

California Healthcare Workforce Policy Commission (CHWPC)
 400 R Street, River Conference Room
 Wednesday, August 3, 2011
 Start: 8:30 a.m.
 Recess: 3:45 p.m.

COMMISSION MEMBERS PRESENT	COMMISSION MEMBERS ABSENT
Elizabeth Dolezal - Chair Roslynn Byous, DPA, PA-C Lauri Hoagland, FNP Tracey Norton, DO Andrea Renwanz Boyle, DNSc Deborah Rice, FNP Katherine Townsend, Ed.D., MSN John J. Troidl, PhD Ashby Wolfe, MD, MPP, MPH	Mario San Bartolome, MD, MBA Angie Millan RN, MSN, NP William Henning, DO Bonnie Wheatley, Ed.D., MPH, MA
	STAFF TO COMMISSION PRESENT
	Stephanie Clendenin, Acting OSHPD Director Angela Minniefield, MPA Manuela Lachica Melissa Omand Yolanda Avalos-Troyer
	ADDITIONAL STAFF FROM OSHPD:
	Lupe Alonzo-Diaz, Acting OSHPD Chief Deputy Director Debra Gonzalez, Clearinghouse Elizabeth Wied, Chief Counsel

ITEM NUMBER	TOPIC	AGENDA ITEM	ACTION ITEM OR DISCUSSION
1.	Call to Order	Meeting called to order at 8:30 a.m.	
2.	Introduction of CHWPC Members and Statement of Recusal	CHWPC Members introduced themselves and indicated whom they represent and which government authority appointed them. Additionally, each Commissioner indicated which Family Practice Residency Training Program they would recuse themselves from.	<u>Recusals</u> Renwanz Boyle: None Byous: None Dolezal: None Hoagland: None Nation: None Norton: Downey Regional Rice: None Townsend None Troidl: None Wolfe: UC Davis
3.	Chair Remarks and approval of May 2011 minutes	Approval of minutes from CHWPC meeting held May 4, 2011 in Sacramento, California.	Motion made (Norton) and seconded (Rice) to approve the May 2011 minutes as presented. Minutes were opposed by Dr. Troidl.

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4.	OSHPD Director's Report	<p>Stephanie Clendenin, Acting OSHPD Director reported on the following items in the Director's Report:</p> <p><u>Retirement from OSHPD</u> Ms. Clendenin stated that Dr. Carlisle departed OSHPD on June 1, 2011 and started his position as the President of the Charles R. Drew University of Medicine and Science on July 1, 2011. She acknowledged Dr. Carlisle's ten years of service and leadership and his support of the Song-Brown Program and the California Healthcare Workforce Policy Commission.</p> <p><u>Background Information</u> Ms. Clendenin stated that Secretary Diana Dooley has asked her to act as Interim Director while the administration determines who will replace Dr. Carlisle. Ms. Clendenin has been with the Office for fifteen years and has held various leadership roles within the Department including the Healthcare Workforce Development Division. She was recently serving as OSHPD's Chief Deputy Director and Deputy Director for the Administrative Services Division.</p> <p>Ms. Clendenin introduced Lupe Alonzo-Diaz, as the acting Chief Deputy for OSHPD. Lupe was serving as the Executive Director of the Health Professions Education Foundation.</p> <p><u>Budget</u> Ms. Clendenin stated that when Governor Brown took office the State faced a \$25.4 billion dollar deficit and a \$21.5 billion dollar ongoing structural deficit. When he proposed the Governor's budget it sought to address ongoing principal problems through three measures; reducing spending, increasing revenues and returning authority to the local government. For the May Revision the State faced an additional \$10 million dollar budget deficit.</p>	

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4.	OSHPD Director's Report – cont'd.	<p>Additional cuts were proposed in the May Revise including the elimination of the California Healthcare Workforce Policy Commission (CHWPC), Rural Health Policy Council and the California Health Data and Advisory Commission. The Office presented the administration's proposals at the Senate and Assembly Budget Subcommittee hearings in May; the Senate Subcommittee voted to adopt to eliminate the CHWPC and the other two OSHPD Boards. At the Assembly Budget Subcommittee Dr. Troidl testified about CHWPC's role in Health Workforce Development. Ultimately, the administration's proposal to eliminate the CHWPC did not move forward. The other two OSHPD Boards will be abolished effective January 1, 2012.</p> <p>On June 30, 2011, Governor Brown signed the Budget a \$129 Billion dollar package with General Fund appropriations totaling \$86 Billion dollars, the budget assumes \$4 Billion of unanticipated funds in the State's confers. If the funds fail to materialize the budget does include trigger reductions to social services, prisons, courts, and universities.</p> <p>For OSHPD the budget included the elimination of the two boards but also the augmentation for some programs to implement legislation, pursue technology projects and continue the efforts in workforce development as it relates to Health Care Reform (HCR). The Office gained positions in HWDD and the Information Technology (IT) Services Division. IT will partner with HWDD and the Health Professions Education Foundation in creating an electronic scholarship, loan repayment and grants program application and monitoring system. It is envisioned that in the future there will be an electronic application for Song-Brown proposals.</p>	<p>Dr. Nation stated the University of California (UC) had received a budget cut of \$650 million in the current year, which is being offset largely by student fees. A UC medical student is paying \$33,000 - \$36,000 in fees only per year. These fees will jump up by \$4,000 next year which will lead to huge ramifications in terms of debt and where students will practice. This will cause huge challenges as the Commission works to meet workforce needs</p>

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4.	OSHPD Director's Report – cont'd.	<p>OSHPD continues to operate under the continued direction to stream line State government and eliminate redundancies which include the hiring freeze, travel limitations, cell phone reduction, all executive orders issued by Governor Brown since January 2011.</p> <p>Ms. Clendenin acknowledged all OSHPD staff for the hard work they continue to do despite the 17% vacancy rate the Office is experiencing. While the Office has received a limited number of exemptions over the last few months they are specifically targeted to public safety and revenue generation.</p> <p>Ms. Clendenin and Ms. Minniefield presented former CHWPC member Dr. Jimmy Hara with a resolution for his many years of service on the California Healthcare Workforce Policy Commission</p> <p>At the conclusion of the resolution presentation Dr. Hara stated that he had recently been appointed to the American Board of Family Medicine and serves on the Program Requirement Task Force. He provided the CHWPC with an update on Family Medicine training and accreditation.</p> <ol style="list-style-type: none"> 1. Effective April 2012 the American Board of Family Medicine Certification Exam will be offered once a year; and the accreditation standard will be that 96% of the 3rd year residents must take the exam in April and 85% must pass for the program to maintain its accreditation. 2. The length of accreditation given to a program is a good indication of the quality of the program and the number of citations has no bearing on the length of accreditation. 	<p>Dr. Troidl thanked Dr. Hara for his many years of service and leadership on the Commission; and for work to make the Commission funding process transparent for the applicants.</p> <p>Commissioner Rice thanked Dr. Hara for helping to create the first evaluation tool for the Commission.</p>

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4.	OSHPD Director's Report – cont'd.	3. The sponsoring institution of every program must conduct an internal review midway through the accreditation period. 4. The Maternity Care standard will now have two tiers. Residents will fall into one of two tiers (low or high). 5. All residency programs must have electronic health records in place by 2013. 6. Currently, residents are required to have 1,650 office visits. This number will be revised to account for the addition of electronic visits.	<p>Dr. Troidl asked if there would be some designation identifying those family physicians with the higher level of maternity training?</p> <p>Dr. Hara stated that currently the physicians receive a certificate stating the additional training they have received; he believes that a certificate and qualifications form will be added that indicates the higher level of maternity care completed by the physician.</p>
5.	Executive Secretary's Report	<p>Ms. Minniefield, Deputy Director of the HWDD reported on the following items in the Executive Secretary's Report.</p> <p><u>Budget</u> As of June 30, 2011, HWDD has spent approximately 77% of the \$17 million budgeted for the division. This reflects the hiring freeze and travel restrictions, local assistance funds were awarded through the Song-Brown Program and the Mini Grants Program. HWDD has had some success in awarding the State Loan Repayment Program awards received through the stimulus funds.</p> <p><u>Song-Brown Program</u> The FNP and PA Base Funding applications were released on June 2, 2011; the Song-Brown PA Mental Health Special Program application was released the same day.</p> <p>Vice Chair nomination requests were sent to Commissioners on July 1, 2011.</p> <p><u>Shortage Area Designations Program</u> Since April 1, 2011, the program has received 15 applications; 11 of them are conventional primary care, 1 dental and 3 mental health applications</p>	

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5.	Executive Secretary's Report – cont'd.	<p>The Shortage Designations Program (SDP) received 3 positions that were approved in the 2011-12 budget and are seeking to hire for these positions to proactively review Health Professional Shortage Areas (HPSAs) in the State.</p> <p><u>State Loan Repayment Program (SLRP)</u> 29 applications have been received since October of 2010, 10 were extensions and 19 were new applications. With the infusion of stimulus dollars into the SLRP Program, there has been some difficulty getting the funds out because of the requirement that clinics have to match the funds that are provided by the program. To eliminate this barrier HWDD collaborated with HPEF to use Steven M. Thompson funds as the match for the clinics. In April 2011, SLRP was able to use the hybrid program and award 30 applications and spend down \$4 million dollars in stimulus funds. On August 1, 2011, SLRP received 52 applications; program staff is hopeful they will be able to award the remaining \$1.7 million dollars in stimulus funds.</p> <p><u>Cal SEARCH Program</u> Provides clinical training and experience to students and residents in Community Health Clinics in California. There are currently 47 sites in the State and 84 students that have applied and 48 students that have started rotations for this year; the goal is to have 62 students complete the program.</p> <p><u>Health Workforce Pilot Project</u> The Office has been monitoring the Access through Primary Care Project (HWPP#171) that demonstrates the role of advanced practice clinicians in expanding early pregnancy care. This project has received a six-month extension through September 30, 2011 and they have requested another six-month extension that is under review by the office.</p>	

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5.	Executive Secretary's Report – cont'd.	<p><u>Health Workforce Regions</u> Health Workforce Regions have been developed and mapped to geographically display regions with Health Professional Shortage Areas for primary care physicians, population-to-provider ratios, census data, and training programs. The regions are intended for administrative use as a common frame of reference for regional configuration and discussions.</p> <p><u>Healthcare Workforce Clearinghouse Program</u> The Clearinghouse will centralize health workforce and education data in the State. The program is on target to go live in June 2012. There are sixteen entities that are providing data for the rollout; staff has completed approximately 92% of the user acceptance testing. The California Post Secondary Education Commission (CPEC) recently informed OSHPD they would be closing since the Governor deleted their General Fund dollars in the 2011-12 budget. Staff is working very closely with CPEC to transfer the education data they have to the Clearing House at least for testing purposes.</p> <p><u>Legislation</u> AB 1360 would authorize healthcare districts and clinics owned by healthcare districts to employ physicians and surgeons directly. This bill failed passage in the Assembly Health Committee.</p> <p>SB 635 (Hernandez) would have increased funding for the Song-Brown Healthcare Workforce Training Act; The last hearing was cancelled by Senator Hernandez, Chair of the Senate Health Committee.</p>	<p>Dr. Troidl stated that OSHPD has been a real leader in the State in the use of Geographical Information System (GIS) technology.</p>

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5.	Executive Secretary's Report – cont'd.	Ms. Minniefield stated that HWDD is willing to provide letters of support for those programs that are interested in applying for the federal grant funding for HCR. Programs can go to www.oshpd.ca.gov to obtain information regarding the letters of support from HWDD. Programs can also sign up to receive information regarding HCR.	
6.	Family Practice Residency – Capitation Presentations	Presentation of capitation funding requests by the following programs: 1. Kaiser Permanente - Orange 2. San Jose O'Connor Hospital 3. Presbyterian Intercommunity Hospital 4. Natividad Medical Center 5. Kaiser Permanente – San Diego 6. Harbor-UCLA Medical Center 7. UCSD Combined Family Medicine/Psych 8. Kaiser Permanente – Los Angeles 9. UCSF – San Francisco General Hospital 10. Pomona Valley Hospital 11. UCSF – Fresno 12. Sutter Health Family Medicine – Sac. 13. Long Beach Memorial 14. UC Los Angeles 15. Riverside County Regional Medical Ctr. 16. Contra Costa County Health Services	Prior to the capitation presentations Ms. Lachica reviewed the document titled "Funding Limits on Family Practice Residency Training Programs."
7.	New Business	Ms. Callie Langton, Associate Director of Health Care Workforce Policy for the California Academy of Family Physicians provided an update on Family Medicine Ms. Langton covered the following items in her presentation. <ul style="list-style-type: none"> • California growth in physician demand is likely to outpace growth in supply of physicians in ten years. The State also has the highest percentage of primary care physicians that are near retirement (34.2) in the United States. 	

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7.	New Business – cont'd.	<ul style="list-style-type: none"> • Family Medicine Residency (FMR) Programs in California are doing well compared to the Family Medicine Programs across the United States. CA FMR added an additional 17 training slots in 2011. • Additional slots were funded by private payers, programs such as Song-Brown, and other grant programs. • Interest in Family Medicine is slowly increasing, however society favors specialization. • California is lucky to have one of eleven teaching health centers (THC) in the Valley Family Medicine Residency of Modesto. Each teaching health center may apply for \$500k a year for up to 3 years. Graduate Medical Education (GME) dollars will flow directly to THC's. • Teaching Health Centers are community based, ambulatory patient care center that operates a primary care residency program. • THC's expose more students to clinic based primary care, allowing students to experience case mgmt. and the satisfaction of continuous care for patients. • California can expect increased numbers of family medicine residency slots financed by private payers. <p style="text-align: center;">CAFP 2011 Family Medicine Update is hereby incorporated as Attachment A</p>	<p>Ms. Minniefield asked if there are specific policy recommendations that CAFP has that the Commission might consider as they think about ways to enhance health care in areas of unmet need in regard to the upcoming Health Care Reform for 2014.</p> <p>Ms. Langton responded with "the Commission can set an example by having everyone work together to improve primary care, everyone has a role to fill."</p> <p>Dr. Nation added that the State is under resourced in regard to medical student education; UC is committed to having the medical school at UC Riverside open in 2013 with a first year class of 40. The state is the number one exporter of medical students to other parts of the country and to out of country medical schools.</p> <p>Dr. Nation further added the PRIME programs admissions are consistent and deliberate in recruiting diverse students that are interested in going back to underserved areas where they come from.</p>
		<p>Debra Gonzales, Research Specialist with the HWDD gave a presentation on Health Workforce Regions.</p> <p style="text-align: center;">California Health Workforce Regions is hereby incorporated as Attachment B</p>	

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3.	Resume Family Practice Residency Capitation Presentations	1. White Memorial Medical Center 2. Scripps Mercy Hospital, Chula Vista 3. UC, Davis 4. Downey Regional Medical Center 5. UC, Irvine 6. Northridge Hospital Medical Center 7. Glendale Adventist Medical Center 8. Valley Family Medicine of Modesto 9. Loma Linda University 10. USC – California Hospital	

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3.	Resume Family Practice Residency Capitation Presentations	11. San Joaquin General Hospital 12. Santa Rosa Family Medicine 13. Mercy Medical Center, Merced																																																																																															
4.	Funding Discussion and Decision	<p>Programs were ranked by the CHWPC in the following order:</p> <table border="0"> <tr><td>White Memorial Medical Center</td><td>1</td></tr> <tr><td>UCSD Combined Family Medicine/Psych</td><td>2</td></tr> <tr><td>Scripps Mercy Hospital, Chula Vista</td><td>3</td></tr> <tr><td>San Joaquin General Hospital</td><td>4</td></tr> <tr><td>Riverside County Regional Medical Ctr.</td><td>5</td></tr> <tr><td>Contra Costa Health Svcs. Family Medicine</td><td>6</td></tr> <tr><td>Natividad Medical Center</td><td>7</td></tr> <tr><td>Harbor – UCLA Medical Center</td><td>8</td></tr> <tr><td>Valley Family Medicine of Modesto</td><td>9</td></tr> <tr><td>UC, Irvine</td><td>10</td></tr> <tr><td>USC-California Hospital</td><td>11</td></tr> <tr><td>Ventura County Medical Center</td><td>12</td></tr> <tr><td>UCSF – Fresno</td><td>13</td></tr> <tr><td>UCSF – San Francisco General Hospital</td><td>14</td></tr> <tr><td>Kaiser Permanente – Los Angeles</td><td>15</td></tr> <tr><td>Mercy Medical Center, Merced</td><td>16</td></tr> <tr><td>Santa Rosa Family Medicine</td><td>17</td></tr> <tr><td>UC, Los Angeles</td><td>18</td></tr> <tr><td>Long Beach Memorial</td><td>19</td></tr> <tr><td>Kaiser Permanente – San Diego</td><td>20</td></tr> <tr><td>UC, Davis</td><td>21</td></tr> <tr><td>Presbyterian Intercommunity Hospital</td><td>22</td></tr> <tr><td>Kaiser Permanente – Orange</td><td>23</td></tr> <tr><td>Glendale Adventist Medical Center</td><td>23</td></tr> <tr><td>Loma Linda University</td><td>25</td></tr> <tr><td>Downey Regional Medical Center</td><td>26</td></tr> <tr><td>Northridge Hospital Medical Center</td><td>27</td></tr> <tr><td>San Jose – O’Connor Hospital</td><td>28</td></tr> <tr><td>Sutter Health Family Medicine – Sac</td><td>29</td></tr> <tr><td>Pomona Valley Hospital</td><td>30</td></tr> </table>	White Memorial Medical Center	1	UCSD Combined Family Medicine/Psych	2	Scripps Mercy Hospital, Chula Vista	3	San Joaquin General Hospital	4	Riverside County Regional Medical Ctr.	5	Contra Costa Health Svcs. Family Medicine	6	Natividad Medical Center	7	Harbor – UCLA Medical Center	8	Valley Family Medicine of Modesto	9	UC, Irvine	10	USC-California Hospital	11	Ventura County Medical Center	12	UCSF – Fresno	13	UCSF – San Francisco General Hospital	14	Kaiser Permanente – Los Angeles	15	Mercy Medical Center, Merced	16	Santa Rosa Family Medicine	17	UC, Los Angeles	18	Long Beach Memorial	19	Kaiser Permanente – San Diego	20	UC, Davis	21	Presbyterian Intercommunity Hospital	22	Kaiser Permanente – Orange	23	Glendale Adventist Medical Center	23	Loma Linda University	25	Downey Regional Medical Center	26	Northridge Hospital Medical Center	27	San Jose – O’Connor Hospital	28	Sutter Health Family Medicine – Sac	29	Pomona Valley Hospital	30	<p>Motion made (Troidl) and seconded (Hoagland) to distribute capitation funding as follows:</p> <table border="0"> <tr><td>White Memorial Medical Center</td><td>\$206,460.00</td></tr> <tr><td>UCSF Combined FM/Psychiatry</td><td>\$103,230.00</td></tr> <tr><td>Scripps Mercy Hospital, Chula Vista</td><td>\$154,845.00</td></tr> <tr><td>San Joaquin General Hospital</td><td>\$103,230.00</td></tr> <tr><td>Riverside County Regional Medical Center</td><td>\$103,230.00</td></tr> <tr><td>Contra Costa County Health Services Family Medicine</td><td>\$103,230.00</td></tr> <tr><td>Natividad Medical Center</td><td>\$154,845.00</td></tr> <tr><td>Harbor-UCLA Medical Center</td><td>\$103,230.00</td></tr> <tr><td>Valley Family Medicine of Modesto</td><td>\$154,845.00</td></tr> <tr><td>UC, Irvine</td><td>\$51,615.00</td></tr> <tr><td>USC-California Hospital</td><td>\$154,845.00</td></tr> <tr><td>Ventura County Medical Center</td><td>\$154,845.00</td></tr> <tr><td>UCSF – Fresno</td><td>\$154,845.00</td></tr> <tr><td>UCSF – San Francisco General Hospital</td><td>\$154,845.00</td></tr> <tr><td>Kaiser Permanente – Los Angeles</td><td>\$51,615.00</td></tr> <tr><td>Mercy Medical Center, Merced</td><td>\$51,615.00</td></tr> <tr><td>Santa Rosa Family Medicine</td><td>\$154,845.00</td></tr> </table>	White Memorial Medical Center	\$206,460.00	UCSF Combined FM/Psychiatry	\$103,230.00	Scripps Mercy Hospital, Chula Vista	\$154,845.00	San Joaquin General Hospital	\$103,230.00	Riverside County Regional Medical Center	\$103,230.00	Contra Costa County Health Services Family Medicine	\$103,230.00	Natividad Medical Center	\$154,845.00	Harbor-UCLA Medical Center	\$103,230.00	Valley Family Medicine of Modesto	\$154,845.00	UC, Irvine	\$51,615.00	USC-California Hospital	\$154,845.00	Ventura County Medical Center	\$154,845.00	UCSF – Fresno	\$154,845.00	UCSF – San Francisco General Hospital	\$154,845.00	Kaiser Permanente – Los Angeles	\$51,615.00	Mercy Medical Center, Merced	\$51,615.00	Santa Rosa Family Medicine	\$154,845.00
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4.	Funding Discussion and Decision – cont'd.	Award Summary is hereby incorporated as Attachment C	UC, Los Angeles \$51,615.00 Kaiser Permanente – San Diego \$103,230.00 UC, Davis \$103,230.00 Presbyterian Intercommunity \$51,615.00 Kaiser Permanente – Orange \$51,615.00 Glendale Adventist Medical Center \$51,615.00 Loma Linda University \$51,615.00 Downey Regional Medical Center \$51,615.00 Northridge Hospital Medical Center \$0.00 San Jose – O'Connor Hospital \$0.00 Sutter health Family Medicine – Sacramento \$0.00 Pomona Valley Hospital \$0.00 Total \$2,683,980.00
5.	New Business	<p>Ms. Minniefield presented the newly proposed funding methodology document and evaluation worksheets to the CHWPC at the May 2011 Policy Meeting.</p> <p><u>Funding Limits on Family Practice Residency Training Programs</u> The proposed funding methodology would limit the number of capitation cycles each applicant could request. Their request would be based on their approved ACGME residency training slots as follows:</p> <ul style="list-style-type: none"> • 1-20 residents could apply for 1 capitation cycle • 21- 29 residents could apply for 2 capitation cycles • 30-38 residents could apply for 3 capitation cycles 	

California Healthcare Workforce Policy Commission (CHWPC)
 400 R Street, River Conference Room
 Thursday, August 4, 2011
 Start: 8:30 a.m.
 Adjournment: 4:30 p.m.

ITEM NUMBER	TOPIC	AGENDA ITEM	ACTION ITEM OR DISCUSSION
5.	New Business – cont'd.	<ul style="list-style-type: none"> • 39 or more approved residents could apply for 4 capitation cycles • Staff believes this new approach could help to distribute funds consistently but it would still be a tiered system. <p>Angela stated there were concerns raised by Commissioners in May over this new proposal. Some felt the new system would discourage small programs from growth opportunities and that we may be favoring the larger programs that can't expand as easily. An alternative that is being considered is allowing everyone to apply for two cycles only and if they are expanding they can apply for up to two more.</p> <p>Public Comment: "Using percentages rewards performance but it also hurts output to the state, meaning that it's harder for a larger program to place graduates in areas of unmet need than it is a smaller program. This program director would ask that Commissioners take this into consideration when awarding funds."</p> <p>Funding Limits on Family Practice Residency Training Programs is hereby incorporated as Attachment D</p> <p><u>Weighting of Song-Brown Statutory Requirements</u></p> <p>In 2008 some major revisions were made to the Song-Brown Worksheets to emphasize the statutory priorities of the program. No weighted values were assigned to those particular categories. Staff has noticed is that it is difficult to articulate and give feedback advice on how programs can improve their application based on the Commissioners worksheets and comments.</p> <p>Staff has revised the worksheets to allow for weighting of the actual statutory priorities of</p>	<p><u>Commissioner Comments</u></p> <p>Commissioner Rice stated her concern that team training is only receiving 2 points. She feels that it should receive more points because it is emphasized by the Commission and of great value to the residents and students being trained in Primary Care. If a program director only loses 2 points when omitting team training then they may choose to do so and make up points in other areas.</p>

California Healthcare Workforce Policy Commission (CHWPC)
 400 R Street, River Conference Room
 Thursday, August 4, 2011
 Start: 8:30 a.m.
 Adjournment: 4:30 p.m.

ITEM NUMBER	TOPIC	AGENDA ITEM	ACTION ITEM OR DISCUSSION
5.	New Business – cont'd.	<p>1. Placing graduates in areas of unmet need</p> <p>2. Attracting and admitting members of underrepresented minority and economically disadvantaged groups</p> <p>3. Location of the program or clinical training sites in areas of unmet need</p> <p>The proposed weighted value for each of the three statutory priorities would be 5 points each with each subcategory receiving 1 point each.</p> <p>The Additional Factors Considered section would have a weighted value of 1 point per category 1 – 5. Commission members would be allowed to award 1 – 3 points to a proposed "Other Considerations" category.</p> <p>Each applicant can achieve a total weight score of 27 points.</p> <p>Weighting of Song-Brown Statutory Requirements is hereby incorporated as Attachment E</p> <p><u>Commission Comments:</u></p> <p>Dr. Troidl recommended that we form a subcommittee and invite program directors, commissioners and may be some academic types to participate. Committees do the work for the Commission and then present their findings. The Commission has used committees or task forces to deal with other Commission issues.</p> <p>Chair Dolezal stated that she sees the process as a two step process; 1) to review the evaluation worksheets and 2) to review the application to clarify the questions to get the data that is needed.</p>	

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ITEM NUMBER	TOPIC	AGENDA ITEM	ACTION ITEM OR DISCUSSION
5.	New Business – cont'd.	<p>The evaluation worksheet will be presented at the next two meeting to ensure that each discipline funded by the Song-Brown Program has an opportunity to provide feedback. Once staff has received and review feedback from all the disciplines then perhaps a committee will be formed if needed. Chair Dolezal stated further that she would also like to see capitation renewal and new expansion cycles separated for funding purposes</p> <p>Dr. Wolfe stated that it is important to review how we are asking the questions to get the answers that we need; particularly the hours spent in areas of unmet need. Another question is whether the Commission is distributing funds equitably between large and small residency programs. Dr. Wolfe would like to see some background information to determine how it was handled before.</p> <p>Ms. Hoagland stated that it did not seem right to be giving funds to "For Profit" organizations.</p> <p>Dr. Norton stated that she sees the evaluation worksheets as a work in progress.</p> <p>Commissioner Rice stated her concern that team training is only receiving 2 points; she feels that it should receive more points because it is emphasized by the Commission and of great value to the residents and students being trained in primary care. If a program director only loses 2 points when omitting team training then they may choose to do so and make up points in other areas.</p>	

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ITEM NUMBER	TOPIC	AGENDA ITEM	ACTION ITEM OR DISCUSSION
5.	New Business – cont'd.	<p>Dr. Townsend stated that she agreed with the need to review the points assigned to team training but also the points assigned to cultural diversity need to be reviewed.</p> <p>Dr. Nation stated that the evaluation worksheets are a move in the right direction, getting comments from programs and then assessing if there is a need for a committee and what its charge might be.</p> <p><u>Public Comment:</u></p> <p><u>Public Comment #1</u> – “Programs will not eliminate team training based on funding rather the issue is that there is no requirement for team training for family medicine residency programs. It is a focus of Song-Brown but it is not a statutory priority and the 2 point value is appropriate. Also comments regarding Sutter Health’s institutional support having deep pockets are inappropriate and it is a misconception that a residency program has a lot of funds because they are affiliated with a certain group. I urge you to not make funding decisions based on an institutional organizations support but on the merit of the residency program applying for Song-Brown funds.”</p> <p><u>Public Comment #2</u> – “It is a wonderful and difficult process that the Commission goes through to provide funding to family practice residency programs. The Commission is reviewing residency programs trying to look at what a program director can provide that is predictive of the fact that they are going to do what the commission wants them to do and what are the real outcomes that they can prove to the commission, like who are the graduates and where are they practicing. I agree with the comments regarding team training, if a program does not have team training then they should lose 5 points</p>	<p>Dr. Townsend agreed with the comments regarding team training, if a program does not have team training then they should lose 5 points because it is the future of primary care.</p>

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ITEM NUMBER	TOPIC	AGENDA ITEM	ACTION ITEM OR DISCUSSION
5.	New Business – cont'd.	<p>because it is the future of primary care.”</p> <p><u>Public Comment #3</u> – “I would like to congratulate the Commission on the new funding methodology; it will make a big difference in helping programs meet the requirements of the Song-Brown Program.”</p> <p><u>Public Comment #4</u> – “It is very evident that the changes that were made worked in the way the Commission intended, there are programs that have not scored well in the past but meet the objectives of the Song-Brown Act and this year were funded. It is a shame to leave two capitation cycles on the table (\$119,000) when there are so many programs that need the funding.”</p> <p><u>Public Comment #5</u> – “The system is struggling to be equitable and programs are looking for stability in funding. This program would advocate for a system that would allow programs to apply for funding based on their size because it would reflect the size and cost differences for the programs. Let’s use it if we got it, let’s not leave funding (\$119,000) on the table.”</p> <p><u>Public Comment #6</u> - It appeared this year that it was much more explicit how the criteria would be used; the data was very accessible to programs. A program leaving with some funds is better than leaving with nothing.”</p> <p><u>Public Comment #7</u> – “The tier system is confusing you don’t know how many cycles to request; another way to do it is by volume, how many residents are in the program and being helped by the Song-Brown Program? Using all the funding now is better than leaving it on the table.”</p>	

California Healthcare Workforce Policy Commission (CHWPC)
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ITEM NUMBER	TOPIC	AGENDA ITEM	ACTION ITEM OR DISCUSSION
5.	New Business – cont'd.	Ms. Omand announced that based on the nominations received Commissioner Rice is the new Vice Chair of the Commission.	
		Meeting adjourned at 4:30 p.m.	

2011 Family Medicine Update

Callie Langton

Associate Director, Health Care Workforce Policy

August 3, 2011

California Academy of Family Physicians

Workforce Crisis in California

- In California, growth in physician demand is likely to outpace growth in supply by between 4.7 and 15.9 percent in the coming years.
- 34.2 percent of primary care physicians in California are near retirement—the highest percentage of any state.



Funding of Residency Positions

- FM residency programs are doing their best, but it is increasingly difficult to stay financially solvent particularly for rural programs.
- In California, residencies are doing well, with family medicine residencies adding an additional 17 training slots in 2011.
- Additional slots were funded by private payers, programs such as Song Brown, and other grant programs.



Challenges for Family Medicine

- Although interest is slowing increasing, there is limited interest in practicing primary care.
- Society values sub-specialization.
- Medical school admissions policy biases.
- Low visibility of Family Medicine.
- Myths and misconceptions.



Opportunities for Family Medicine: Teaching Health Centers

- Health care reform authorized \$25 million in FY 2010, \$50 million in FYs 2011 and 2012 and “such sums as may be necessary” in subsequent years to expand or establish new residency programs in Teaching Health Centers (THCs).
- THCs may apply for up to \$500,000 a year for up to three years to establish or expand a residency program.
- GME payments will flow directly to THCs.

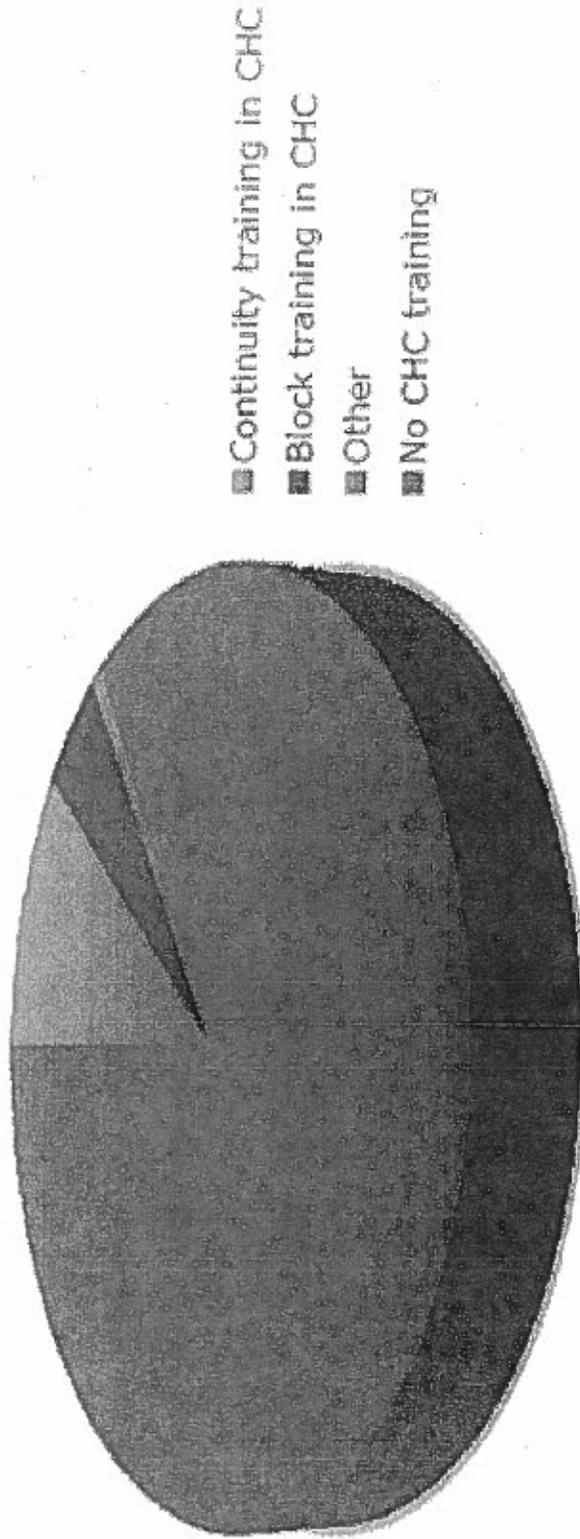


Teaching Health Centers: The Basics

- A Teaching Health Center (THC) is a community-based, ambulatory patient care center that operates a primary care residency program.
- Examples of current THCs are Federally Qualified Health Centers (FQHCs), rural health clinics, Indian Health Services Clinics, and Title X family planning programs that contain a teaching component.
- THCs would expose more students to clinic-based primary care, allowing students to experience case management and the satisfaction of continuous care for patients.



Community Health Center Training Experience of 7,535 Residents



Source: Center for Researching Health Outcomes, 2007



Why Teaching Health Centers are Important

- Studies show that students exposed to community health centers during medical school are more likely to choose primary care specialties.
- Residents often stay where they train.
- THCs are the perfect place for team-based care and training, particularly in primary care.



Future of Family Medicine

In addition to THCs, what can we expect in coming years?

- ▣ Increased numbers of family medicine residency slots in California financed by private payers.
- ▣ Hopefully rejuvenated interest among medical students in family medicine as health care reform takes hold.
- ▣ Major changes in GME funding strategies, hopefully targeted toward increasing funding for primary care.
- ▣ Opportunities for collaboration and team-based training with other medical professions.



Questions?

Callie Langton, MPA

Associate Director Health Care Workforce Policy

California Academy of Family Physicians

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CALIFORNIA HEALTH WORKFORCE REGIONS

August, 2011

Briefing

to the

Healthcare Workforce Policy Commission

Debra Gonzalez

Research Program Specialist, GIS

Office of Statewide Health Planning and Development

Background Summary

- **Considerations for Regions:**
 - Total civilian population
 - Rural and Urban clusters of population recognized
- **Purpose Defined**
- **Emphasis on Administrative purposes for OSHPD**
- **Not to replace service planning areas or rational service areas**

Background Summary

- **Identify regional areas as defined by our workforce and education partners**
- **Matrix of regional configurations created and evaluated.**
- **Proposed a framework for:**
 - Health Workforce Regions**
- **Briefing presented to Health Workforce Development Council**

Regions

Intended for:

- **Common frame of reference for OSHPD**
- **OSHPD administrative purpose**
 - regional configuration will be useful for base line and long term evaluation of results (such as Song-Brown Awards)
- **Inventory of health workforce shortage areas.**
- **Assess Education training and availability**

Regions

Not Intended for:

- Displaying where population in a given region will seek health services.
- Analysis of travel time from one geographic area to another
- Use as regional health service planning areas (i.e. not replacing Service Planning Areas)

Health Workforce Regions

1. North
2. Bay Area
3. Central
4. Central Coast
5. Los Angeles, North
6. Los Angeles, South
7. Orange
8. Inland Empire
9. South

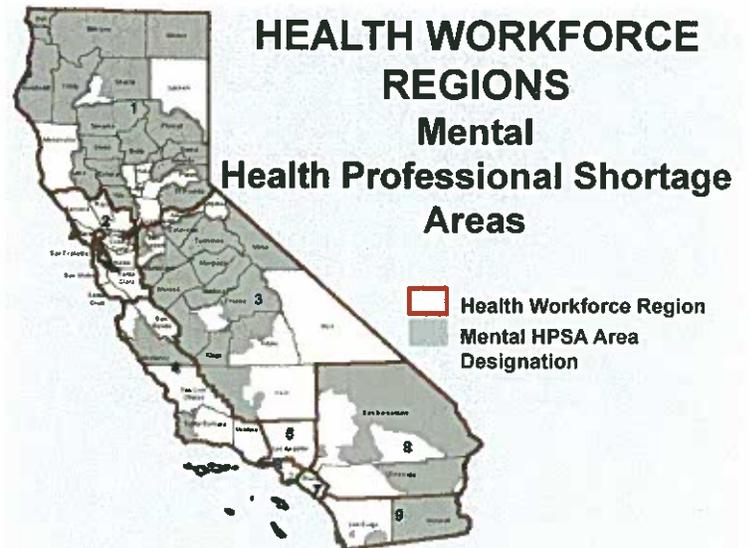
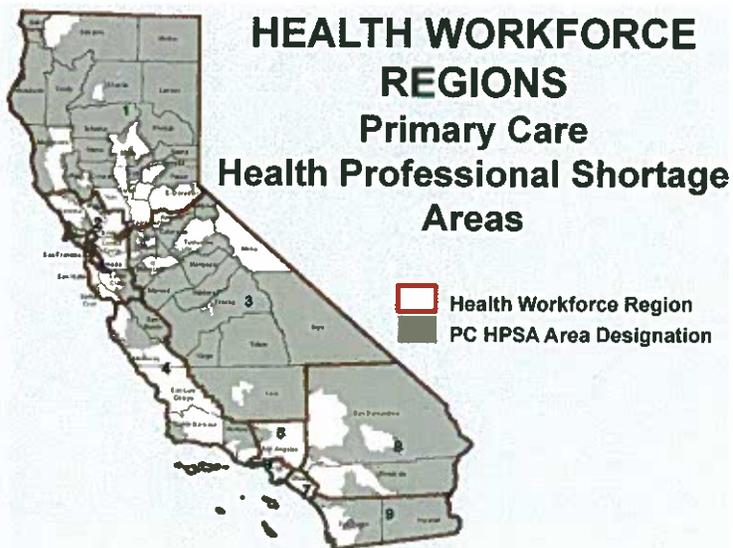
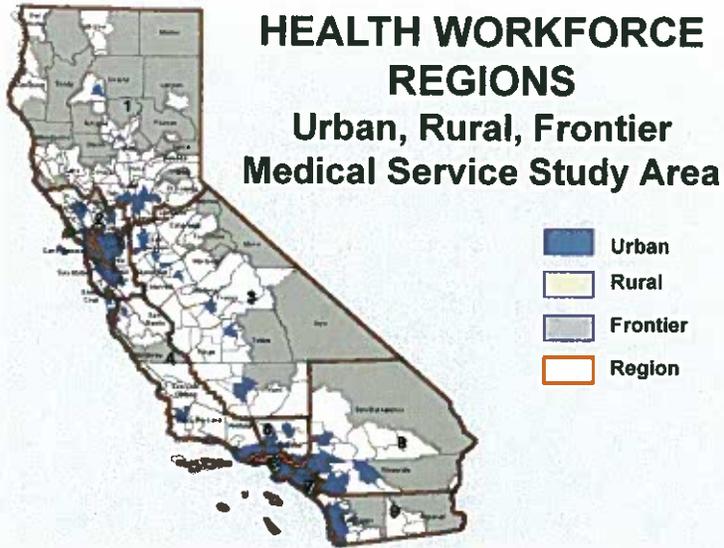
Regions

Not Intended for:

- A requirement for grant submission to any OSHPD administered program
- Replacement of federal, local regional definitions or boundaries
- Identifying rational service areas for health services or health workforce planning

HEALTH WORKFORCE REGIONS





HEALTH WORKFORCE REGIONS Song-Brown Family Practice Awards 2010



- Family Practice Awards, 2010
- Health Workforce Region
- PC HPSA Area Designation

**FAMILY PHYSICIAN TRAINING PROGRAMS
FUNDING AWARDS
AUGUST 2011**

Training Program	Total Amount Requested	Average	Rank	Tier	Awards
White Memorial Medical Center	\$206,460.00	3.10	1	1	\$206,460.00
UCSD Combined Family Medicine - Psychiatry	\$103,230.00	5.30	2	1	\$103,230.00
Scripps Mercy Hospital, Chula Vista	\$154,845.00	6.20	3	1	\$154,845.00
San Joaquin General Hospital	\$154,845.00	9.00	4	2	\$103,230.00
Riverside County Regional Medical Center	\$154,845.00	9.20	5	2	\$103,230.00
Contra Costa Health Services Family Medicine	\$154,845.00	9.80	6	2	\$103,230.00
Natividad Medical Center	\$206,460.00	10.10	7	2	\$154,845.00
Harbor - UCLA Medical Center	\$154,845.00	10.30	8	2	\$103,230.00
Valley Family Medicine Residency of Modesto	\$206,460.00	12.10	9	2	\$154,845.00
UC, Irvine	\$51,615.00	12.30	10	2	\$51,615.00
USC - California Hospital	\$206,460.00	12.60	11	2	\$154,845.00
Ventura County Medical Center	\$206,460.00	12.70	12	2	\$154,845.00
UCSF - Fresno	\$206,460.00	13.00	13	2	\$154,845.00
UCSF - San Francisco General Hospital	\$206,460.00	13.10	14	2	\$154,845.00
Kaiser Permanente - Los Angeles	\$103,230.00	13.30	15	2	\$51,615.00
Mercy Medical Center, Merced	\$103,230.00	13.90	16	2	\$51,615.00
Santa Rosa Family Medicine	\$206,460.00	14.80	17	2	\$154,845.00
UC, Los Angeles	\$103,230.00	16.70	18	3	\$51,615.00
Long Beach Memorial	\$51,615.00	18.30	19	3	\$51,615.00
Kaiser Permanente - San Diego	\$206,460.00	18.90	20	3	\$103,230.00
UC, Davis	\$206,460.00	19.56	21	3	\$103,230.00
Presbyterian Intercommunity Hospital	\$51,615.00	20.90	22	3	\$51,615.00
Kaiser Permanente - Orange	\$51,615.00	22.00	23	3	\$51,615.00
Glendale Adventist Medical Center	\$103,230.00	22.00	23	3	\$51,615.00
Loma Linda University	\$51,615.00	22.20	25	3	\$51,615.00
Downey Regional Medical Center	\$103,230.00	22.22	26	3	\$51,615.00
Northridge Hospital Medical Center	\$103,230.00	23.80	27	4	\$0.00
San Jose - O'Connor Hospital	\$51,615.00	24.80	28	4	\$0.00
Sutter Health Family Medicine - Sacramento	\$103,230.00	25.00	29	4	\$0.00
Pomona Valley Hospital	\$51,615.00	26.00	30	4	\$0.00
Totals	\$4,025,970.00	463.18			

\$2,683,980.00

(\$2,581,000.00)

\$1,444,970.00



Office of Statewide Health Planning and Development



Healthcare Workforce Development Division
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Attachment D

To: California Healthcare Workforce Policy Commission Date: May 4, 2011

From: Office of Statewide Health Planning and Development

Subject: Funding Limits on Family Practice Residency Training Programs

Background

In September 2008, a funding policy was developed to ensure that the limited amount of funds available to award to Family Practice Residency Training Programs were allocated in a consistent and fair manner.

Issue

Even though Song-Brown Program goals, review process (ranking), and outcomes have become more structured and consistent over the last few years, it has become apparent that Family Practice Residency (FPR) Programs are continuing to request the maximum amount of capitation cycles allowed (4 cycles per year) for funding regardless of the number of approved ACGME slots they have and that the Family Practice funding methodology should be revisited.

Current Funding Methodology

- 1) Limits the types of capitation cycles to renewal and new cycles only.
- 2) Limits capitation cycles to a maximum of four cycles each year.
- 3) Capitation funds are awarded using the Tier method as follows:
 - a) Tier 1, full funding, maximum of 4 cycles and minimum of 1 cycle
 - b) Tier 2, full funding, minus 1 cycle or minimum of 1 cycle
 - c) Tier 3, full funding, minus 2 cycles or minimum of 1 cycle
 - d) Tier 4, no funding, applicant not competitive

The Commission is responsible for determining the ranks within the four tiers and retains the right to award no monies if warranted and to distribute any remaining funds starting with the second tier.

Proposed Funding Methodology

Limit the capitation cycles to size of Residency Slots/Positions

Allow applicants to continue to apply for renewal and new capitation cycles, and base the number of cycles a program is eligible to receive on the number of residents trained by each residency program as of July 1 of the prior academic year.

The number of cycles would be based on approved ACGME residency training slots as follows:

APPROVED ACGME SLOTS	# CAPITATION CYCLES ELIGIBLE TO APPLY PER YEAR
1 – 20	1
21 – 29	2
30 – 38	3
39 +	4

Limit new capitation cycles

Limit new capitation cycles to only those residency programs that have ACGME approval to expand and/or to FPR programs that do not have an existing Song-Brown capitation contract. Each program would be allowed to apply for up to two new capitation cycles if they are expanding; or if a program does not have current Song-Brown Program funding.

Distribute funds consistently

Continue to use the Tier funding method for Capitation awards as follows:

- Tier 1, full funding, maximum of 4 cycles and minimum of 1 cycle
- Tier 2, full funding, minus 1 cycle or minimum of 1 cycle
- Tier 3, full funding, minus 2 cycles or minimum of 1 cycle
- Tier 4, no funding, applicant not competitive

The Commission would still be responsible for determining the ranks within the four tiers and would retain the right to award no monies if warranted and distribute any remaining funds starting with the second tier.

Song-Brown Program Recommendation

Song-Brown Program staff recommends the Commission adopt the following revisions to the Family Practice Residency (FPR) Training funding methodology as follows:

- 1) Limit the capitation cycles to the size of the residency training slots, with no program receiving more than four cycles per year;
- 2) *Limit new capitation cycles to FPR Training Program that have ACGME approval to expand and/or to those programs that do not have an existing Song-Brown capitation contract would be allowed up to two new capitation cycles;*
- 3) Continue to use the Tier funding method. This will provide Family Practice Residency Training Programs with a consistent funding mechanism and ensure that the limited Song-Brown funds are distributed in an effective and efficient manner.



Office of Statewide Health Planning and Development

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Attachment E

To: California Healthcare Workforce Policy Commission Date: May 4, 2011

From: Song-Brown Program, Healthcare Workforce
Development Division

Subject: Weighting of Song-Brown Statutory Requirements

Background

In 2008, the Song-Brown funding worksheets were revised to emphasize the statutory requirements of the Song-Brown Program and to provide individual program data in a format that could be reviewed easily by Commission members during funding meetings.

Issue

Although the review process (ranking) and funding of awards has become more transparent at each meeting over the last few years, staff continues to receive inquiries from program directors about the basis of the Commission's decision relative to their application. Staff has sometimes had difficulty interpreting and explaining the application results due to the inability to link funding decisions to Song-Brown statutory priorities.

Current Worksheets

The current Song-Brown Program worksheets (Attachment I) are used by Commission members to rank applicants for funding. The SB funding worksheets currently list the Song-Brown statutory requirements, additional factors and program information such as underrepresented minority enrollment, program graduate and clinical training site information but no weighted values are applied to the worksheet.

Proposed Weighted Values of Song-Brown Worksheets

Statutory priorities 1, 2, and 3 (below) will each have a five-point maximum weighted value for a total of 15 possible points:

- A. Weighted Values (Attachment II) of the three statutory priorities are as follows:
1. Placing of graduates in areas of unmet need (% of graduates in areas of unmet need);
 2. Attracting and admitting underrepresented minorities (URMs) and/or economically disadvantaged groups to the program (% of URMs);
 3. Location of the program and/or clinical training sites in medically underserved areas.

Commission members will use the data analysis to assign points to the statutory priorities

- B. The statutory priorities/considerations will have a weighted value of 1 point for each category as follows:
- 1a. Counseling and placement program to encourage graduate placement in areas of unmet need;
 - 1b. Cultural competence/culturally responsive care incorporated into the program curriculum;
 - 2a. Procedures implemented to identify, recruit and admit residents, students and trainees who possess characteristics which would suggest a predisposition to practice in areas of unmet need;
 - 3a. Percent of clinical hours in areas of unmet need.
- C. The "Additional Factors" section will have a weighted value of 1 point per category for categories 1 – 5, as follows:
- 1) Does the residency training program structure its training to encourage graduates to practice as a health care team that includes FNP and PA providers?
 - 2) Does the program have an affiliation or relationship with an FNP and PA Training Program?
 - 3) Does the faculty's experience and background lend support to the intent of the Song-Brown Program?
 - 4) Does the program utilize family physicians from the local community in the training program?
 - 5) Has the program developed coherent ties with medically underserved multi-cultural communities in lower socioeconomic neighborhoods as evidenced by letters of support?
- D. Additional Factor, category 6 "Other Considerations", allows Commission members to award 1 through 3 points for presentation, application, program improvement or another consideration each Commissioner deems appropriate. Commission members must be specific in their comments identifying what they are awarding points for.
- E. Each applicant can achieve a total weighted score of 27 points. Commission members will transfer their scores to a ballot; the scores will then be averaged. From the averages, the applicants will be ranked and funded according to the tier method currently in place.

Song-Brown Program Recommendation

Song-Brown staff recommends the adoption of the revisions to the Family Practice Residency (FPR) Training worksheets to provide transparency and clarity to the Song-Brown Program awards process as follows:

CATEGORY	WEIGHTED VALUE	MEETS CRITERIA
Statutory Priorities: 1, 2, 3	Maximum of 5 (1- 5) points each	Meets statutory category
Statutory Priorities: 1a, 1b, 2a, & 3a	1 point per question	Yes = 1 point, No = 0 points
Additional Factors: 1, 2, 3, 4, and 5,	1 point per question	Yes = 1 point, No = 0 points
Additional Factor: "Other Considerations"	1 through 3 points	Specify why points are awarded

The maximum points an applicant can receive is 27.

Applicants will be ranked based on the total points awarded; Commission members will continue to use the tier funding method.

Adoption of the evaluation worksheets as discussed above will provide Family Practice Residency Training Programs with a consistent funding mechanism and ensure that the worksheets can be used to provide transparency and feedback to those applicants seeking limited Song-Brown funds.

Attachments

