not afford things, but if you identify a need very clearly, and explain your usage program, they may be able to fulfill that need. One of the responsibilities of the AMA is to disseminate

data, which includes providing data for our studies in shortage areas. Utilization rates are in the "Profiles of Medical Practice," a 35-40,000 sample drawn from the master file by regions (metropolitan and non-metropolitan), by speciality, number of hours worked, and number of visits made.

MS. HILLEMANN: How about the dental association?

MR. STAMBLER: They have not published any information available to non-members. They have visit data, fee data, and expense data at a national level.

MS. HILLEMANN: Dentists were having problems maintaining practices in the rural areas in Missouri. The university from Washington had a mobile dental unit visiting sparsely populated or indigent areas, bringing dentistry at minimal fees and using mostly students. This program ended due to the liability rates.

MR. STAMBLER: As there are only 50 dentists for placement in this next cycle, it is important to recognize the worst.

MS. HILLEMANN: Once the liability issue cools down, the HMSA supported dentists will be helpful in terms of helping what few target areas are in need of dentists.

MR. STAMBLER: That should happen in the next three or four years. The National Council of Medical Education, meeting next month, will discuss the issues of malpractice and supply requirements.

MS. WASHINGTON: Malpractice is a problem especially in the rural areas where OB/GYN situation is very critical.

MR. STAMBLER: We had a case in California where the OB/GYN were not providing the services. We did not designate, but the BHCDA program formed a coalition and finally got the OB/GYNs to provide the services.

MR. WELLES: The OB/GYNs issue is a crisis in the State of Missouri, and throughout the United States, but that it is an issue to be solved locally. Are there any federal initiatives to help resolve the crises?

MR. STAMBLER: It will be several years before legislative initiatives are made.

MR. WILSON: Iowa has been interested in that issue. Hospitals, physicians and medical societies in Iowa are looking at legislative statements for solutions.

MR. STAMBLER: In Massachusetts you either accept a patient or lose your license.

MS. WASHINGTON: Due to the increasing cost of malpractice insurance, many doctors are not economically able to treat many Medicaid patients.

MS. HILLEMANN: There is discussion about whether or not the insurance companies are to blame. In attempting a study of this issue we encountered

a legislative confidentiality issue that, even as a sister state agency, we can not breach. We can not determine if there is, in fact, cause of increasing those premiums.

MS. WASHINGTON: There are differing reports on that. Some of them claim that they use the same gauge and then some of them can't, but then they said that it's because of the way things are going now. They're kind of anticipating, but they want to keep their pocket larger, alive and healthy. In Maryland nobody would insure the nurse midwives.

MS. HILLEMANN: Oral surgeons often can not get insurance.

MR. BERRY: How did you resolve the midwife problem?

MS. WASHINGTON: Presently, they are paying pretty exorbitant rates, on a short-term basis.

MR. BERRY: We started a pool with other states.

MS. WASHINGTON: Insurance in Maryland is doctor-funded and, thus, reasonable.

MS. HILLEMANN: A representative form the primary care council, made up locally of community health center people, belongs to a national organization which is looking at a nation-wide risk pool for primary care centers and others.

MS. ROONEY: The State of Kansas put a cap on insurance awards for malpractice. In the State of Kansas, there were only four awards over $1 million in the last five years.

MR. WILSON: Iowa is discussing caps and other measures.

MR. KAPLAN: We have caps in Nebraska, and I feel they are a breach of civil rights.

MS. ROONEY: Well, that is the big issue.

MS. WASHINGTON: That is one place where I agree with the attorneys and the consumer. There are some cases of gross negligence, people incapacitated for a whole lifetime receiving a few thousand dollars. But many lawyers have commercials advertising a no-fee policy unless you receive a settlement.

MR. KAPLAN: Malpractice lawyers only accept one out of ten cases, and a good lawyer will not accept a case that can not be won.

MR. WILSON: I know a man who is a private investigator for a medical malpractice law firm in Kansas City that only accepts one out of ten cases. They refer those they do not accept to other lawyers since they refuse cases smaller than $1-1/2 million.

MR. KAPLAN: Why would a lawyer take a case that they are not going to win?

MR. WILSON: The odds are the settlement will be $250,000.

MS. WASHINGTON: One of the discussion groups was talking about the malpractice situation, and an attorney was present. She presented a case for attorneys; while a law firm may not be able to prove a case of malpractice, the provider or the providers insurance company may not risk a trial and be will to settle out of court, thus protecting the provider's reputation.

MR. WILSON: Also, when a provider has to appear in court, they are losing income by not working. A tactic often applied by malpractice law firms is to drag out the suit, forcing the provider to lose additional work hours or make a quick settlement. In one case in Iowa, a group of OB/GYNs were complaining about the insurance increases. Four of the eight spokesmen owned the insurance company. The rates were increased, not on actual claims but on the likelihood of future claims.

MS. HILLEMANN: There is a doctor who is honestly brain damaged. He had a stroke, is brain damaged, and is still practicing. The community doctors are aware but will not take any licensure restrictions against him. Malpractice insurance rates will continue to increase until the physician community takes responsibility for removing or restricting the licenses of incompetent doctors.

MS. WASHINGTON: Last year, a legally blind doctor was doing brain surgery or cardiac surgery. Someone like that should not be licensed. If doctors would police themselves, malpractice suits would decrease. You can not sue for just a bad outcome.

MR. STAMBLER: Unfortunately, it is not always malpractice or negligence, often it is just for an unfavorable outcome. One law in the new bill passed concerns the vaccine of DPT and some unintended result, limiting the amount of awards. You can not sue for malpractice unless the doctor was negligent. A good number of awards are not for negligence, but for an unfavorable or unintended outcome.

MS. WASHINGTON: Other than some things you have indicated, there are no substantial revisions to criteria?

MS. KOKINOS: No.

MS. HAMBLETON: We have been taking into consideration the contribution of psychologists towards mental health. There is a study in the second phase of determining how to consider various professionals and whether any changes should be made. So far, there are no changes in terms of the criteria, and I do not foresee any in the future.

MS. HILLEMANN: I have heard that there are not any psychiatrists to place. Does the Corps have any obligations with other health professionals?

MS. HAMBLETON: No obligations I know of, except to psychiatrists.

MS. WASHINGTON: It is difficult to place a psychiatrist in a rural area?

MR. KAPLAN: If it is a very rural area, placement is not feasible. You need a big population base for a psychiatrist. In Nebraska, our one psychiatrist draws from a 12-county area.

MS. KOKINOS: I want to thank you and hope you learned a lot from this discussion. Thanks for sharing with each other.

The proceedings were concluded at 4:15 p.m.

PARTICIPANT EXPERIENCES/PROBLEMS WITH HMSA DESIGNATIONS (EMPHASIS ON POPULATION GROUP DESIGNATIONS)

Small Discussion Group B
Regions IV and VI

Moderators: Jasper Battle
David Brand

MR. BRAND: One point which came up in discussion yesterday was number one, one of the things that was pointed out to me about the way we handled it yesterday is that this is your meeting rather than ours. We want to emphasize what is going on with you folks and have you tell us what your problems are in the context of the discussion. You are going to hear less from us and more from you people.

One of the handouts is a form addressed to Mr. Stephen Paschall in Pittsburgh, Pennsylvania. Since this is a population group request, this form is a prototypical designation request with all variables included, as well as providing a result. Since no one is here from Pennsylvania, I asked that Mr. Armstrong from Mississippi glance at it and get this discussion started. While not limiting the discussion to this, we will use it to lead into the topic as it contains a good number of the important elements. Mr. Armstrong.

MR. HAROLD ARMSTRONG: I will start off by saying that the moral in this story is that if you do not want to wait six to nine months to get an area designated, you might do it correctly the first time. I do not mean to be overly critical of Stephen Paschall, but it appears from the letter that there was really insufficient statistical information to make all the necessary determinations.

The single most important task is the establishment of rational service areas, apparently not included in this list. Other necessary qualifiers were not submitted, such as infant mortality rate of birth for one year or poverty level statistics above 20, causing the minimum designation ratio to be one to 3,500 instead of one to 3,000. The latter two things mentioned cause them to be in the unusually high needs category or insufficient capacity.

It was denied, but later resubmitted as a population group designation. The November 1982 Federal Register explains in fairly intricate detail the necessary steps towards a medically indigent or poverty population designation or a Medicaid-eligible population designation. The formulas all have slight differences.

The second time this application was submitted it had support letters, apparently from a religious group and it all relevant material, such as maps of proposed designation areas, statistical information, letters of support

from local medical and dental societies, and current census figures. Including all of this in the original application will expedite the review process, effectively eliminating the 30-day waiting period for comments from medical groups.

Mr. BRAND: The floor is open. Mr. John Hisle, from the Primary Care Branch, is in the room. Marcia, do you have a question?

MS. MARCIA COLLINS: What is the position on support letters? I received about 10 letters in the past.

MR. BRAND: I do not think there is an official position. While knowing that lots of people in the area support a particular designation is handy, it will not influence the computation of a ratio. If the ratio is below the minimum necessary, we are still not going to designate the area.

MR. LEE: If you do not send in one, you are not derelict in your duty.

MR. BRAND: No, you are not required to. We will submit the application to the state medical society and try to get it.

MR. ARMSTRONG: The point that I was making is that since the local medical society is given the opportunity to come in, if you can get all the information to send in together, it is sometimes quicker to do it at the state level than to wait for Central Office to contact the local medical society.

It is helpful to know that there is community support, but it won't influence the computation of a ratio.

MS. COLLINS: I am interested in more general information.

MR. ARMSTRONG: A professional society and the official agencies in the state are more likely to be involved in that area.

MS. COLLINS: The hospital administrator, I'm just asking do you want us to solicit letters from medical resources in the area? While I have seen them in other examples, I have never done that.

MR. BRAND: Since we must give those different groups a chance to respond, they are included in the application procedure at that point. If they are not included, there is a certain list prepared in our office and we mail a request for comments. I do calculations for the application until I reach a point at which I cannot proceed without the comments. If I do not have them available, the application goes to the pending file where it may remain for up to 90 days depending on my work flow.

MR. LEE: If you think it is useful, put them in, but we do not find it necessary.

MR. SHAPLEIGH: To what extent will the designation process be affected timewise by not having those comments? We have in the past, when not hurried, always gotten letters ourselves from professional associations and sent them in to be sure you have everything. But we wait for comments for three weeks,

that's three weeks that we could have had the application without the letters. My solution to this problem is to send in the data with cc's of the letters sent to professional societies requesting their comments go directly to Dick. The society sends me a copy of their comments so that I have everthing in my office, and Central Office already has the data.

MR. DEMAREST: Medical societies do not respond to us at all. We usually send up the data first and receive a copy of the letter that Central Office sends to them asking for comments but we never receive a copy of the response.

MR. BATTLE: I have recommended in the past that you send the request to the society at the same time you send it to me, to expedite the case.

MR. DEMAREST: Do they ever respond to you?

MR. BATTLE: When we receive your letter, we in turn send back a form letter to the medical societies stating receipt of your letter, asking for comments within 30 days.

MR. BATTLE: Mark and I have been doing that for a couple of years now to speed the process. You have the whole package, which is what he essentially sends in. He has the comments from the HSA, the medical society.

MR. BRAND: Which does help.

MR. BATTLE: But we still have to wait for their comments. That's true.

MR. HISLE: In your experiences with the state, how do the current regulations and processes that we have talked about inhibit your ability to get an area designated as a population group? If you were to rewrite the regulation around the process of documenting an area as a population in need of medical services, how would you change the current regulation?

MR. LICHT: Are you talking about the process?

MR. HISLE: The regs will dictate the process.

MR. LICHT: There are a number of definitions of what is medical indigency. (sic). I would like to point out that it would facilitate much of the process should we come up with some definition of the level below which there is the risk of medical indigency.

These different definitions exist because there is a recognition that the poverty level itself, while a good starting place, is not enough when we are talking about medical indigency, the working poor, the working not-so-poor, and the working people in general who do not have third-party coverage with either catastrophic needs or needs for regular acute care.

We need to define that upper level so that we can go beyond the types of designations here and educate the ignorant, help the poor, and make health facilities available to the medical indigent. Our aim is to assist

sick people who otherwise would not get care. We need to expand our definitions to fill in that gap.

MR. LEE: We do need a unified definition. You should not have various programs using different percentages of poverty to define it. Back in 1982 we put out guidelines on only two populations and designations, and started in with 200 per cent of poverty. If you are below 200 per cent in poverty, you are entitled to a sliding scale. We thought that would be a good number to use since it ties into the Public Health Service program. Poverty is poverty. People can not be labelled medically indigent when the definition of indigent is different from the Federal poverty standard.

MR. HAGLER: Within a state, different counties set their own poverty levels. Using 200 per cent of poverty as the upper limit, having a sliding fee scale from 100 to 200, produces a program without resources available in the country to meet the manifest need or exhibit all the current shortage areas, amounting to an elitest or selective beneficiary.

MR. HISLE: Is poverty a good measure of lack of access to care? Are you talking about poverty, are you talking about Medicaid eligibility combined with medical indigency? In all of your experiences, is that limiting people from getting care? Is the 200% poverty level the best indicator of need?

MR. LICHT: We compiled an index of economic access in this last year. We ranked all of the counties on two items: unemployment and medical indigency by per cent of population in a county, 200 per cent of poverty, subtracted out the Medicaid eligibles that are actually on the roles, resulting in the portion of each county's population indicating the number of medically indigent. We correlated that figure, for example, with a perinatal health index, built on percentage of live births with low or no prenatal care.

So things that, according to our MCH bureau were status indicators of poor prenatal health, the top 10 counties that we had in our state, because of the worst economic indicators, agreed, with one exception, with the top 10 counties that we had with the maternal/child health indicators.

Where is the worst public health on this particular indicator. We can say that economic issues, particularly poverty and unemployment related issues, seem to have more of a correlation with perinatal health that even such issues as how many public health dollars went for prenatal care.

The access issue for that one item would seem to indicate that nothing better than institutive (sic) verification seems to work very well.

MR. LICHT: In our index, we include premature birth and infant death, and have a different poverty mechanism. We have five criteria. We rank the counties, since we have the worst infant death rates. The index we use is 200 per cent of poverty and below for medical indigency and poverty. If we could make regulatory changes, moving it up would be one of them.

MR. DEMAREST: The rate would be 200 per cent below, just actually 100 per cent. You are not catching more than, I would say, 60 percent.

MR. LEE: If you did 200 per cent for the whole country, there is no way we could meet the needs.

MR. ARMSTRONG: If the population group ratings are considered for re-writing, we should include some threshold of unemployment as a criteria, as well as including uninsured or underinsured. There are large numbers of people that work for employers that employ less than five people or are part-time, and they have no health insurance. Or if they have any it is dreadfully inadequate. There are some groups that are floundering, particularly the unemployed who do not fall into any designatable group being discussed.

MR. HISLE: How does unemployment differ with professional poverty.

MR. LICHT: It's a leading indicator. Poverty has existed for follow-up later on, because you have 38 weeks before unemployment stops.

MR. HISLE: It may.

MR. LICHT: It may, but if it is structural unemployment, not just seasonal, it is a leading indicator. That is why we included it, and found it did help.

MR. HAGLER: Chronic unemployment is three years of unemployment, average.

MR. GLASS: We can capture the unemployment figures on the state level, and as I mentioned yesterday and this morning, we are all guessing at what poverty is. Unemployment figures are much more up-to-date than poverty statistics.

MR. LICHT: The actual rate is just an indicator unless you get their discouraged worker rates, which includes the people who are no longer actively seeking work. And a combination of those two things would work out really well, because otherwise you lose large numbers of people when the industries close down.

MR. ARMSTRONG: My point is that the poverty information is seven or eight years old now.

MR. HAGLER: If you have any insights on the location of good data on the underinsured or uninsured, I think that would be really helpful. We find that a void, one of the major areas we just can not get a handle on.

MR. ARMSTRONG: We are also having a problem with getting information on that group.

MS. RAEL: I think you have to do your own study. We made this study several years ago to determine the extent of underinsured, by mail survey. Other states have done similar studies, but only on a state-wide basis. The sample was not structured so that we could get figures by counting.

MR. HISLE: On the other hand, if you show that there is a greater degree of need out there, you sometimes begin to see a creation of resources where you would not have had them before. The other thing it would do is, if we opened a primary care CHC for an NHSC clinic in an area, and if we

really are trying to know who is going to come to the door looking for care because they can not afford to get if from a private physician, whether one can be reimbursed by the existing system in that eventuality, so you are really trying to find out what is the real demand where you do have a clinic. Although we can't fund all of these, we will fund those with the greatest demands. Believe me, we will have a more realistic figure of demand.

MR. LICHT: The fear is that in going to the 200 per cent of the maximum will double the numbers. Above that, people have some resources, and in calculating the need that must be subsidized, there will be the unserved and the level of underservice. You must do the same thing with the sliding fee scales.

If you want to set up a linear thing, those between 100 and 125 per cent -- say there's 1,000 of those; let's count them as if there were 750 FTEs, counted 25 per cent. I mean, 100 per cent of poverty and 150 per cent of poverty, we could discount the numbers in that range by 50 per cent, because what we are saying is that they have a certain amount of resources which they can bring to it. It was as if we had another FTE, if you will, or equivalent of 100 per cent, so that in fact, the discounted rate, if we had good enough information to be able to structure that to get a sense of the level of underservice, that would need to be subsidized by somebody. Those people at the top are not necessarily going to be fully subsidized. It is quite manageable on that basis.

MR. LEE: It can be discussed without changing the regulations. People have said that the designation threshold is being abandoned when it come to CHC projects. Perhaps you should demand analysis for a CHC in a particular HMSA. What is going to be the real demand and what is the need demand threshold will not be designation threshold but demand threshold, and you can use an easier formula for calculating that, and that would get us out of the problem of either having to change the regs or abandon them.

MR. BRAND: Is there any consistent ratio that can be applied to the number under the poverty line claimed when you change from 100 to 200?

MR LICHT: Our counties are too varied to have any consistency. You know, when you are running from a county of 1,000 people to a county with 350,000 or 400,000, there are some big differences.

MR. BRAND: What kind of changes have you seen?

MR. LICHT: Between about seven and 30's. When we go to the medical indigency where we have 30 per cent below, we back out the Medicaid. The range starts at about 25 per cent; 23 to 25 per cent of the population within a county is potentially medically indigent, with the majority in the 25 to 48.5 per cent range, with a few as high as 63 per cent in very rural and very poor counties.

So typically you get an increase, although not quite what you would expect. There may be a doubling, however I do not use any particular rule as the figures vary too greatly.

MR. DEMAREST: In South Carolina, we have a medically indigent assistance act as well as a medically needy program which covers the 100 percent to 200 percent of poverty which covers cases below that.

We have done evaluations of both programs and found that 85 percent of the medically needy program group are being served either through public assistance or under programs in force, while 60 percent of the medically indigent assistance act are seeking services through that program. We are trying to develop a new program to cover persons not being served by either of the current assistance programs.

MR. BRAND: Why are these people not covered?

MR. DEMAREST: They do not seek service. They are either uninformed or mistrustful of the current assistance available.

MR. BRAND: Any other issues? For the benefit of the new people among us, will someone quickly explain the difference between Medicaid-eligible, medically indigent, and poverty pockets?

MR. HAGLER: There are several definitions of medical indigency. We realized that there were a significant number of people not covered by Medicaid service being included in our figures. We developed a method for determining the average daily Medicaid or full time equivalent Medicaid eligibility. This number is 35 or more per cent less than our original figures, leaving the rest of the pool to be served much larger.

MR. BRAND: Anybody else?

MR. SHAPLEIGH: That is a controversial issue in Arkansas, as well. It is difficult to tell which figure is being presented. This causes a great deal of work; we must constantly verify the figure and identify which of the two definitions it represents.

MR. BRAND: Why not give us an average?

MR SHAPLEIGH: We are giving four or five of the most recent month averages to show some consistency.

MR. HAGLER: Those need to be made available to people who work with these numbers in computing designations.

MR. BRAND: Anyone who is having difficulty understanding any part of the worksheet, please ask questions so we can clarify the problem. These are worksheets relating to Medicaid-eligible migrant pop group designations and poverty pocket spots.

MR. LEE: The one for poverty and migrants is for if you are able to determine the number of migrant workers. If you are not able to do that, then you use the other one. If you have got Medicaid data and you have got ethnics and migrants, then you can use Medicaid-eligible/migrants. We developed this for Florida because they have Medicaid and migrant data, but were unable to estimate the medically indigents' care. You can use the worksheet to cover the total poverty population once you have data or conditions.

MR. BRAND: Does anyone have any specific comments or questions about migrant groups?

MR. GLASS: Computing valid numbers is a continual problem. In contacting the State Department of Labor and the State and Federal Departments of Education, you receive widely different numbers. We just use the biggest one we receive.

MR. BRAND: What is the continuing problem? Are the numbers increasing?

MR. GLASS: It is impossible to exactly count a migrant population.

MR. DEMAREST: The departments are providing estimates that cover 75 to 80 percent.

MR. BRAND: The method used is to apply the number of children registered in a school system to a ratio of the average family size.

MR. DEMAREST: In using that method, we found we were covering about 33 percent of the total population, since the children also work. Most do not regularly attend school.

MR. HAGLER: Many migrants do not have families. This is a very different calculation.

MR. BRAND: Mr. Licht?

MR. LICHT: I was wondering if anyone had experience with the method employed in the agriculture document, whereby they multiplied the number of acres by --

MR. DEMAREST: I have seen that.

MR. LICHT: How is that as an estimate? That method worked fairly well for our group. Has anyone tried to verify it?

MR. DEMAREST: It also worked fairly well in our state, applied to the peach crop.

MR. HAGLER: Frankly, I don't know how well it works. I have worked with it, and have found the numbers were double the numbers the Agriculture Department calculated for migrant workers. The Department of Agriculture employed a survey.

Every set of methods I have compared have obvious differences. There are some fundamental flaws in that set of formulae because it does not take into consideration people moving across the state with the change in season. The peak number for each county within the state is added cumulatively, which does not consider that the same people are being counted in different counties.

MR. LEE: If you computed the number of migrant workers in a county because of the peach harvest, would you also come up with the number of months they were in that county?

MR. HAGLER: They are in the county multiple times.

MR. BRAND: David Ober, in your time working with the California unit, what method did you employ?

MR. DAVID OBER: I remember I found it really useful with the migrant designation in the state of California that used ... (inaudible) ... and that particular state -- I do not remember which one it was -- apparently did not have a lot of migrants that camped out or were unaccounted for, so that measure gave a pretty good approximation of the numbers.

MR. LICHT: In Arizona, until the time the union was instituted, 25 to 30 per cent of the migrant workers were living under the trees, literally. Those figures have dropped down to about 15 or 25 per cent.

The camp capacities sometimes reflect the Wagner Act. When the capacity in a migrant work camp is full, workers often are forced to sleep under the trees, or become day labor. I think there is a bias on the under-count.

MR. OBER: The thing that was nice about measuring migrants is that any organization such as the medical service that wanted to question the days of the group designation was there for their examination, and they were free at their leisure to try to disprove it if they wanted to, keeping mind that the need to be responsive to any organization that suggests that they are being less than scrupulous.

MR. DEMAREST: Since most migrant groups start in Florida, and move north as the seasons change, perhaps a combination of states could estimate the populations as they enter each state, then a comparison could be done between the states. The result being that each state would have figures on the number of migrant workers per month.

MR. LEE: One point we discussed a study of migrant streams.

MR. BRAND: The problem with that type of study is that often a similar crop is being harvested in two states, for example, the peach crop in Georgia and in Pennsylvania.

MR. DEMAREST: I believe that different migrant groups cover Pennsylvania and Georgia peach crops.

MR. LEE: The only data we have is the 1978 inter-America report, which is over eight years out of date. We would like to do a new study. We recommend using more current data at the state level. We realize that the figures we are given will not be totally accurate, but they will be more accurate than those in the 1978 report.

MR. BRAND: The report was useful in a recent designation in California. Perhaps some of the data is still helpful. Marcia, you have a lot of migrants in Texas.

MS. COLLINS: The problem we face is incomplete data. The Labor Department can tell you the registered labor camps, and give you an

estimated population. The missing variables are family size and number of dependents. The schools can supply registration figures, which are not accurate indications of family size.

The data was actually about 10 years old, not eight years old, by the time it was compiled at the national level. We work with the migrant health centers to enumerate the migrants, but the figures available are fragments of the population. The only areas able to quantify the migrant workers are those who have done their own survey. As this takes money on a state-wide scale, it will be some time before we can attempt it. In the meantime we can supply only fragments of the data.

MR. LEE: Are there any other population groups that you all are concerned about or that we need to collectively figure out a way to calculate some appropriate ratios for?

MR. GLASS: In Florida we have many Haitians and Cubans entering illegally. We have currently been supplying estimates in our designation requests. It's a devastating problem.

MR. LEE: I really was thinking in terms of a couple of times we have varied in the direction of the homeless population. What about the homeless?

MS. PEASE: This is a growing problem in Atlanta due to the number of psychiatric patients being released. A group has contacted me about providing some service to the vast number of homeless in the area. There are increasing numbers of women and children in this pool. What is the definition of a homeless person? I mean, it seems real simple. I mean. It is not always as simple as saying a homeless person doesn't have a home. If the economy continued to worsen it is going to be a much more pressing problem, one that must be studied. I would appreciate hearing any ideas on solving this problem. The homeless have a limited amount of access, as they don't utilize community mental health centers, often because they are unaware of the facilities available.

MR. OBER: There are certain limited health care resources available to them.

MS. PEASE: Yes.

MR. OBER: Is there an outreach program to inform the homeless of available resources?

MS. PEASE: It is difficult to educate people who move from shelter to shelter. Some hospitals have a van that visits different shelters, using volunteer personnel in an attempt to care for the medical needs of the homeless. This program needs to become formalized and employ full time doctors.

The homeless are sheltered night by night. There is not one shelter in which a person can stall all day long in Atlanta. Even the two that are strictly devoted to women and children return them to the street at 5:00 a.m.

MR. BRAND: Five a.m.?

MS. PEASE: Five a.m. They want to disburse them before rush hour.

MR. BRAND: Where are they going to go between 5:00 and 7:00?

MS. PEASE: I don't know.

MR. LEE: If a shelter did not disburse them at 5:00 a.m., you could count the average number of people in the shelters.

MS. PEASE: Right.

However, those figures vary when the weather gets warmer and the vast majority of these shelters shut down until the temperature drops below 32 degrees. There is never a consistent number of shelters open.

MR. BRAND: Any ideas on solving this problem?

MR. DEMAREST: We set up in Columbia, South Carolina, a free medical clinic, with volunteers from the physician community. We have done a survey every two weeks of patients to get unduplicated figures. We now serve about 50 patients a day over a two-week period, and then the cycle repeats.

During the summer our census dropped almost completely, because during dry weather, they found other places to live. In December and January, we are probably going to see a lot of overflow patients coming into the U.C. shelters.

Unfortunately, the shelters themselves turn the homeless out in the streets early in the morning.

MS. HATMAKER: In Nashville, the Metro Health Department will take over the shelters as of January 1, but our problem is differentiating between the homeless and the street people. The street people are migrating in to the city from all of Davidson County to receive free health care. The Salvation Army, the Rescue Mission, and the Metro Health Department plan to build a shelter in coalition with the Johnson grant.

MR. DEMAREST: We probably would be overstating the homeless, as our free clinics are treating both the street people and the homeless in addition to other transients who may be receiving public financial assistance.

MR. BRAND: Since Dave Ober is here, does anyone have any questions about his presentation this morning?

MR. SHAPLEIGH: In the metropolitan area of Little Rock, one of the seasonal health centers (in connection with the medical school), is devoted to child psychiatry. We have chronic shortages of qualified people.

We have dozens of psychiatrists in the MSA, the unit I am working with, but when we try to determine the number of hours each spends on indigent

children, we find only a small group needing psychiatrists. Does anyone have any experience or solutions to offer?

MR. BRAND: If there is a real good answer, I would be interested.

MR. SHAPLEIGH: This group does not fit the psychiatry designation for a facility because the total number of visits are not great enough, and it is to small an operation to quality in a facility category.

MS. RAEL: Is this a regional or state facility?

MR. SHAPLEIGH: It is the child psychiatry center for the state, while the rest of the state has psychiatry centers -- half of which are in shortage areas for just general psychiatrists. The vast majority of his outpatients are from outside his area, and the majority of his inpatients are from within his area. It is generally recognized as being a state facility. It is not the type of facility that serves every corner of the state.

MS. RAEL: I assumed the state was the ultimate contributory.

MS. CRISCOE: Are children referred to this center from mental health treatment centers around the state?

MR. SHAPLEIGH: Yes. They may take the overflow cases from the general psychiatry centers since there is such a shortage. The question is ultimately, are there enough child psychiatrists available? I would like to achieve a designation for this problem so that we will be prepared in the future. To reiterate the question, does anybody have experience in the population group category for child psychiatrists?

MR. BRAND: Not many places actually have a framework within which to work. Does anybody have any comments or ideas about that issue?

(No response)

Are there any other subjects to discuss? Perhaps we should reiterate the process of generating a medically indigent designation.

MR. ARMSTRONG: Again, the 1982 federal register contains the formulas. In Mississippi, there were six counties indicating in various ways the justified need for placement of an additional physician, mostly due to the geographics of the county.

While in most cases the county seat is close to the center of the county, in some instances it is at one end with two or three equally sized towns. It becomes a problem to actually place the health manpower resources, especially when one town has been more successful than the others in recruiting physicians.

Geographically, each county was not designatable under the geographic criteria. In response to the need, we developed a designation based on the medically indigent criteria. You identify that population by substracting the Medicaid-eligible population of the county from the percentage of individuals below the poverty level. Next, determine what per cent of full time

health care physicians are devoted to serving these various populations and convert to a ratio. Five of the counties qualified for medically indigent population, which met our criteria.

MR. ARMSTRONG: One of the requests was for a poverty population designation. Only one of the potential pools it qualified for still needed to designate the county.

When reviewing counties on an individual basis, as opposed to the annual review, we do not get involved unless a request is in writing. We do not have a great working relationship with the state medical association. We inform the person requesting a county or a population group designation that the local physicians virtually hold veto power over the request. To expedite the application, get the proper letter from the local medical society and mail it to us.

MR. BRAND: Thank you.

MR. BATTLE: The real problem is in estimating the percent of time that private practice practitioners devote to medically indigent population groups. Those last two worksheets distributed were the direct result of a workshop in redefining the computation of the percentage of return. Typically, you use around five per cent throughout Mississippi based on physician concurrence in most of the counties. Correct?

MR. ARMSTRONG: Correct.

MR. BATTLE: If you do not have the concurrence of the physicians in the county as to the percent of time they devote to the medically indigent population, how do you estimate what per cent of their time is provided?

MR. BRAND: Eventually, we reach a compromise that suits all parties involved.

MR. BATTLE: However, when you estimate five per cent, they can still veto it.

MR. DEMAREST: Yes.

MR. BRAND: Any ideas on proceeding when a compromise can not be reached?

MR. LICHT: You can get county Medicaid statistics. Theoretically you can come up with some percentages of those covered by Medicaid.

MR. BATTLE: This is the assumption we used.

MR. LICHT: Right, and again if you say, well, gee, they probably are not seeing more Medicaid, even just setting it equal to the number of Medicaid or the percentage of Medicaid.

MR. BATTLE: We went a step even further. We took half of the figure that you had, you know, two doctors accepting Medicaid, and you might have

one doctor accepting the medically indigent, or 50 percent, which he bought on that one particular county, but he would not buy it on any other counties.

MR. BRAND: How do you get the Medicaid statistics?

MR. LICHT: You can convert the dollars expended on primary care Medicaid for the county into numbers the county.

MR. BRAND: Who keeps those kind of numbers?

MR. LICHT: The state.

MR. BRAND: Is that true for everybody?

MR. LICHT: You get claims, too.

MS. PEASE: Sure.

MR. LICHT: You get claims paid also

MS. PEASE: And you get claims per doctor paid.

MR. BATTLE: In lieu of that first computation, that the dollar amount for the year and divide by the average cost per visit to come up with the visit money.

MR. BRAND: Can you get claims per doctor by doctor?

MS. PEASE: Yes. That is what we did.

MR. ARMSTRONG: In some states.

MS. PEASE: In Georgia you can. In an area where I am told they are not serving the Medicaid population, I call Medicaid, ask for the dollar value and number of claims for these doctors in this county, and they will call me with the specific information.

MR. BRAND: How common is that?

MR. ARMSTRONG: We can get it in Mississippi, but that is considered confidential information. That is equity payments to providers. We never release any names of anyone. The only way we can get it is by signing a promise not to release any names, but it is equity payments to providers.

MS. PEASE: We do not release the information.

MS. SUE ELLEN RAEL: By type of provider, individual provider like all the GPs and an amount for each GP that is Medicaid.

MR. LICHT: The problem we have is the cost involved in getting the data.

MS. RAEL: One tape from EDS is based on payments, and when the payment is made, you can not get any data off the type.

MR. BRAND: Is there a fairly good consensus that we have problems in putting these kinds of designations together? If there are real problems, we should discuss them.

MR. SHAPLEIGH: What is the transfer mechanism between Medicaid and the medically indigent? You can not assume similar utilization patterns, because that's probably not true.

MR. BATTLE: I understand. That is quite a problem, which is why it is included in the criteria. Ideally, the medical society would inform you what per cent of their time they spend with both groups. Perhaps we should give them some proportion, five or 10 per cent, in order to designate an area.

MR. BRAND: You have to fix upon a number that they feel comfortable with. Sometimes it is necessary to force an issue, in order to work out a compromise with five per cent.

MS. HATMAKER: If the Medicaid printout shows zero for the previous year, can you assume they do not accept Medicaid?

MR. BATTLE: Yes.

MR. BRAND: When a county loses its designatability, it is a good idea for new people to look for another way to designate the county, and find criteria consistent with population groups. He found in four or five cases that the medically indigents -- in Mississippi you make the assumption that most counties need designation in some way or another, and if you can't find it geographically, then perhaps you can look and see if one of the populations is the common population which is relevant for a designation and kind of switch it over and do the basic calculations necessary.

MR. LICHT: It might be an angle using what Mark was using with at least the state level medical society. In our state the local medical societies switch hats and go over across on occasion -- in a couple of counties, and of course not the counties of the people listening to this tape.

One can negotiate with the state medical society and arrive at a figure acceptable to both the society and Central Office criteria which can be applied statewide.

MR. BRAND: That would need to be put in writing.

MR. PEASE: In Georgia, we are doing an ongoing indigent care study for the hospitals, soon to begin. Shortly we will be beginning our third six-month period. We will do some trend analysis by county. Is there any was of combining the charity care for hospital rooms statewide?

MR. BRAND: Does anybody have any idea?

MR. ARMSTRONG: This is how the figure five percent was developed. I would change the subject to end the question equating charity care, giving it the same weight as Medicaid, because I am thinking of one county that has 24 physicians. None of those make in excess of $150,000 a year; one makes

about $300,000 a year Medicaid alone, so I do not think that much charity care is occurring.

MS. PEASE: For my study, we are not getting that kind of charity for nothing.

MR. ARMSTRONG: Should they challenge you on the five percent, have them submit some documented proof.

MR. BRAND: Anybody else?

MR. HAGLER: Looking specifically at the primary care delivered in the emergency room can be helpful.

MR. ARMSTRONG: In some rural areas, much of the primary care is delivered after 5:00 o'clock, on Saturdays and Sundays in the general hospital.

MS. PEASE: A small rural hospital has been very willing to give me that type of information.

MR. BATTLE: But for primary care designation purposes, we do not use emergency numbers.

MR. BRAND: I propose we adjourn for the evening.

The proceedings were concluded at 5:00 p.m.

PARTICIPANT EXPERIENCES/METHODS (EMPHASIS ON POPULATION GROUP DESIGNATIONS)

Small Discussion Group C
Region V

Moderator: Philip Salladay

MR. SALLADAY: The subject for today's small group is population group designations. I think we will follow the general format that we did yesterday. First off, if there is anything that came up in the morning session that you want to raise a question about or comment on, we will start there. Secondly, we do have an example of a population group request in our packet which we can discuss. Thirdly, I can respond to any questions about specific cases pending or recently completed that you would like to talk about.

I do have an additional handout here. This is the data base for primary care for each state which would be current through the September 30 determinations. I brought these along for reference, and I will give each of you one for your state. Are there any questions on today's presentations?

MR. HEINZ: Regarding the handout, what does "withdrawn" mean? Doe that mean that at one time it was a HMSA and it was withdrawn at one time?

MR. SALLADAY: In terms of the HMSA data base it shows a column that says "Designated" on your printouts. It has a "W" referring to the second date. Where it says date of last update would be the date it was withdrawn. It stays on the data base, unless the area is later redesignated.

MR. JOHNSON: In Mark's presentation when he surveyed for the Medicaid/ Medicare patients, regarding the question: Do you accept new Medicaid or Medicare patients? Because we found when just using the broad question that could say: Yes. But still we are hearing the the Medicaid population is not being served. And when we started saying: Do you accept new Medicaid/ Medicare patients? We found the true picture.

MR. SALLADAY: If they are accepting one or two percent and that is it and then everyone else gets turned away, that would be an additional piece of information that you could use in developing a request.

MR. HEINZ: It would just be additional support.

MR. SALLADAY: Right. We would calculate an FTE based on the estimated amount of care presently being provided to the Medicaid population.

MR. DARGA:I have some questions relating to the first presentation this morning. In the discussion about new Federal programs that might take up some of the slack as to poor people for National Health Service Corps, is that actually funding expected for the new career people in the Public Health Service or is that a hypothetical idea being discussed.

MR. STAMBLER: Most of it is really plans, things that people are thinking about to pick up the slack the Corps is going to leave. In terms of the Commission Corps people, funding would more than likely come out of some existing BHCDA program. We do not anticipate a separate authorization with appropriation. But that is still very new. That is something that has been proposed.

The loan repayment program has been wandering for about six months to a year withir the department. It started with basically ad hocs to the Corps. It has changed a couple of times. How it finally come out of the department in OMB is still in question. But it is being put into a program that would begin hopefully to replace the scholarships on a test/trial basis. There are a lot of things you have to go through to get it accomplished on a new program.

MR. DARGA: The loan repayment program would be repaying loans for people who are not obligated scholars?

MR. STAMBLER: There will be no more obligated scholars and this would essentially be a brand new program. It would be an improvement over the previous one in 1980 since it would payback all of the education loans, not just the Federal loans. I think they plan to put a limit of $20,000 or so a year in order to pay back those loans on the agreement. It is basically that a decision would be made approximately a year and a half before the individuals were needed, not seven years before entry to medical school.

MR. SALLADAY: I want to call your attention now to the worksheet handouts which we gave you this afternoon. These were developed in the course of reviewing the population group designation requests in Florida. You will notice this is like a hybrid population group. In one case it was a combination of poverty and migrants since Florida has a considerable number of migrant workers as well as the poverty population. The other combination was the Medicaid-eligible and migrants. I think these worksheets are fairly self-explanatory. You may want to utilize these in some of your own calculation in your own state. You are not limited to these two combinations. You could have a combination of migrant population and medically indigent if the situation was that persons who were Medicaid-eligible were obtaining primary care while it was the migrant and indigent facing an access problem. These worksheets are good tools for future use.

Poverty population is always persons with incomes below the poverty level. Then we define the medically indigent as the poverty population minus Medicaid-eligible.

MR. JOHNSON: How firm are you on the poverty population in the census?

MR. SALLADAY: I think it has been our experience that it is rather difficult to extrapolate an updated county poverty population count. In the

past we have seen attempts at updating it based upon unemployment. I do not know of any updates of the poverty population since the 1980 census other than statewide estimates.

MR. JOHNSON: The legislature has been working toward bringing access for medically indigent people. You have six different kinds of bills, but as a result of that, two years ago poverty studies were done in different parts of Ohio. They were done by the State Department of Health, the Department of Development and the Department of Vital Statistics. We are trying to get a handle on it to assist the legislature in making a decision on medically indigents' bills.

MR. STAMBLER: Is that true of any other states here?

MR. HEINZ: Wisconsin is doing the same thing.

MR. STAMBLER: Statewide, or is it done in counties, Estimates?

MR. HEINZ: I am not sure. The legislature has mandated the department to come up with a program for the indigent by January 1989. They have to have four plans to the legislature by January 1987 from which they are to choose one.

MR. STAMBLER: You can also look at it another way. The census estimates are through income in 1979. They are 1980 census figures. But if you can think of what has changed between 1979 and 1986 in your neighborhood or state or county, such as a change in income or a complete change of an area in terms of slums being torn down and highrises being built, it could just be the opposite. We are never terribly happy when using something as old as that. At the same time we do not want the thing which we in the rational service area call gerrymandering. Where somebody says: Well, this area is doing very badly in poverty. But we will apply that same thing over here to an area that is not. So we discount it if it there does not seem to be a rational approach to it. But if you have anything, even from a coupe of years ago, or from a current legislative report, you can send us a report, and chances are that we would accept it.

MR. SALLADAY: Mary, do you know if the has been any further examination of poverty in Chicago?

MS. RING: I would imagine that there are, but we have not looked specifically for anything. We have not been doing updates for HMSAs. Someone is always doing a study in Chicago. I think there is some if we needed something.

MR. SALLADAY: I know that in the case of Chicago there are a very substantial number of areas that will come up for reevaluation in the next annual review. The case may be that on a geographic area basis some of those may not qualify. If someone felt that there was still a population group need, then updated information on the poverty level would be very useful.

MR. JOHNSON: Can this format be applied to the census as well?

MR. SALLADAY: When we do a population group review, we look at an area of residence. So an area of residence may be a grouping of census tracts in an urban area.

MR. JOHNSON: I am looking at whether or not we get any change in where you say county population to grouping census.

MR. HEINZ: Sub-county going in there.

MR. SALLADAY: This particular format was set up for analysis of counties in Florida. Where you see county you could substitute area of residence or maybe a particular neighborhood such as East Toledo.

MR. STAMBLER: Ultimately, the most important thing, one of the primary, most premiere things involved in all of these is that we are trying to get at something. We are trying to get at the people who do not have access to care. We know it is very hard to collect the data. Sometimes it is almost impossible. You cannot always do it by survey. You cannot ask them most questions because you do not know what it means when you ask them of the doctor. Just remember that if per chance you have some hard data that really indicates within these rough categories people who are not getting access to care, then you do not have to create it.

The ultimate end product is to provide something that says these people are not getting Medicaid services.

MR. SALLADAY: We have Norbert Budde from the AMA joining us and we also have John Drabek.

MR. HEINZ: I would like practice addresses and hours worked by county or by city for physicians.

MR. BUDDE: The address we would not do, but we could do county..

MR. HEINZ: I do not need the address if the work address is in the city.

MR. BUDDE: We have a county code, a city code and some other codes that I do not know exactly what they are. If we can sort them, then we can tally them up any way you want them and put that out.

MS. RING: What about zip code?

MR. BUDDE: Zip codes we can do in non-scarce careas. We do not want to have a cell with three cases in it. We collect data by hours. We do not release it by hours because we do not want Fred's hours worked, because then Fred will not give it to us. We break it by under 20 hours and over 20 hours. We have patient care, and then, solo practice, two-man practice, group and hospital.

These things can be broken out and they can be tabulated by small geographic areas. The big breakthroughs that the Bureau of Health Professions helped us with is that we were able to do it for all the states

at the county level instead of doing one for you and one for Illinois, and each one a little different and so forth.

MR. SALLADAY: We also have with us John Hisle who gave the presentation this morning on CHC's and the activities of migrant health centers and managing systems of care. Does anyone have a comment for John or any questions on his presentation?

MR. JOHNSON: In Ohio we are having some of our National Health Service Corps physicians that are not enjoying hospital privileges or they are put on provisional courtesy privileges which greatly handicaps their ability to provide a comprehensive rate of care to the medically indigent and the poor. We have done a lot of the studies that we have contracted out to the Health Systems Agency over this last year to give us a handle on provider representation, where the locations are, what they are or are not doing. One of the interesting and frightening things we are finding happening in both the rural and urban sects is that these physicians are not being provided hospital privileges. If they are, they are being very restricted and limited. I do not know how to stop that.

MR. HISLE: We have a couple of cases on that very issue. I think it depends on the provider, where it is and what the medical staff qualifications for that particular hospital are. If in fact, the physician that we are talking about which is a National Health Service Corps physician, has the same kind of training and background as the other physicians on that medical staff and that hospital is excluding that person, then we'll take them to court.

MR. JOHNSON: Good.

MR. HISLE: There have been enough test cases around, certainly in New Jersey and other test cases where hospitals and medical staffs are attempting to exclude people from full practice, and they have lost time after time.

Does everybody understand what I was trying to say this morning when I said the distinction is made between a Corps contract and a cooperative agreement? I was talking about the direction I think that things are going Corps contractors are very, very important and have been. The bottom line of what I was saying is that it is now recognized as a piece of a much bigger action that needs to take place between the Feds and state and private organizations and associations and the private sector and so forth. We are trying to pull in more people and more factors. The Corps contracts were good for when they were first written, but they now seem kind of limited, especially given the fact that the number of Corps people we have is going down.

MR. SALLADAY: John, under the cooperative agreements are there provisions for data collection and an analytic type of work which feeds into the shortage area review?

MR. HISLE: We have provisions for it, yes.

MR. SALLADAY: How many states do you have, 30?

MR. HISLE: It is around 30. There are provisions in there, but that is AP's and MNL's and small pieces of the entire reaction. There are data collections and so forth, but in the more important piece of the cooperative agreement effort is to get people at all levels to begin to work together. Just open up and introduce yourself to the primary care association people or the AHA or the AMA or county medical society, if you have not already done that, and get to know each other. That is really what we are pushing.

MR. HEINZ: That sounds like what I tell my staff. Go meet the people in the county and state because they are a whole different business. They are not part of AMA. They are different companies that are structurally different, although it is a federation.

Usually what we have found is that once you get out and meet and talk to the people and stop being that distant AMA, then we can work with them. But we have all the same problems that you guys do.

DR. DRABEK: On that Characteristics of Physicians volume, we probably can send copies of their state to each person here when we get the 1983 volumes out. They will be coming out before too much longer. I'll check and see if we can do that.

MR. SALLADAY: That would be a useful tool for each state to have.

MR. DARGA: I have some questions regarding the physician master file publication. Related to it, could you say something about the physician movement reports and the information they contain and how they would be available.

DR. BUDDE: What we do with them is to provide them to the state and county societies for membership prospecting and to the licensing boards who ask for them. Because we want them to know who is moving in so that those bad apples can be found. Well, we have not thought about whether anybody else would be interested in it, so maybe no is not the answer. What would you want them for?

MR. DARGA: Actually, I was thinking it would be useful to our licensing board. I have been doing some work with our licensing board, and they have a problem especially with our three-year licensing cycle, and they just do not have addresses for people after a certain point. We do not have a good handle on people moving in and out. I was wondering if that would be something they should ask for.

DR. BUDDE: I don't know if Michigan gets it or not, but all they need to do is ask for it and they will.

MR. DARGA: And what information does it contain?

DR. BUDDE: Name, address; name and address of where they moved from; and there is a flag on there if they had a problem. I do not know what else, but I know it is being designed to put more information in it.

MR. DARGA: With what frequency does it come out?

DR. BUDDE: Monthly.

MR. DARGA: And is it available in readable format?

DR. BUDDE: Just printed. Again, it is a case where it is easier to run it off on paper and then burst it and send it. It is all a matter of what we have got at the time and the budget to do, like anything else. We are looking at going on-line to the licensing boards, but that is another whole batch of cost and development. If we start today it will take maybe two years.

MR. JOHNSON: It is a good move.

DR. BUDDE: Well, that is what I have been telling the people, but everything is a budget. AMA is like everybody else, you know. We can not afford to do all the things we would like to do and have got to contend with our budget. So some of the things we have been able to do, like this report, the Bureau of Health Professions broke the log jam on that and go us going. We spend millions of dollars collecting the stuff, and then it sits there because you do not have $8.50 to do the next step.

Again, if we can demonstrate need and if there are requests and I can build a case, then I can say here are these people who we think should get it.

MR. DARGA: Is there a cost associated with the Licensing Department.

DR. BUDDE: No. In fact, our basic philosophy is that people who provide use data, we give data. People who do not provide us data but we think should have it, we give it at cost.

MS. FOSTER: Do you have any idea what kind of turn around you would have if we submitted a request or would it depend on what we wanted?

DR. BUDDE: Yes, it depends on what it is and how close to doing it we have come in the past.

MS. FOSTER: It is hard to say, the time frame.

DR. BUDDE: Much longer than you would think.

MS. RING: Six months or a year?

DR. BUDDE: Gee, I hope not. Again, it depends on what it is. Part of it is that if it is something that we have done before and we know what --

MS. FOSTER: Then you have already set the program up.

DR. BUDDE: Well there are two things. One is that we have to make a decision if it is something we want to do. If we have already done it, then we know that step one is handled. However, if we manufactured it the last time, then we can dust those programs off and hope they will work this time. Sometimes they do not because, as I mentioned, we are changing all

our software. I mean, everybody spends a day and-a-half a week getting that overhead, that new software system going. We are still trying to do everything we did last year and a few more things. So it is just like back home.

I think what we are good at is saying: yes, no and when. Then we do that. So we may tell you it will be six months or whatever. But then we almost always deliver on that. It helps, of course, if it is along the horizon to enrich the system every now and then like everything else.

MR. JOHNSON: How far along are you on linking with the Licensing Boards of the states.

DR. BUDDE: Well, we are working with them now. We get their information and we give them our information. I think we did probably 70,000 profiles for the Licensing Boards last year. There is new legislation that I mentioned that may pass; and if that comes to pass, then we will be doing much more.

MR. JOHNSON: The only reason I am asking is because week after next we are having a meeting with the Licensing Board, Medical Society, the Dental Society, the Osteopathy Society, the Primary Care Association, the Department of Health, the Department of Human Resources and the Department of Development just to get a handle on the data of physicians. This past year has been a very awakening year for physicians in terms of how they are listed. We are finding that it is very conflicting for them because we have had some in years past that had a specialty. Now they want to jump to primary care, and we are saying to hold up. We know you are chasing dollars, but be realistic, really look at the percentage of time you are putting into primary care. A lot of our data base comes from the AMA information and Licensing Board. They are telling us now that that is unclean data. Do not do anything on it. So we ask them to help us clean it up.

DR. BUDDE: I am sorry, but I do not know who "we" are.

MR. JOHNSON: Ohio. We are at a point now where everybody recognized that it is a problem and we can do something about it. We are going to be meeting for the second time within two weeks to go over this.

DR. BUDDE: Is Katherine Wissey the rep from the state society?

MR. JOHNSON: Yes. She helps. We are able to explore and work out a lot of the gray area and start getting ings into focus.

DR. BUDDE: One of the early things we did was with Katherine. Sometimes it is hard to get the cooperation of the state. One of the things we wanted to get was address corrections from them. They are all principalities, so they don't want to deal with us. We put a map together at our convention and we colored the states that were cooperative blue and left the ones that were not white. Twice a year their leadership comes in and all of a sudden they are part of the federation. They are electing people and doing all of those things you do at a convention. We immediately lined up a whole lot of people. But Ohio was one of the very first to come on board. We sent people to every single medical school in a whirlwind with Katherine and got the home

addresses and set things up. We cleaned up the state and got everything working. She's good.

MR. JOHNSON: We are trying to build on that because it is vital, especially when we are looking at HMSAs that that data is right.

MR. SALLADAY: I think I might add that the HMSA review process has had quite a bit to do with precipitating the close scrutiny of primary care physician data for various counties in Ohio. Some of those reviews are still on-going. That leads us in some cases to the population group considerations where counties that were previously designated as geographic areas have been withdrawn. There is still a feeling that there are certain population groups within the country that are facing shortages of primary care. That has been very much in evidence in Ohio.

DR. BUDDE: The definition of speciality which has been particularly onerous for us lately. We have three definitions of specialty: What are you Board Certified in? That is a fact, Then we have: What is it that you tell us that you do or what is it that you self-designate as your specialty? And the third is: What do you have a residency in? Basically, the Otolaryngologist would do facial plastic surgery, and the plastic and reconstructive surgeons who are fighting to get all that lucrative face work have been just hammer and tong at us.

It has brought about a lot of clarity on those three different definitions. In the self-designated we have primary, secondary and tertiary specialities on those physicians, if they have that many. So we can cut it pretty tightly depending on what you are after.

MR. SALLADAY: In the course of the designation review process we try to review all of the sources available to us. In Ohio, in one particular county there is a physician who has written in in opposition to a particular designation county request. His letterhead clearly states his specialty is Aviation Medicine. He is listed in the AMA directory with a speciality other than primary medical care. I think you know the one I am speaking of, Fred. I will not name his name or the county. We will give him a little bit of confidentiality. He has stated in the course of the reviews conducted by the Ohio Department of Health that he is full-time in primary care. We find that somewhat hard to believe based on the other information we have seen. It is a real problem in trying to do the reviews. Everything we have seen in writing is totally contrary to what he asserts. So we are still working on that case.

MR. JOHNSON: Of these categories, which one carries the most weight?

DR. BUDDE: When we publish it, it is self-designated practice speciality. We have a table that lists physicians by self-designated practice speciality whether they are Board Certified in that speciality and whether they are Board Certified in something else. We have that at the national level, but I do not think we have that in here. In fact, I am sure we do not.

MR. JOHNSON: Why do you lean toward that rather then Board Certification and residency?

DR. BUDDE: Because we were interested in what people actually do instead of what they were trained for or tested in. It is very, very normal for physicians, just like real people, to change what they do as they go through life. Facial plastic surgery is something Odolaryngologists never did before. But with antihistamines there is nothing to do inside and they have learned new skills. They evolve and change.

We were interested in what people do. We are not interested in what you call yourself but what you are doing. So that is how we tried to do it on the hours worked and get primary, secondary and tertiary specialities. I think I mentioned that sometimes the doctors disagree with us. They say I am a specialist, and we have them in primary care; or we say they are a specialist, and they say they are primarily in something else.

MR. JOHNSON: How do you validate that?

DR. BUDDE: Oh, that's tricky. The physician is the source, and it is the only source that we can think of. But when you ask detailed questions of how you spend your hours, that is when you frequently get the fancy answer. And you get the more simple answer when you look at the hours worked.

MR. SALLADAY: We have had one other person join us, Mr. David Ober of the Resource Development Branch of the National Health Service Corps. So if there are any particular NHSC-related questions you want to ask, direct them to him.

MR. JOHNSON: Are there any recruitment pamphlets or brochures that you have developed on the national level?

MR. OBER: I brought two things with me that I will have available tomorrow morning. You can pick up a copy of it if you want to. There are two descriptive brochures about the National Health Service Corps. The other is a formerly developed brochure to assist individual physicians that are in their final year of residency and thinking seriously about what type of practice they really want. It sets out certain questions they need to answer: The types of geographic areas, the types of community they want to live in, recreation, etc., all considerations to think about for practice.

They have both helped them to define in their own mind whether they are interested in opportunity we have, and it gives us a good headstart on the type of community that we think we should refer them to. If anybody wants a copy, they will be available tomorrow.

DR. BUDDE: Can I make a comment. AMA has a physician placement service. I am sure you are familiar with it.

MR. SALLADAY: I was curious if that was still functioning.

DR. BUDDE: It is functioning and it seems to be getting more business than it used to. We seem to have, relatively speaking, no shortage of physicians looking for a position because physicians think of AMA when they think of whatever it is they need.

But I do not know if you folks are familiar with that. If you want, we can provide that information.

MR. SALLADAY: I know I have the name of Jo Ann Jackson back at the office.

DR. BUDDE: Right.

MR. SALLADAY: I am not sure if you will appreciate this or not, but when a foreign medical graduate calls up and asks where he can find a job, I said, well, we do not have a listing of employment opportunities but you might try the AMA placement service. We send them on to you on occasion.

DR. BUDDE: We have also added a program called MAP. In an urban area, you can give it coordinates like 8th and Main, and it will tell you what the population looks like within five blocks, then blocks, a mile, two miles, three miles. In the rural areas, the same thing. You define the concentric circles and we tell you what is inside that. The notion was that that would help physicians find out both how many physicians are there and how many of the public or what the potential customers are. We put that Rand McNally kind of data in there.

MR. SALLADAY: Do you have more or less a compilation of information that has been supplied to you on job opportunities available? How does your placement service work? What do you have available?

DR. BUDDE: I don't know.

MR. SALLADAY: On occasion we have also suggested to people that they look in the back of professional journals for job opportunities. Are there positions available listed in the back of the AMA Journal?

DR. BUDDE: Yes.

MR. SALLADAY: I wondered if you have some formal mechanism for compiling job opportunities. I guess Jo Ann Jackson would be the person to call.

DR. BUDDE: Yes. If you give me something with you name on it and what you want, I will pass it on when I get back. I will have that sent to you. It might be easier.

MR. OBER: There are also recruitment meetings sometimes in the community where prospective physicians can come, and I wonder whether those are listed in the AMA Journal or anything like that.

DR. BUDDE: I just do not know.

MS. SINGER: If I get a call from a physician who is looking for a position, I should refer him to Jo Ann Jackson; is that what you are saying, rather than on a state level?

DR. BUDDE: I do not know what the states do, but we have that.

MS. SINGER: I would like to get that.

DR. BUDDE: Okay. Give me something with you name on it and we will do it.

MR. SALLADAY: Did everyone get a clear understanding of how the HPOL is developed from this morning's presentation by David Ober?

MR. HEINZ: When is the next one coming out?

MR. OBER: July.

MR. SALLADAY: The other thing that I wanted to go over today was this example request. Have any of you had an opportunity to read through it or take a look at it?

MS. FOSTER: One of these two gentlemen asked about funding for the non-obligees for the Corps. Do you remember in the beginning of our meeting this afternoon?

MR. SALLADAY: Yes.

MS. FOSTER: I think you raised the question about if there is funding. Did Howard answer the question?

MR. DARGA: Pretty much. The question was regarding the Public Health Service career people who may potentially serve in the designated areas. The question was whether funding had been lined up for that or whether it is just an idea in discussion.

MR. OBER: What you are referring to is increasing the number of physicians and other health care providers in the Public Health service that are members of the Commissioned Corps that will be rotated?

MR. DARGA: Right.

MR. OBER: The ceiling for the National Health Service Corps allows for at this point probably 400 or 500 which is what we expect it to be. We expect we will have funding to keep it at that level.

MR. SALLADAY: David, does that 400 or 500 include obligated scholars and careerists and volunteers?

MR. OBER: There is a special authority to bring obligated scholars on in a separate ceiling. So, while we have a number of obligated scholars on Federal salaries, we will try not to cut the number of permanent full-time career physicians. But as the numbers of obligated scholars drop off, the funding will be diverted to permanent full-time.

MR. SALLADAY: Thank you David. I am now going to briefly address this Medicaid-eligible population group example. One thing you may note if you start at the back and work forward, you will see a letter dated August 3rd, 1984, in which rejected a geographic area request for this area. In that letter we suggested to the applicant that it may be more appropriate to look at it as a population group designation. The applicant proceeded to do that. I thought it was a good example to use. It is very similar to the recent

case in Lorrain, Ohio, which Fred is very familiar with. It was originally looked at as a geographic area, and they subsequently wound up doing it as a population group designation. I think the subsequent information they provided was very good. One notable item is a letter of endorsement from the Allegheny County Medical Society. The Pennsylvania Medical Society just commented on what the Allegheny Medical Society had to say. Does anyone have a question on this case?

You might also notice that we came up with a slightly different FTE count for the Medicaid-eligible population since we added in a physician who practiced full-time in a community health center. Dr. Hall, I believe it was. I think the rest of it is fairly self-explanatory. It is a good example for an urban Medicaid-eligible population group request.

MR. DARGA: As the designated person to tell the group tomorrow what our recommendations are, I would like to know if we have any recommendations.

MR. SALLADAY: Good point. I am glad you asked that. We should try to summarize our discussions here. We have had a number of questions and points raised about the FTE count. I think that has been one of the areas we spent considerable time on. Plus what Dr. Budde from the AMA had for us tied into the physician counting and the multiple speciality question.

MR. DARGA: I have the notes from yesterday on the different topics we discussed. We talked a little bit about OB shortages and whether they might be a need to designate shortage areas and individual specialties like OB.. Do we have a recommendation there? Is that something we want to mention to the group?

MR. SALLADAY: Maybe we should ask it this way, just giving a little bit more time on that subject. How many of you find that to be a major problem in your state?

MR. JOHNSON: I do.

MR. DARGA: I do.

MR. SALLADAY: Ohio, Michigan.

MS. RING: For what?

MR. SALLADAY: For shortage of obstetrical services. Karen, are you getting specific requests from Indiana for that type of service?

MS. DARWISH: Yes.

MS. RING: Obstetrical and pediatrics.

MR. SALLADAY: Let me ask one further question: Does it appear to be a problem that may decline with improvements in the malpractice insurance situation or is it something that would continue even with that decline in insurance rates?

MS. RING: The pediatricians are declining. For OB, we are not seeing any decline in the malpractice rates.

MR. SALLADAY: What I am getting at is it a problem that is tied to the malpractice insurance crisis or is it something that will still remain when and if that problem is resolved.

MR. DARGA: It is hard to tell whether it is caused by the malpractice crisis or whether it is blamed on the malpractice crisis as one of the arguments for malpractice.

MR. SALLADAY: Okay.

MS. RING: I think we had a problem prior to the increase in malpractice.

MR. SALLADAY: Is the problem tied into Medicaid-funding changes? Is that part of the issue?

MS. RING: No. There are just rural areas where they are not obstetricians practicing. There are family physicians delivering, but that presents a serious problem at the hospital if there is a Board Certified OB available on the staff.

MR. OBER: In those areas, how many complex deliveries are you talking about in a given year? A substantial number?

MS. RING: In some of those areas you could have a substantial number. In Fulton Contry with a population of something like 30,000 or 40,000, they do not have an OB. They would be doing a significant number.

MR. OBER: Who was doing the delivery?

MS. RING: We were sending them 45 to 50 miles away. They are sufficient on the ratio. If you just looked at the primary care to the ratio, it looks good. But there are not enough OBs.

MR. JOHNSON: For Ohio, part of that problem is malpractice, but also the perception on the part of the physician that poor people sue a lot faster than those who have the ability to pay for it. They seem to be building that perception that poor people will sue.

MR. SALLADAY: Anything else on the OB shortage? Ken, what else do you have on the list?

MR. DARGA: Yesterday there was some discussion of the population threshold for "frontier areas." The problem of physician burnout was mentioned and the possibility of having a circuit rider going from area to area providing assistance to the physicians.

MR. SALLADAY: Dave, has the NHSC developed that type of delivery system?

MR. OBER: We have had circuit rider replacements before. What comes to mind immediately is the area in Maine where three separate shortages that were not quite contiguous to one another, in the northeast part of the state. The population in each one of those was not great enough to use a physician on a full-time basis. The biggest town in each of three shortage areas had what could be best described as a neighborhood clinic. Where a mid-level nurse practitioner or PA worked full-time. We placed a National Health Service Corps family physician in that group of three shortage areas.

He would spend two days in one; one day in the next, and two days in the third, rotating through. He would see those patients that the mid-levels felt he should handle. While it has happened in the past, it does not happen very often because where would you find enough agreement between the various areas about what their need is? There are also problems about how you would salary somebody in a position like that. But it has happened and it can happen.

MR. DARGA: In Ohio you are providing a circuit rider to provide relief?

MR. JOHNSON: Well, we do a cut for the OB and pediatrician in terms of child health. We do have circuit riders. But we also are trying to work with the CHCs in setting up a locum tenens type program where we could provide at least a two or three month relief for physicians in isolated rural areas allowing them to continue their education. That is a hard one to sell especially when the CHCs have limited funding, but we are working on it.

MR. DARGA: Has there been any consideration given to establishing a federal salary for local tenants or circuit riders?

MR. OBER: Not locum tenens so much. I mean, that is not providing the sort of primary care services that we have in mind. As far as circuit riders, if it is appropriate we do consider it. There is a place that comes to mind in not only northern Maine, but Nevada, Arizona, and some places where there is a sparse population. But other than those two examples out west, upper Midwest, there is usually enough of a population to support at least a full-time mid-level. The most we would probably look for are the ones like in Maine which I mentioned. They could be feds, mid-levels, sharing federal work with a private physician part of the week.

One of the things that I did not talk about before was that the National Health Service Corps has developed a career vacancy list which is available to members of the Commission Corps of the Public Health Service and it identifies placement opportunities for them just like what is provided for the scholar obligated. It also identifies the other opportunities available to them, such as training opportunities.

MR. JOHNSON: I think it is their concept that the Feds are not going to count against their altercation toward getting the Service Corps employees because of that fact that they would be circuit riding. They are not available for use in the clinics as such as the other providers are.

MR. OBER: When we identify placement opportunities either on HPOL or career vacancy or whatever, unlike the designations, we take into consider-

ation all the providers that are there and what they are doing and what the needs of the center are. So if you can imagine a situation where there is a physician based out of one community health center that was sharing this time with several other community health centers, doing some circuit riding, we would not automatically count that full-time equivalent against the needs. We are very flexible in that regard.

On the other hand, we may not identify that sort of position as appropriate for a member of the Commission Corps. A lot of these individuals have a number of years in. They have had a lot of experience and are board eligible. They may have been practicing three or four years. They may have a Ph.D. in Health Care Administration. So it might be more appropriate for them to share administrative and supervisory duties at the clinic instead of being a medical director, and have one of the staff physicians do the circuit riding.

MR. JOHNSON: Are volunteers strictly confined to HMSAs of areas or can it be a light area?

MR. OBER: Since the volunteers will still help us meet the mission of the Corps, which is to meet the needs of the underserved populations as defined by a health manpower shortage area of population groups, most of the placement will be in shortage areas just like the scholarship recipients.

Because they are not obligated scholarship recipients, we are not mandated by law to place them in shortage areas like the scholarship recipients. We, therefore, have room to make exceptions to the rules. We will do so in cases where we think it is appropriate. The type of case that I can imagine would be, for instance, a community health center that is clearly to the National Health Services Corps and the Division of Primary Care Services, serving a needed population that has no other evident access to care. And yet, for whatever reason the population designation does not exist in that area, whether it is because there is no one able to develop the request, or whether it is because of objection from the local medical society, that no data can be agreed upon to enable a designation. For whatever reason, we will consider identifying a slot like that.

MR. SALLADAY: Do we have any other questions on that point?

MR. DARGA: The volunteers that you were talking about, are they the same people whose educational loans are forgiven? Not through the National Service Corps, but the people we talked about earlier.

MR. SALLADAY: They are separate from the volunteers. I think the volunteer approach is just non-obligated physicians.

MR. OBER: Right.

MR. SALLADAY: He mentioned the loan repayment program; is that the HEAL program?

MR. JOHNSON: Yes, that is the HEAL.

MR. OBER: There has been various programs before the Senate and the House to adopt and fund loan repayments in a number of different varieties. The most popular has been a proposal to allow the Federal Government to repay a physician's medical school loans up to the rate of $10,000 per year providing that physician is practicing in a high priority health manpower shortage area.

So what you could imagine under a program like that is a physician takes out loans through medical school, delays repayment of those loans while he goes through a residency program, and is ready to go into practice, and finds himself with a $152,000 loan that he needs to repay at the rate of $22,000 a year. Say he is a family physician. The opportunities available to him are not such that he could both earn a comfortable living and pay back $22,000 a year. Under the loan repayment program that has been recently proposed, if that individual were to take a job at the community health center in a shortage area, the Federal Government could agree to repay $10,000 a year of his loans while he was practicing in that area.

If a family physician would go to a community health center, he would pay $12,000 of his educational loans and the Federal Government would pick up the other $10,000 a year. Those remain just proposals, however, and could not be considered until the next Congress.

Now that would be something entirely different from what we were referring to when we talked about a volunteer. That is a specific mechanism of getting physicians into the National Health Service Corps if it is recognized by everybody that the volunteer effort is not bringing in enough providers.

MR. DARGA: So is there any incentive for volunteers?

MR. OBER: There is not because we do not have the authority to offer any incentives at this point and time.

MR. JOHNSON: Are there any plans to do that?

MR. OBER: No, not really.

MR. SALLADAY: I think we have just about come to the time to adjourn for the day unless there are any further questions.

Thank you all very much, and we will see you in the morning.

PRESENTATION: STATE PROGRAMS INVOLVED WITH HMSA DESIGNATIONS

Betty Hambleton
Distribution Shortage Analysis Branch
Bureau of Health Professions

MR. LEE: This morning we will hear from Betty Hambleton on state programs involving HMSA designations and discuss current efforts at revising HMSA criteria and guidelines. In closing, we will hear from the small group session representatives.

MS. HAMBLETON: One of the major objectives of the program of the Bureau of Health Professions is to improve the geographic distribution of health care personnel. Because it is important to have current information on the states' needs and involvement in distributional efforts, and the different approaches used to identify areas needing additional health care personnel, we recently completed an update of a study, done in 1981, not under federal contract, by the University of Michigan. Under this study, a previously published compendium which described state health professions distribution programs was updated. The 1981 compendium included about 144 programs for which the contractor has updated the information for the new compendium by recontacting the program administrators, contacting the regional offices, other state officials, looking at new Federal and state legislation, and obtaining current information on the content and extent of state programs aimed at redistributing physician manpower and on the methods state suse to identify areas in need of additional health personnel. In this process, they identified 113 state distribution programs. These 113 programs do not represent all states' effort to affect the distribution of health personnel.

The current study resulted in a compendium report which updates and expands the information in the 1981 University of Michigan Report. The 1986 report describes the changes over the last five years in most state programs, including those that have been initiated, expanded, reduced or terminated. The differences among the different programs are discussed both in general and in specific terms at the beginning of the report. Information is provided on changes in state initiatives as a result of the national increase in the overall supply of physicians, together with other factors, both national and at the state level.

The methods states used to identify areas of need were examined to determine the extent of their reliance on federal HMSA criteria. One hundred thirteen programs were identified, distributed among 43 states. Nine states are without programs directed specifically at health manpower distribution, while 11 states report four or more programs in place.

On the average, state funds represent 76 percent of the total program budget, Federal funds represent 11 percent, local funds six percent and private funds seven percent. Funding levels do vary in proportion to a state's commitment to health profession distribution, and with the availability of appropriations at the state level to the particular types of programs.

Financial support for these non-Federal health profession distribution programs has increased substantially between 1980 and 1985 while Federal support to health profession programs is declining.

States' programs have been designed primarily to address the problems of an overall lack of physicians, or their scarcity in certain geographic areas, usually in remote rural communities and depressed inner-cities. Realizing that various personal and professional factors influence physician speciality and location choices, the approach of state programs has been to intervene at strategic points in the health career decision process. The identified approaches are grouped according to four mail strategies.

First, the selective recruitment to undergraduate medical schools; second, experience during the educational process; third, financial incentives to locate practices in certain areas; and fourth, aid in establishing and maintaining those practices.

The selective recruitment process gives preferential treatment to in-state applicants or those likely to select rural practices. State programs have attempted to influence speciality and location choices during the educational process by increasing resources to primary care, supporting public medical schools, sponsoring curriculum changes to focus on primary care activities which increase students' exposure to primary care and underserved areas during the educational process.

The most common approach to distributional problems is state programs offering financial incentives to health professionals to locate in certain geographic areas. Of the 113 programs in the compendium, financial incentives account for 39 programs among 26 states. Financial incentives may take the form of loans, scholarships or grants. Thirty-five of these programs require that recipients serve in shortage areas, similar to the National Health Service Corps Scholarship Program. Participants in these programs number 2,217, according to available information. Four hundred fifty-four participants are in service-contingent programs that provide strict buy-out provisions.

The fourth approach is directed towards recruiting and retaining health professionals after completion of the educational process. There are 32 programs, ranging from placement services to direct financial aid in the form of loans for establishing a practice or guaranteed income to support a practice, to aid in establishing and maintaining a practice.

Of all 113 programs, slightly more than half have a form of shortage criteria. One-third of those use the Federal health manpower shortage area criteria or a modification thereof. Four states have developed shortage criteria that are different from the federal criteria. The remaining programs place their health personnel in areas using more lenient guidelines.

Generally speaking, state programs rely heavily on HMSA criteria in placing their health personnel in the shortage areas.

The final report of the contractor is soon to be published as an ODAM staff report and it will be available through the National Technical Information Service. Copies of the report will be mailed to state health planning and development agencies and to each of the 113 program administrators who provided information. If you do not find this report available at your state offices within the next month, please contact my office. In your packet you will find a summary of the report.

Are there any questions?

MS. WASHINGTON: Could you clarify or open for discussion the provision for buying out once a provider who has been assigned to a shortage area, including the problems of placement and maintenance of health care professionals? Often providers seem to exercise this buy-out provision. Does the study show any difference across the states to prevent that particular problem?

MS. HAMBLETON: The report found that the strict buy-out provision did offer a great deal of inducement for the practitioner to stay in the program. Statistics are given on the number of people who are in a buy-out phase in those particular programs that have the buy-out provisions. There was no overall comparison, but they found that it was a very strong incentive in those programs to keep the physicians in the area.

MS. WASHINGTON: To keep them there. The majority were staying. In other words, retention was not a problem?

MS. HAMBLETON: Retention was higher in programs with strict provisions.

MS. WASHINGTON: Thank you.

MS. HAMBLETON: Any other questions?

(NO RESPONSE)

MS. HAMBLETON: Thank you.

PRESENTATION: CURRENT EFFORTS AT REVISING HMSA CRITERIA AND GUIDELINES

Richard C. Lee
Chief, Distribution Shortage Analysis Branch
Bureau of Health Professions

MR. LEE: The next presentation is entitled, "Current Efforts at Revising HMSA Criteria and Guidelines." I have to revise the title as we are not in the process of revising the criteria, to any significant degree. The one exception to that is the correctional facilities. Please see if you received the handout entitled, "The Criteria for a Designation on A Technical Amendment." If you don't have one, raise your hand and it will be distributed.

I am going to stress that that is a draft. However, it will indicate the direction that we are taking with correctional institutions. Basically, we are redefining the term "internees," so that we do not arrive at ridiculously high requirements for physicians called for by our criteria.

In the existing regulations, we perform ratios based on the number of internees to the number of primary care physicians, dentists and psychiatrists, serving the population of the correctional institution. We have a formula whereby you take the number of inmates and we add the number of people entering the facility each year. With a facility with a high turnover, that number could be many times the number of inmates. In these calculations, we radically increase the population and, therefore, arrive at a population figure incompatible with the average population in the institution at any given time.

At the time, we originally developed those criteria from the information given by well informed people that the greatest demands on the prison health services related to problems prisoners had upon entering the institution. Prisoners were examined, treatments established, and problems began to trail off, although with a fluctuating population, there continued to be a need for health care.

We calculated unreasonable "high" de-designation thresholds for correctional institutions as a result of that procedure. So, we looked for a study that would tell us what are the continuing care needs and are the needs on entrance and how to merge the two in developing a requirement.

Unfortunately, there are not many studies available. A study done by the Federal Bureau of Prisons gave us some information. They used loose estimates of the ratios done by different people. We also wanted to minimize the regulatory activity, as regulations are not very popular with any

administration. The easiest way to handle the change was to change the definition of "internees."

The definition in this draft basically modifies the number of internees by several variables. The first variable is the length of stay. An institution with a length of stay averaging two months, with 5,000 people released during the year, you multiply that 5,000 by two-twelfths and figure the transient population is cut down by that factor.

Secondly, we determined the number of intake exams actually performed by a physician, dentist or psychiatrist as opposed to a physician assistant, since we did have data indicating that a number of intake exams were performed by persons other than our placements. Information is available on this variable, and should also be considered.

I anticipate that we would not collect much new data, simply utilize the number of inmates or the number of inmates plus the number of admissions modified by the factor for the length of stay. As we review new and existing designations for correctional facilities, we are trying to apply this approach. We are trying to start using this approach as we expect it to be published in the near distant future. Questions?

FROM THE FLOOR: Will the states be expected to review all existing designations in light of these criteria?

MR. LEE: Once they are published, I would anticipate the review of designations not recently done to reflect the new criteria. It could be done in the context of the annual reviews. As they come up for review, we will make the appropriate changes, or changes could be made immediately even if the facility is not being formally reviewed.

We are using the new approach in our current reviews of facilities to avoid later inconsistencies. Effectively, it assumes the maximum population for any institution is twice the number of inmates, regardless of the turnover rate. This will significantly change the numbers for certain institutions.

We have included in your packet the new guidelines for full-time equivalent calculations based on office hours. Some questions arose concerning the most effective method calculation. We have to be consistent with our regulations which state that office hours must be related to a 40-hour week, despite the increased complexity of the calculations needed.

Now, apparently the previous guidlines were not distributed to everybody -- not every HSA and not every SHPDA received it, and so there were some cases where we had battles with people over particular designations where they were coming in and basing it purely on the office hours. And they said: But you never gave us the guidance. And we said: But it says in the regulations that guidance would be provided. And we thought that everybody knew that -- either had it or knew that we had it and got it from us when they needed it, but that was not the case.

In the past, problems have arose when offices were not aware of the existence of the guidance, so we have distributed copies to you here, and we

will mail an additional copy to insure that you officially receive it. Are there any questions on the FTE guidelines passed out a couple of days ago?

(NO RESPONSE)

MR. LEE: In the small group session I attended yesterday, the problems of counting migrants was discussed. As I mentioned there, much of the data that we collect on migrant population groups comes from the outdated 1978 Inter-American Study. We needed to find more recent sources of data. In some states, the State Department of Agriculture and the State Department of Labor have some numbers. In other states you can count the numbers in migrant labor camps. In still other states there may be some numbers from national figures. And then there is the relatively recent study on migrant health, based on crop, acreage and other factors indicating where the maximum number of laborers in this particular area that could be found working during the harvest season. The questions of estimating the actual number of workers truly present, and calculating the size of the family that travels with them, are a perennial problem in terms of counting.

I do not feel comfortable accepting requests based on the 1978 Inter-American Study any longer. We must find something more recent than that. We are asking states to provide the best estimates possible.

What is going to happen in the future in HMSA criteria or related criteria? "A Second Generation Study" raised questions about the future role of the Health Resources and Services Administration, and tries to quantify who will be served. We will be working with population groups that do not have access to health services, but how do we define those? Are the current definitions by the HMSA process and/or the current definitions by the MUA process sufficient to do that? And, if not, what measures should we take?

In order to answer these questions, they did a contract study to determine what data bases were available on population groups with access problems. There was not enough data to develop any measurement criteria, besides the problem of what criteria should be used for particular population groups. Further research is needed.

Since the "Second Generation Study" has not collected anything significant we will go on doing the best we can with populations like the homeless and the developmentally disabled, based on existing criteria for the time being.

Another future look, "sentinal health indicators," will try to determine what the health indicators are when a particular area or population group is having a specific health problem that needs to be addressed by community health centers, the National Health Service Corps or other programs in practice. Our office will be working with the Bureau of Health Care Delivery and Services and the HRSA office in developing indicators using data bases that we have.

So, what is the focus of the efforts of Distribution and Shortage Analysis Branch right now? Specifically, completing the review of psychiatric HMSAs, and dental HMSAs of 1983 and 1984, as well as the primary care review that you have been asked to provide information for. We are emphasizing any

HMSAs already on the HPOL needing to be reconfirmed before the people can be matched. Most important is that we have an updated list so that the placement process is using updated data.

I want to make a couple of comments on yesterday's presentations before we move into the final presentation. One of the things that came up yesterday was the use of the de-designation threshold in the National Health Service Corps placement process, particularly regarding primary care projects. There was a question about why were six going into an area where the threshold was for three.

It is the understanding of our operation that this is not supposed to happen. If the area is not properly defined or if the project is serving a larger area or population than covered by the designation, a revision of the designation should be made such that it addresses the true area or population in need. Once revised, the thresholds should reflect the numbers accurately. There are times when the placement people are working on the immediate problems without waiting for my office to change the designation, but this should not be done. We will work to maintain consistency as best we can.

Similarly, the related issue of a community health center using the National Health Service Corps to serve an area. It is our joint responsibility to make sure that the corps is serving a designated area because that is what the law requires. Again, we will work with them to assure that the necessary areas are clearly either designatable or not designatable, so that activity will be consistent.

The third point on the HPOL criteria, the one that came up yesterday was emergency rooms. I do not think that is the most important one, but it is an example. Unlike the HMSA criteria, the HPOL criteria has never been published anyplace, and I can not say it ever will. It would be a positive step if a guidance for how the HPOL is developed was made available, especially to the state people.

Since our office is questioned about what the criteria are, we will try to make the information available. Now, I'm going to turn the discussion over to Howard for the presentation of issues and recommendations from small group sessions. Reporters from the groups, please come up here with Howard.

SMALL GROUP DISCUSSION SUMMARIES: PRESENTATION OF ISSUES AND RECOMMENDATIONS FROM SMALL GROUP SESSIONS

Reporters: Jeanette Washington
Discussion Group A
Regions III & VI

Sue Ellen Rael
Discussion Group B
Regions IV & VI

Ken Darga
Discussion Group C
Region V

MR. LEE: Here to share the happenings of the small group sessions are three reporters. Why don't we start with Sue Ellen Rael from New Mexico who was with the Group A, Regions IV and VI.

MS. REAL: The first overall issue raised came from the Central Office Staff, concerning the need to identify alternative sources of data in the state because HSAs are going under, and SHPDAs may be going under soon, depending on whether or not state governments pick up those functions and fund them. There is a need for the Central Office staff to know who else they can turn to as their contacts in the state start disappearing.

The issues and concerns in the geographic session have been divided into those of the state people and those of the Central Office. From the state side, there was a request that the frontier area considerations become a part of the designation process. This applies to New Mexico, Arizona and the western states of Montana, Idaho and Wyoming, with a low population density and very few resources.

The second concern relates to areas outside of large metropolitan centers. Often an area needs to be designated, but because resources are available in the nearby metropolitan area, there are difficulties getting designated, even though the resources are not being used. Examples cited were Atlanta and Greenville. Urgent care centers raise the question of proving whether or not they are serving the targeted population in that area.

Another major concern on geographic designations was in presenting a case in which the health services are concentrated in a particular quadrant of a major metropolitan area or in which major high traffic areas need to be crossed to access those services. Taking these things into account, travel time adds up to more than 30 minutes from the proposed designated area.

From the Central Office came a request for more documentation, good maps that show the census tracts, main roads, bus routes, topography, and good markings of the location of health care services. The states responded by requesting Central Office spend more time doing sites visits.

On the topic of population designations we had more questions than answers. Concerning data on the Medicaid eligibles, we found that there is no indication of the length of time that people spend in enrollment under Medicaid. The tendency is to accept the highest numbers showing the largest group of population as Medicaid-eligible. We also need a new definition of "medically indigent," including such considerations as chronic unemployment.

Again, a major problem is getting an accurate count of the migrant population. Other populations identified as being very difficult to accurately quantify were the homeless, legal and illegal aliens such as the Cubans and Haitian populations. We did not address undocumented workers and illegal aliens, but while in many states it is not a severe problem, in Texas and in California it is probably worse.

Our final discussion was on the need for good methodology to estimate the percentage of time a physician spends in providing services to the medically indigent population. A variety of questionnaires are used, but none really seem to supply accurate information on all groups. Mark Shapleigh is requesting ideas in developing a designation for child psychiatry.

Final advice from the Central Office was to consider all the designation options before actually applying because where one approach does not work another may. A strong request was made that Central Office staff visit the states to see what 30-minutes travel time means in those designated areas. And the final request, please speed up the process of reviewing a designation.

MR. LEE: There is a box on the desk out in the lobby where you can drop off your evaluation forms. Ken Darga will report on what happened in the Region V Group.

MR. DARGA: We discussed six or seven issues that I would like to share this morning.

In our region, several states are having problems with localized shortages of obstetric and pediatric services. In some instances family practitioners in the area can deliver babies, but the problem of handling high-risk pregnancies or complications that arise in the hospital remains.

More serious problems arise in areas where family practitioners do not handle deliveries at all. The area can not be designated because it has a family practitioner, although there remains an access problem for obstetric services. Further, there are doctors who handle deliveries, but not for poor people. If the poor receive other primary care, then there can be a problem in designating even that population group. In our region there are problems such as there not being handled by current programs.

Various problems were discussed regarding physician surveys. Often we are getting information from the physicians themselves, which is later proven or incorrect. We did not find any easy solution to this problem. It

has to be addressed case-by-case, and, in some cases, a designation decision must be made without agreement by all parties on the relevant facts.

A similar difficulty is found in assessing the number of Medicaid patients a physician serves. While they may accept Medicaid, they might not accept new Medicaid patients. It was suggested that a question on the number of new Medicaid patients served be added to physician surveys.

Physician mobility creates a problem in accessing the physician supply in an area, because the licensing records and published data available becomes obsolete. One piece of useful information that the American Medical Association can supply is their monthly Physician Movement Report, which includes the name, the old address and the new address of the doctor. And these can be provided, free of charge, to the licensing department, which will be very helpful to our licensing department in updating their address lists of physicians.

Another problem encountered is using 1980 census data in estimating the percentage of an area that is below the poverty level, information that is already seven years out of date. We also discussed the problem of funding state efforts in our region, data collecting, working on designations and other related activities. Our final discussion concerned Corps physicians unable to obtain hospital privileges in their area. If the physician's credentials are comparable to the credentials of the physicians who do have hospital privileges, we should be successful in challenging the hospital's decision in court. This is something that BHCDA would be able to pursue for us.

MR. LEE: Jeanette Washington will fill us in on the events of the Groups III and VII.

MS. WASHINGTON: Our discussion group covered a number of different topics, which I divided into four different areas.

The first list of issues and concerns that were raised dealt with the designation process itself. First, we discussed the time-frame. Central Office explained to us some of the limitations of the process and difficulties which slow the process down, specifically that with the HMSA designation process becoming better known, more interested parties want to be involved and make comments which increases the gestation period. Also, if the original information submitted is not complete, the process becomes lengthened. Some states offered information that they have available, such as automated data base printouts, to the Central Office, which indicated that the data would be of use.

A final issue in this area was the long-term outlook for the whole designation process, noting the Corps personnel are rapidly diminishing. While this was addressed on a panel for the larger group, in the workgroups we discussed the potential usefulness of the HMSA designations for other programs, the local and state program and grant-funded efforts in particular.

The second area of discussion centered on data needs and constraints involved in this whole process. There was a concern raised by the states

about the limitations of the Census data in terms of population definitions, especially for a very small population, as well as in documenting the extent of un- and under-insured residents of the area. We recognized the problem and the varying ways that the local entities have of indicating the extent of that need.

There were questions regarding the printout the Central Office produces for the annual reviews in terms of possible modifications, and if that printout could be marketed in some way to the states. The Central Office indicated that, first of all, it was not something that they were marketing or distributing, and although they were sensitive to local needs it was difficult to change the format. They were willing to provide a HMSA data base printout upon request.

The two recommendations of this particular discussion were the need for sufficient data to address the criteria and substantiate the problem, as the Central Office is very dependent on the local level for this input. Secondly, on the local level, every effort should be made to get a very broad base input from the local provides and other interested parties.

In a discussion of the mechanics of population designation criteria, Central Office highlighted the potential usefulness of the Medicaid data. We discussed the impact of manage care systems, malpractice concerns and liability insurance issues, and the dental HMSAs. Finally, Central Office pointed up the potential usefulness of the AMA master file both at the state and Federal levels.

MR. LEE: Thank you, Jeanette; thank you, Ken; thank you, Sue.

One problem that Ken mentioned was about incorrect or incomplete physician information, where later data disproved the original information. For example, if you do know that they have got office hours in two locations then you can complete the FTE using that information.

In Sue's report, one problem was the frontier criteria and the desire for that to become part of our criteria. In what way? As I understand it, that is a criteria for how to distribute funds in the CHC grant program. Howard would use it in the HMSA program.

MS. RAEL: Harvey could probably better respond to your question as it was his concern.

MR. LICHT: It may strengthen cases to confront BCHOA with an official designation that an area is a frontier. The guidance from that area was originally designed to indicate that a priority would be given to certain types of areas; however, if we could formalize that indication to some degree in the course of designation, it would eliminate some problems.

MR. LEE: You are asking us to identify the frontier areas to clarify which should have that priority, correct?

MR. LICHT: Yes.

MR. LEE: It has been a recurrent issue at past workshops that the HMSA criteria discriminates against sparsely populated areas. You may be saying that we ought to have a lower ratio of physicians for these rural areas. We understand the problem but we do not have a viable solution at this time.

When trying to designate an area on the outskirts of a city, make it clear that health resources are over 30 minutes away. We will typically reject an area within 30 minutes of the center of a city, but we will take into consideration an area over 30 minutes away.

It appears that six different programs have six different levels of what is considered medically indigent, be it 100, 125, 165, 150, 185, or 200 percent. We recognized this in developing the population group guidelines. There appear to be inconsistencies in different departmental programs as to what is the level of indigency. We will look into it.

How can we get a designation for OB in an area where there are sufficient primary care physicians, no OBs, or no OBs serving the poor? I think the OB problem is getting increasing recognition. I am not sure how this will be resolved, but that is certainly an issue that must be dealt with.

Unless it is a primary care shortage area, we do not get involved in specialist shortage under the existing regulations. But if it is a primary care HMSA, then the NHSC may favor putting an OB in the shortage area. It would be their decision which specialist to place.

In the area that is not designatable and the issue with the poor people is the malpractice, the two things go together. The people are not serving poor people because of the number of malpractice suits that they get as a result, and they are just backing out of that. It is an agency issue and I probably should not have even tried to respond to it. At the moment, we do not have a designation solution. Conceivably, we could develop a childbearing population group designation, but once we develop criteria for shortage of OBs, we really have to change the whole set of criteria.

The designation process is delayed for several reasons, the most obvious of which is the number of applications received. Second, we receive many requests with incomplete information. And third, the complex cases in which the hidden agenda addresses a deficiency not normally covered in the designation process, such as a specialist shortage. Many of these complex cases are set aside while a straight-forward case is resolved.

Fourth, the annual review has increased our total volume of work. Add to it not only primary care but psychiatry and dental as well and the volume of work increases. The time-frame is definitely too long.

We have developed a mail log to keep better track of what has been received, what is really old, and who is holding up the specific applications. But I still have to allocate time to complete the process. Unfortunately, some of the requests get set aside because of other priorities. We will work on speeding up the whole process.

Howard will now address comments relevant to his office, and when he is through, we will take questions from the audience.

MR. STAMBLER: Thank you, Dick. One point I wanted to make is that Dick Lee is a branch chief with a lot of responsibilities. He has five staff members responsible for 2,000 primary care designations throughout the entire United States, annual reviews, new requests, the dental and the psychiatric shortages. This is an overwhelming task and we have not been able to get any additional resources to deal with it. We are trying to do a better job, but the programs are changing which creates even more work.

It is the same kind of thing as occurs when the individual physician may not be providing services. Criteria do not permit us to modify, at this point, the issues of OB/GYNs and pediatrics. The primary care criteria does not permit us to break out child psychiatry separately. We have published criteria which save us from some of the disasters that occur when you can not defend your actions by referring to published rules. The problem with our office is that you can not always do your job and we can not either. It's a data issue. We face that; you face that. The criteria are specific mostly to help pin down information we need to make a designation.

The SHPDAs in many states will remain in existence, but at the same time they will become very different kinds of organizations. We do not know what it is going to be. Perhaps a Certificate of Need will be the only criteria dropped; perhaps it will be that only the Certificate of Need activities will remain in some states -- that we do not know.

We still have to count on you. We try to make your job easier, not make it so complicated that nothing can be accomplished. The real world is very complicated. Data collection can be incredibly complicated. It is almost impossible to have every single case perfect. So, we all have to accept that data are just the most information we can find. If your output looks ridiculous, start thinking twice. If not, and you have reasonable support for an application, go ahead. If we question something, it is because we hear another side. It is not an easy job.

We had a discussion about developing individual specialities within primary care, which ended with sharp disagreement between, not only our Bureau and the Bureau of Health Care Delivery and Assistance, but disagreements in the Department and among the doctors themselves. The problem with the classification system is that you get data on a physician as a G.P. who spends, perhaps, 45 percent of his time as a G.P., and 55 percent in specialities. While this is not provable in many cases, we know it exists. Part of ODAM is collection data on the specific question of the speciality breakdown during the G.P.'s working hours. We hope to answer that nationally, and perhaps by county, in another year or so.

The OB/GYN issue is another one causing a lot of trouble for the Department. We recognize the problem, but do not have a solution, as yet. The Bureau of Health Care Delivery and Assistance, because of its flexibility and funding, has found ways to deal with the problem.

This issue occurred in Holyoke, Massachusetts. Because of malpractice, the doctors will not make deliveries. There was nothing we could do, based

on the criteria. But we involved the BHCDA who were able to find money to help deal with it, apart from a shortage area designation. This is going to continue to happen. It is an issue of a much greater magnitude than simply not having a physician in the area. Two of the major issues concerning the Secretary are malpractice, and the implied OB/GYN issue.

There are a couple of other things. Poverty ratios are another big issue. There are different definitions of poverty, generally set up for different kind of programs. One of the programs within our Bureau uses a different poverty level for different types of grant programs. There are probably five or six poverty levels, between 100 - 150 percent of poverty being used.

Many of you have asked if unemployment is part of HMSA criteria or could be part of a criteria for shortage areas? It was used in a BCHDA program last year, but that was a one-year kind of thing. One reason that we have not viewed unemployment as being a valid indicator is that unemployment is a passing thing, in most cases and rates fluctuate widely.

I was in charge of the Employment/Unemployment Statistics of the Department of Labor 16 years ago. It seems like a long time ago but nothing much has changed there either.

The chronic unemployment is unemployment lasting over six months. Very few people, strangely enough, are unemployed over a six-month period. The uninsured might be a better group to quantify rather than the unemployed as the two do not necessarily go together at all. But in many cases the unemployed are people who either have resources from the state, are still covered by a program, or may be forced to go from their own physician to a clinic. There is an overlap there that would make it difficult for you to identify a group of people that do not cross-cut another group of people that may be employed or unemployed and continue to go to the clinics or do not have the funds for health care. And that is also similar to what Dick was saying about the second generation. That was one of the considerations. But what you would need would be a 90 by 90 matrix so that nothing would be overlapping anything else. If you want to try that for yourselves, please send us the results.

Of course, the unemployment statistics are available by county. Those can help in evaluating the situation in more general terms of health care and what might be happening in the community.

As far as the poverty level is concerned, the Census Bureau puts out national poverty statistics every year with a tremendous number of variables. They also divide it, I believe, by four regions, and may put it out by state. One of the things that might be feasible -- and, I think we would generally accept that -- is to look at the most current national poverty statistics, look at the changes from what you might have, look at the composition of the poverty. And, in many ways, like the criteria that has visits per age, essentially create something that seems to make sense. I think, again, this is an analytical job and maybe the state health statistics department, maybe some other part of the SHPDA or the university could help in doing this. And this is, incidentally, one of the things we have been finding very frequently lately, and that is the universities are very

much more heavily involved in some of the manpower and other kinds of issues than we had thought before. And I think that is partially because the impetus is moving toward the state set of activities and away, somewhat, from the federal level. So, it might be worthwhile to contact the medical school in your area, because these are not doctors that necessarily have an axe to grind. They will very often be the MD, MPH physicians who are studying the health care system. It can be helpful and it does not take more than a couple of phone calls, really.

And in the dental schools, too, because where you are concerned about things, you study them. And the dental schools are concerned about dropping enrollments and applications. So, therefore, they are looking into the whole health care issue and the health manpower issue. It might very well be worthwhile to do that.

On your evaluation forms, please give us any suggestions or ideas on improving programs. We are not looking for ideas as much as solutions.

One of the things I have always wanted to respond to is the issue of 30 minutes for contiguous and rational service areas. In the development of the criteria, we did a great deal of work, both in-house and through contracts, and later on have revised and reviewed that work, which provided the levels of cut-off points for various factors. This was based on national or regional statistics which showed what the average was or a particular quartile cut-off. In the case of the 30 minutes, it represented the fact that 90 percent of the U.S. population was less than 30 minutes away from a primary care physician. The study was eight years old, I think, or maybe ten at the time. Now, we would expect that 95 percent are close. But, essentially, if 90 to 95 percent of the population is able to get to the doctor in 30 minutes, that means that if you have to go over 30 minutes to get to a doctor, that is not a good situation. And some of it is arbitrary and judgmental, but that is how a lot of the criteria were developed. We have the reports, we have reviewed them and not much has changed since that report was prepared ten years ago.

Undocumented workers, census undercount. If you have some data which is put out by the state or by somebody who really is trying to objectively identify the issue and collect data, not just to support something or to play an advocacy role, we want to see it. I think that we would deal with that. It would be a case-by-case basis. The same is true of the census undercount. Everybody knows there is a ten or 15 percent undercount in the decennial census. It varies by state, it is heavily a racial/ethnic undercount. But we have just had to turn down a couple of requests on it, simply because there is no indication of what it is in a particular city or rural area or community with which we can compare to the rest of the country.

There was a question about the future of the designation activities. This program is going to exist for a good many years. It may not be in the Bureau of Health Professions; it may be in a completely reorganized Health Resource and Services Administration. It could be a subset of the administrative office, it could be in BCHDA. There are a lot of things that could happen. But I do not see that this particular activity can be eliminated. Even if the funding goes down to next to nothing, it is going to be needed even more. If you have 50 dentists coming out, you have got to identify the

areas even more effectively than you did when you had 200 because you had a margin for error. But if you do not identify the areas and keep them updated, the actual placement becomes a disaster. I think that it will be here for a while because the Corps will be here at least until FY 1990, and then we will have more programs. And even if a volunteer program exists, there is going to have to be some quantitative objective look at the areas to compare them to other areas. And I think we will probably end up with the same people, hopefully, doing something maybe a little bit different, maybe a little bit better. Dick, do you want to say something else?

MR. LEE: I think the NHSC is going to be around and I think HMSA designation is going to be around. The levels, the numbers of NHSC practitioners may be smaller; the number of HMSAs may be smaller; the number of people doing the work in any of these programs may be smaller, but it is going to go on.

One thing that did not come up in the three reports that I remember was the degree of shortage criteria. Could they be changed to be more realistic in terms of not just being based on the population to physician ratio and high poverty or high infant mortality. Something that would be better distinguished among the HMSAs so that as all the HMSAs go into the development of the HPOL, there is a better discrimination among HMSAs on an objective data analysis basis, prior to the development of the HPOL.

I think that is a positive approach to it. It would probably make it easier for the people developing the HPOL if there was more sense to, Group 1 areas versus Group 2 versus Group 3 and Group 4. I think that they would probably pay less attention to that because it does not really tell them anything. Whether we could do anything on that, I do not know, but if the NHSC wanted us to, I am sure it is a possibility.

There was a question that was raised by Jeanette in Regions III and VII, which I did not cover. It was about the printouts. Did I gather that what was wanted was for us to give you the printouts more frequently?

MS. WASHINGTON: There were some concerns about possibilities for changes in the format. The way the service areas are listed at the ends of the format and then the components earlier, and also in terms of providing information for contiguous areas where they might be in another state that is not in you particular region but it would be helpful because of the cross-cutting patterns.

MR. LEE: If Betty was in your group she might have mentioned that there is an effort to revise the whole system which generates the printout in which case we could get different formats for those printouts. So, that is a possibility.

Do you consider it sufficient for your purposes, given whatever the current formats are, to simply get the printouts when we are asking you for an annual review, or do you need it more often than that? What we are assuming is that when we send you out the designation letters, they tell you what designations have been done in your state. The only time we provide the data is when we are asking you to do an annual review. You may have your own plan of attack for reviewing your own areas and you may want that

printout in January instead of whenever we are sending it to you Let me just say, if you need that, let us know. I do not want us to provide it to you once a month.

We have typically, on a quarterly basis, provided those kinds of printouts to our regional office people and we are updating that data base at least monthly. So, it is possible for us to give you an update more often than annually. Contact us if you are getting ready to do a review process of your own and need that data base. At this point, let me ask if anybody has questions on things that either did or did not come up in the small group sessions or questions about reactions Howard and I may have just made?

FROM THE FLOOR: In Mississippi, I do not have a current printout on the dental shortage areas. One other small suggestion is that occasionally some of the information that we send to you has errors in it and occasionally some of the material you send to us originates its own typos. Is there a simple process for correcting these without having to send in packages of material, but just simply say that this is a typo?

MR. LEE: You mean on the printout?

FROM THE FLOOR: Yes.

MR. LEE: Yes. There are two ways of doing it. One is a phone call and one is with a letter. We would like to know that. Whenever we do send you a printout, I think it says in the letter to correct the errors, but if there is an actual error, rather than waiting until you get together your full-fledged response to that request, you can call us up with the errors or drop a one-liner in the mail, either one, because we try to keep the data base as accurate as possible.

As we talked about in a couple of the presentations, everybody that works with the data base knows that no matter how good the data base is, it is only as good as the people inputting the data and the people writing the piece of paper that they give to the other people to input the data. And the piece of paper can get lost, too. So, there are sometimes cases where we sent out a letter designating or de-designating an area but the data sheet that goes to the computer people does not get filled out or disappears somewhere along the line. We have much less of that now than we used to. Betty's devoting an awful lot of time to checking through that process, not only to make sure that the data goes to the computer people, but also checking with the computer people on the input before we generate the next written report from the data base. So, that is something that we want as accurate as possible, so if you see a mistake please tell us either in writing or by phone. And I will write down that Mississippi needs a dental printout.

Any other questions or comments?

FROM THE FLOOR: There are about three-fourths or about 110 primary care designations that we have that have designation dates in 1984. That was the last time they were updated. They are going to be coming up for review in 1987. Do you have some plans for prioritizing which designations we should look at first? It is going to be a pretty massive effort.

MR. LEE: We are having nightmares about it, I think, is what we're doing. This year I thought that, we might be able to help that situation by asking the people to when they are sending in their reviews of the 1983 designations, to also send in the reviews of those 1984 designations that were going to be on this year's HPOL. So, we put that in the letter. Some people noticed it; some people did not notice it; some people ignored it. Where that information has been provided, we are processing it. And it will make the job easier next year. We are not t king them off the list if it was not provided. So, next year we will still have the issue of if we should take it off the list if it is not provided. I would assume the answer to that is, theoretically, yes.

We will prioritize, obviously, those areas, so please make sure you update any 1984-designated areas. It is the one for placement in July of 1988. Then that means that in your reviews, if you have 120 or whatever the number is, that you may want to concentrate on updating those that you know either you or another component of the state wants included on the HPOL, wants included in those that somebody maybe will be placed in. That would also extend, I would assume, to anyplace where somebody has been placed. So, that would be a way for you to prioritize it, and make sure you get that stuff in early, and then the other ones send in later. Because if they do fall off the list it would not have as much of an impact.

I mentioned that I thought we may be a little more flexible this time in terms of the degree to which you have to reinvent the wheel on sub-county designations. Maybe you could give us the counts of the people and not try to change the service area definition. If we can look at it and look back at the 1984 data and say, that we still believe this, maybe we will not need as much detail.

I think probably what we should do is have our staff people look over for each state what the situation is and have you talk person-to-person with the person on our staff that does your state designations and find out from them which ones look to us like they are kind of shaky and you really better give us the complete thing, and for which ones we are comfortable with, the rational service area definition or the population group designation that exists. If you can just update the numbers, that will be fine. Good question.

CLOSING REMARKS

Howard V. Stambler
Director
Office of Data Analysis and Management
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MR. STAMBLER: One or two very, very minor last-second things on which I will not entertain any questions. Mail problems are going to exist for all of us. There were a couple raised here today. Please let us know if there is any change whatsoever in an address or where we can deal more directly with you rather than, perhaps, going through a nine-level organization. In addition to that, recognize that the mail as it leaves us can take anywhere from a week to two weeks to get to where it is going, which implies some kind of a problem. But it is not yours or ours, it is just very often the mail. I think we are going to try this time around, although it is much more expensive, to send these on a special kind of mail delivery. I am not sure what we can do, but I think we can do something to get them out into your hands quicker than they are getting. And I would suggest that in some respects it might work well the other way, too, if you are running close to a deadline.

We have covered quite a bit of ground. I think it has been very useful to us and I hope it has been useful to you. We do this every couple of years and we'll be doing it again, in San Diego for the rest of the state people. I hope you will fill out the evaluation forms, not only on the content but some other aspects of it.

I really appreciate your coming. It has been very good. I would like, also, to really thank my staff who has done a great deal of work. They have really worked hard to get the materials together, to really think through the issues and problems that might arise, and participated. Just in case you are not fully aware, again, Melba Kokinos, Betty Hambleton, Phil Salladay, Jay Battle, and I don't know if David Brand is here right now, but they have done the bulk of the work.

But I hope that this has been useful and helpful. I hope you will keep in touch, not only with the individuals who work with you, but in a sense keep in touch with me or with broader issues and try to give us a chance to respond and try to give us a chance to at least explain why we do not do something which seems very reasonable and rational to you.

In the meantime, again, thank you very much. Have a safe trip home if you are leaving today. Enjoy yourself going back and thank you very much.

The proceedings were concluded at 11:40 a.m.

APPENDICES

APPENDIX A

LIST OF PARTICIPANTS

HEALTH MANPOWER SHORTAGE AREA WORKSHOP

SHERATON HOTEL
New Orleans, Louisiana

November 4-7, 1986

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APPENDIX B

AGENDA

HEALTH MANPOWER SHORTAGE AREA WORKSHOP

Sheraton Hotel, Canal Street
New Orleans, Louisiana
November 4 - 7, 1986

AGENDA

TUESDAY, NOVEMBER 4, 1986

6:00 - 8:00 p.m.	REGISTRATION	LANIAPPE FOYER

WEDNESDAY, NOVEMBER 5, 1986

8:00 - 9:00 a.m.	REGISTRATION	RHYTHMS FOYER
9:00 - 10:30 a.m.	WELCOME AND INTRODUCTION Overview of ODAM/BHPr/HRSA Organization and Functions Howard V. Stambler Background and Overview of HMSA Designation and this Workshop Richard C. Lee Trends in Geographic Distribution/ Diffusion of Physicians; Projected Impact on Number of HMSAs and Number Needed Therein John Drabek, Ph.D.	RHYTHMS ROOM
10:30 - 10:45 a.m.	COFFEE BREAK	RHYTHMS FOYER
10:30 - 11:15 a.m.	AMA Viewpoint: DeWitt C. Baldwin, Jr., M.D. American Medical Association	RHYTHMS ROOM
11:15 - 12:00	Current HMSA Criteria and Guidelines; Designation Procedures Betty Hambleton	RHYTHMS ROOM

	Question and Answer Session	
12:00 - 1:30 p.m.	LUNCH (ON YOUR OWN)	
1:30 - 2:30 p.m.	PANEL DISCUSSION	RHYTHMS ROOM
	State Agency Experience/Methods Employed in Geographic HMSA Designation	
	Sharon Sowers Mary Ring	
	Question and Answer Session	
2:30 - 3:30 pm.m	SMALL GROUP DISCUSSIONS	
	Participant Experiences/Problems with HMSA Designation (Emphasis on Geographic Designations)	
	HMSA Discussion Group A (Regions III and VII)	ROOM 816
	Moderators: Melba Kokinos Betty Hambleton	
	HMSA Discussion Group B (Regions IV and VI)	ROOM 820
	Moderators: Jasper Battle David Brand	
	HMSA Discussion Group C (Region V)	ROOM 821
	Moderator: Phil Salladay	
3:30 - 3:45 p.m.	COFFEE/COLA BREAK	8TH FLOOR FOYER
3:45 - 5:00 p.m.	Reconvene Samll Groups	
5:00 p.m.	RECESS FOR THE DAY	

THURSDAY, NOVEMBER 6, 1986

9:00 - 10:30 a.m.	FEDERAL PROGRAMS RELATED TO HMSA DESIGNATION (Introduction) Richard C. Lee National Health Service Corps - Federal, PPO and PPA Placements; HPOL Development; Placement Policies and Priorities; Volunteer Recruitment David Ober Other HRSA Primary Care Programs - Rural Consortia; Migrant Health; Frontier Initiative; Urban CHCs John Hisle Medically Underserved Population/Area Designations - Historical Development; Effect of PL 99-280; Regs Development; Relationship Between MUAs and HMSAs	RHYTHMS ROOM
10:30 - 10:45 a.m.	COFFEE BREAK	RHYTHMS FOYER
10:45 - 11:45 a.m.	Professional Association Involvement in HMSA Review Process James Marshall Norbert Budde, Ph.D.	RHYTHMS FOYER
11:45 - 1:15 a.m.	LUNCH (ON YOUR OWN)	
1:15 - 2:15 p.m.	PANEL DISCUSSION State Agency Experience/Methods Employed in Population Group HMSA Designation Marcia Collins Mark Shapleigh	RHYTHMS ROOM

2:15 - 3:30 p.m.	SMALL GROUP DISCUSSIONS (Emphasis on Population Group Designations)		
	HMSA Discussion Group A (Regions III and VII)		ROOM 816
	Moderators:	Melba Kokinos Betty Hambleton	
	HMSA Discussion Group B (Regions IV and VI)		ROOM 820
	Moderators:	Jasper Battle David Brand	
	HMSA Discussion Group C (Region V)		ROOM 821
	Moderator:	Phil Salladay	
3:30 - 3:45 p.m.	COFFEE/COLA BREAK		8TH FLOOR FOYER
3:45 - 5:00 p.m.	Reconvene Samll Groups		
5:00 p.m.	RECESS FOR THE DAY		

FRIDAY, NOVEMBER 7, 1986

9:00 - 10:30 a.m.	State Programs Involved with HMSA Designation Betty Hambleton Current Efforts at Revising HMSA Criteria and Guidelines Richard C. Lee	RHYTHMS ROOM
10:30 - 12:00	Presentation of Issues and Recommendations From Small Group Sessions; Discussion Jeanette Washington Sue Ellen Rael Kenneth Darga	

	ODAM Response - Future Efforts to Improve HMSA Process
	Howard V. Stambler
12:00 noon	SUBMIT WORKSHOP EVALUATION FORMS
	ADJOURNMENT