WEST VIRGINIA LEGISLATIVE AUDITOR

PERFORMANCE EVALUATION AND RESEARCH DIVISION

Preliminary Performance Review

Rural Health Advisory Panel

Rural Rotations of Health Sciences Students Increase Healthcare Resources in Rural Areas of the State, but Rural Rotations Have a Modest Impact in Encouraging Students to Establish Their Practices in Rural Areas

There Is No Explicit Statutory Authority that Allows the Use of RHEP Funds to Purchase Fixed Assets and to Have Those Assets Titled to Non-State Entities

January 2004
PE 03-31-306

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John Sylvia
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January 12, 2004

The Honorable Edwin J. Bowman
State Senate
129 West Circle Drive
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The Honorable J.D. Beane
House of Delegates
Building 1, Room E-213
1900 Kanawha Boulevard, East
Charleston, West Virginia 25305-0470

Dear Chairs:

Pursuant to the West Virginia Sunset Law, we are transmitting a Preliminary Performance Review of the Rural Health Advisory Panel, which will be presented to the Joint Committee on Government Operations on Monday, January 12, 2004. The issues covered herein are "Rural Rotations of Health Sciences Students Increase Healthcare Resources in Rural Areas of the State, but Rural Rotations Have a Modest Impact in Encouraging Students to Establish Their Practices in Rural Areas;" and "There Is No Explicit Statutory Authority that Allows the Use of RHEP Funds to Purchase Fixed Assets and to Have Those Assets Titled to Non-State Entities."

We transmitted a draft copy of the report to the Rural Health Advisory Panel on December 19, 2003. We held an exit conference with the Advisory Panel on January 5, 2004. We received the agency response on January 7, 2004.

Let me know if you have any questions.

Sincerely,

John Sylvia

JS/wsc

Joint Committee on Government and Finance

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The Rural Health Education Partnership rotations are used as a mechanism to recruit these students into practicing in rural areas of the state once their educational training is completed.

The RHEP rotations are used as a mechanism to recruit these students into practicing in rural areas of the state once their educational training is completed. There has been an increase in the number of healthcare professionals who completed a RHEP rotation and established rural practices. However, there is concern as to the influence the RHEP rotation had in leading to these decisions. Survey results of practicing health care professionals who completed a RHEP rotation show that the most determining factor for a health care professional wishing to practice in a rural area is the fact that the person is from the area and/or that the person was already planning to practice in a rural area. Still, the RHEP rotation does provide possible employment opportunities to those who complete them. Survey results show that healthcare professionals who practice in the same area where they did their RHEP rotation occurred 40% of the time. Also, ways to increase the recruitment and retention should be considered such as increasing financial incentive awards, making them tax free or adding money to them to offset income taxes that are assessed to them.

Issue 2 There Is No Explicit Statutory Authority that Allows the Use of RHEP Funds to Purchase Fixed Assets and to Have Those Assets Titled to Non-State Entities.

Some of RHEP's funding has been used to purchase vehicles and buildings for the purpose of facilitating the RHEP program. The question arises,

does RHEP's statute allow for the purchase of such items? A legal opinion from the Office of Legislative Services states that the statute does not explicitly allow for such purchases, however, a liberal interpretation of the statute could allow for such purchases. Therefore, the Legislature may wish to clarify the relevant statute(s) to either allow or disallow the purchase of items such as automobiles and buildings, which have totaled to $959,045 since the program's inception. RHEP passed a moratorium on capital purchases with RHEP funding in November 2003.

Rural Health Education Partnerships passed a moratorium on capital purchases with Rural Health Education Partnerships funding in November 2003.

Another area of concern is the legality of such items mentioned in the above paragraph being titled to entities that are not state government agencies. The same legal opinion also indicates that there is no explicit statutory authority allowing for such assets to be titled to non-state entities. Therefore, the Legislature may wish to clarify the relevant statute(s) to specify who can receive the title to such purchases.

Recommendations

1. The Legislative Auditor recommends the Rural Health Advisory Panel be continued.

2. *The Performance and Evaluation Research Division should continue to research ways to improve the recruitment and retention of healthcare professionals in rural areas of the state.*

3. *The Legislature should consider amending §18B-16 to clarify if the purchases of automobiles or similar items can be made with funding designated for rural health education.*

4. *The Rural Health Advisory Panel should no longer permit the purchasing of vehicles and buildings with funds appropriated for the Rural Health Educational Partnerships program until further clarification of statutory language is made by the Legislature.*

5. *All vehicles and buildings that have been purchased with funding appropriated to the Rural Health Educational Partnerships should have their titles transferred to the appropriate state agency until further clarification of statutory language is made by the Legisature.*

Review Objective, Scope and Methodology

Objective

This Preliminary Performance Review of the Rural Health Advisory Panel is required and authorized by the West Virginia Sunset Law §4-10-5 of the West Virginia Code, as amended. The objective of this review is to ascertain if the Rural Health Advisory Panel through the Rural Health Educational Partnerships (RHEP) has increased the amount of healthcare services in the rural areas of the state. The review is to further determine the effectiveness of the rural rotations required of health science students who attend West Virginia colleges, universities and medical schools in the recruitment and retention of healthcare professionals. Finally, the review is to identify if the agency has the authority to make capital purchases with funds designated for rural health education and who should receive title to such assets.

Scope

The scope of this review is from 1999 to 2003.

Methodology

Information used in completing this report was gathered from the Rural Health Education Partnership's website, meeting minutes, telephone interviews, survey of site coordinators, survey of health science professionals, annual reports, recruitment and retention reports, policies and procedures and interviews and information from similar out-of-state agencies. Every aspect of this review complied with Generally Accepted Government Auditing Standards (GAGAS).

Issue 1

Rural Rotations of Health Sciences Students Increase Healthcare Resources in Rural Areas of the State, but Rural Rotations Have a Modest Impact in Encouraging Students to Establish Their Practices in Rural Areas.

Issue Summary

The Rural Health Advisory Panel, through the RHEP rotations, has a positive impact on a short-term basis by increasing the amount of healthcare services in rural areas of the state. However, the RHEP rotations have had a modest long-term impact in terms of attracting healthcare professionals to practice in rural areas of the state.

The three-month RHEP rotation required of all health sciences students attending West Virginia colleges and universities and medical schools does provide health care resources that would not normally be there if such a program did not exist. Over the last five years, the number of students completing RHEP rotations has increased by 17%. In 2003, rural areas of the state received the benefits of 674 students, of which 378 were medical school students, who provided 6,621 weeks of medical service.

Survey results of practicing health care professionals who completed a Rural Health Education Partnerships rotation show that the most determining factor for a health care professional wishing to practice in a rural area is the fact that the person is from the area and/or that the person was already planning to practice in a rural area.

The RHEP rotations are used as a mechanism to recruit these students into practicing in rural areas of the state once their educational training is completed. There has been an increase in the number of healthcare professionals who completed a RHEP rotation and established rural practices. However, there is concern as to the influence the RHEP rotation had in leading to these decisions. Survey results of practicing health care professionals who completed a RHEP rotation show that the most determining factor for a health care professional wishing to practice in a rural area is the fact that the person is from the area and/or that the person was already planning to practice in a rural area. Still, the RHEP rotation does provide possible employment opportunities to those who complete them. Survey results show that healthcare professionals who practice in the same area where they did their RHEP rotation occurred 40% of the time. Also, ways to increase the recruitment and retention should be considered such as increasing financial incentive awards, making them tax free or adding money to them to offset income taxes that are assessed to them.

Growth of Student Involvement in RHEP Rotations

A direct benefit of this mandatory rotation is the increase in healthcare resources it provides to rural areas of the state.

In order to attract and retain health science professionals in the rural areas of the state, students in the state's health science professions are required to do a three month rotation in rural areas. A direct benefit of this mandatory rotation is the increase in healthcare resources it provides to rural areas of the state. Here, the Rural Health Advisory Panel has been successful in meeting the goal to "provide improved availability of healthcare services throughout the state," as stated in §18B-16-2 of the *Code*. There has been a 17% increase in the number of students participating in the RHEP program, going from 578 during the 1999 academic year to 674 during the 2003 academic year (see Table 1). Most notably, the number of medical students participating in the RHEP program increased by 22% during the same time period. Also, medical students account for between 53% to 55% of all students that participate in the RHEP rotations.

Table 1
Number of Students Involved in the RHEP Program, Academic Years 1999-2003

	Academic Year				
Profession	**1999**	**2000**	**2001**	**2002**	**2003**
Medicine	310	333	338	366	378
Nursing	84	76	93	101	116
Nurse Practitioner	3	7	5	4	6
Physician Assistant	65	59	61	71	34
Dentistry	31	37	37	38	32
Dental Hygiene	15	16	22	19	16
Pharmacy	57	54	49	63	70
Physical Therapist	13	26	30	24	22
Total	**578**	**608**	**635**	**686**	**674**

Perhaps a better measure showing the increase in the amount of healthcare resources provided to the rural areas would be the number of student weeks spent doing rural rotations, which has risen 14% during the same time period from 5,814 during the 1999 academic year to 6,621 during the 2003 academic year (see Table 2). However, as Table 2 shows, **there are many rural counties that are not benefitting from the RHEP rotations**. Sites in the RHEP program report that there are many factors influencing increases or decreases in RHEP rotation distribution. These factors are student choice, availability of preceptors, availability of housing, and curricular changes at institutions, issues of malpractice in the state and how it impacts the availability of field faculty in rural areas, focus of recruitment and retention needs in different consortia.

Table 2
Number of RHEP Student Weeks by County,
Academic Years 1999 - 2003

	Academic Year				
County	**1999**	**2000**	**2001**	**2002**	**2003**
Barbour	13	39	37	24	35
Berkeley	231	342	269	326	275
Boone	140	112	138	79	179
Braxton	155	136	119	182	157
Brooke	0	0	0	0	4
Cabell	124	128	124	103	96
Calhoun	57	34	90	51	17
Clay	0	21	16	24	41
Doddridge	0	0	0	0	0
Fayette	231	236	266	289	216
Gilmer	21	4	4	0	4
Grant	185	171	257	229	200
Greenbrier	569	321	521	614	704
Hampshire	15	54	62	53	48
Hancock	0	0	0	0	0
Hardy	44	18	12	9	35
Harrison	214	121	126	112	159
Jackson	165	190	244	165	76
Jefferson	117	167	221	186	175
Kanawha	254	253	210	485	463
Lewis	105	115	156	133	199
Lincoln	68	62	60	36	24
Logan	159	198	189	218	79
Marion	117	81	116	123	203
Marshall	224	184	155	188	200
Mason	320	194	212	175	209
McDowell	97	63	89	102	41
Mercer	0	0	0	0	0
Mineral	47	77	75	54	46
Mingo	12	n/a	5	27	11
Monroe	50	21	50	41	44
Monongalia	59	93	32	14	0
Morgan	66	102	70	91	81
Nicholas	73	42	101	208	108
Ohio	7	12	18	34	37
Pendleton	22	20	4	7	8
Pleasants	25	28	25	8	30

Table 2
Number of RHEP Student Weeks by County,
Academic Years 1999 - 2003

	Academic Year				
County	**1999**	**2000**	**2001**	**2002**	**2003**
Pocahontas	0	6	0	0	8
Preston	194	160	207	371	444
Putnam	86	177	157	258	376
Raleigh	54	121	84	62	61
Randolph	157	135	179	147	246
Ritchie	45	61	31	69	34
Roane	141	185	102	95	162
Summers	57	19	36	37	27
Taylor	302	245	290	257	324
Tucker	72	31	34	42	6
Tyler	43	34	38	24	29
Upshur	224	221	203	222	261
Wayne	114	224	169	187	241
Webster	181	158	85	122	98
Wetzel	0	0	0	0	0
Wirt	17	0	12	0	0
Wood	0	0	0	0	0
Wyoming	141	84	124	70	100
TOTAL	**5,814**	**5,500**	**5,824**	**6,353**	**6,621**

*Does not include rural rotations with non-WVRHEP preceptors.
Source: WVRHEP

Services Provided By RHEP Rotations

The RHEP rotations provide a myriad of health care services that are focused towards the development of effective health promotion and disease prevention. For instance, students participating in RHEP rotations conduct health screenings for items such as cholesterol, blood sugar, osteoporosis and blood pressure. They also provide dental services, fat analysis, as well as electro-cardiograms. Future physicians and other health care professionals get the chance to experience working in rural areas and confront different challenges that exist in that environment. If this program were amended to not being mandatory for all health sciences students or terminated altogether, the students participating in the RHEP rotations would most likely be attending classes on campus or doing internships. More notably, the health care services provided by the RHEP rotations would be either reduced or no longer exist.

Increase in the Number of Rural Healthcare Professionals

During the last five years, there has been an overall increase in the number of health care professionals who have done an RHEP rotation and established practices in rural parts of the state (see Table 3). This can be expected since RHEP rotations are required of all health sciences students attending West Virginia colleges and universities. Also, the values shown in Table 3 are cumulative in nature. The question arises, how much effect has the RHEP rotations had on these number? As mentioned in the first issue, survey results showed that the RHEP rotations played little in the decision to practice in a rural area in the state, as opposed to the more influencing factor of being from the area of practice and/or already planned to practice in a rural area.

Table 3
Cumulative Number of Health Care Professionals in Rural Practice Who Have Done a RHEP Rotation

Profession Type	1999	2000	2001	2002	2003	1999-2003 Difference
Physicians	88	92	103	124	142	54
Nurse Practitioners	54	50	57	59	59	4
Nurse-Midwives	0	2	2	2	2	2
Physician Assistants	n/a	51	56	60	60	9*
Dentists	55	40	35	48	65	10
Dental Hygienists	12	11	12	14	18	6
Physical Therapists	14	17	23	26	31	17
Total	**223**	**263**	**288**	**333**	**377**	**102**

***Represents change from 2000 to 2003 only since data was not available for 1999.**
Source: RHEP Annual Recruitment and Retention Reports, 1999 to 2003.
Note: Pharmacists have not been included on this table because data was incomplete for the time frame reviewed. However, it should be noted that during 2003, there were 110 pharmacists listed as practicing in a rural area.

Survey of Rural Health Care Professionals

The survey showed that the single most determining factor that a health care professional is going to practice in a rural area is if that individual is from that area and was planning to practice in a rural area.

The survey's results showed the Rural Health Education Partnerships rotations accounted for 13% of those surveyed as being the main reason for their decision to practice in a rural area.

To determine the effectiveness of the RHEP rotations in terms of encouraging students to establish practices in rural areas, the Legislative Auditor conducted a survey of health care professionals who completed a RHEP rotation and are practicing in rural areas of the state. The survey showed that the single most determining factor that a health care professional is going to practice in a rural area is if that individual is from that area and was planning to practice in a rural area (see Table 4). It should be noted that the response rate for this survey was 35%, therefore, no definitive conclusions should be made from its results. The survey's results showed the RHEP rotations accounted for 13% of those surveyed as being the main reason for their decision to practice in a rural area. If the 13% from the survey were applied to the number of health care professionals who have completed a RHEP rotation and listed in rural practice within the state, 488 in 2003, it would account for approximately 63 individuals.

Table 4
Factors Determining the Decision to Practice in a Rural Area

	Percentage Responding		
Response	**Physicians* (number of answers)**	**Other Health Sciences Professionals** (number of answers)**	**All Health Science Professions (number of answers)**
Required as part of an agreement or contractual obligation.	17% (2)	7.7% (2)	11% (4)
You are from the area where you practice and/or you had always intended to practice in your current location.	58% (7)	77% (20)	71% (27)
The Rural Health Educational Partnerships (RHEP) rotation completed during your educational training attracted you to practicing in your current location.	25% (3)	7.7% (2)	13% (5)
None of the above	0% (0)	7.7% (2)	5% (2)

*Includes Medical Doctors (MDs) and Doctors of Osteopathy (Dos), also some respondents selected more than one of the survey choices.
**Includes Nurses, Nurse Practitioners, Physician Assistants, Dentists, Dental Hygienists, Pharmacists and Physical Therapists.

Rural Rotation Sites Provide Employment for New Healthcare Professionals

The survey of health care professionals practicing in rural areas of the state showed that approximately 40% of the time the area where health care professionals practiced in is the same area where they did there RHEP rotation. This could show that the healthcare professional had successful rotation at the location and was hired there upon the completion of his/her education. This could also be due to the fact that the health care professional is from the same area that individual did his/her RHEP rotation and was going to practice there anyway. Still, an RHEP rotation can lead to employment opportunities to a health care professional wishing to practice in a rural area once education is completed.

The survey of health care professionals practicing in rural areas of the state showed that approximately 40% of the time the area where health care professionals practiced in is the same area where they did there Rural Health Education Partnerships rotation.

Possible Ways to Increase Recruitment Retention of Healthcare Professionals

Consideration needs to be directed to improve the recruitment and retention of healthcare professionals to rural areas by doing such things as increasing financial incentive awards to healthcare professionals to practice in rural areas of the state. Comparatively, West Virginia's financial incentive awards are less than those of most surrounding states. For instance, West Virginia's loan repayment program pays up to $40,000 for a two year commitment to serve in a rural area, while Kentucky's pays up to $70,000 and Virginia pays $50,000 for the same time period (see Table 5).

Comparatively, West Virginia's financial incentive awards are less than those of most surrounding states.

Another way to increase the value of financial incentive awards is to make them either tax free or add additional money to the award to offset income taxes that are assessed to them. All loan repayment awards given by the loan repayment program reviewed are taxable, which can reduce there amounts by 30% to 40%, thus reducing the incentive of the recipient. The loan repayment award provided by the National Health Service Corps (NHSC), a Federal agency, includes an additional 39% of the award amount to cover income taxes. It should be noted that competition for NHSC loan repayment awards is high and there are only 550 of them given out nationwide annually.

It should be noted that although other states do pay higher financial incentive awards, it is not yet known as to the effectiveness of these programs at recruiting and retaining healthcare professionals in rural areas. PERD is continuing to research other loan repayment programs to determine their effectiveness.

Table 5 Comparison of Selected Loan Repayment Programs			
Loan Repayment Program	**Initial Contract Amount**	**Contract Extension Amount**	**Tax Status**
West Virginia	Up to $40,000 / for 2 years	Up to $25,000 / year for 3rd and 4th year	taxable
Kentucky	Up to $70,000 / for 2 years	None	taxable
Virginia	$50,000 / for 2 years	$25,000 / for each additional year	taxable
Indiana	Up to $40,000 / for 2 years	None	taxable
National Health Service Corps (Federal)	$50,000 / for 2 years + 39% of that amount to cover income taxes	$25,000 / for each additional year + 39% of that amount to cover income taxes	taxable

Conclusion

The Rural Health Advisory Panel, through its RHEP rotation program is meeting one of the goals of the overall program by providing increased availability of healthcare services throughout the state. In 2003, 674 health sciences students provide over 6,600 student weeks of service to rural areas of the state. The number of students participating in RHEP rotations as well as the number of student weeks they provide has increased over the last five years. If the RHEP rotation program is amended to not being mandatory or terminated, then a portion or all of the various services that are provided through RHEP rotations will no longer exist. Still, there has been an overall increase in the number of healthcare professionals who have completed an RHEP rotation who are now practicing in the rural areas of the state. However, it should be noted that the area where the healthcare professional is from and/or that they already planned on practicing in a rural area is a more significant factor than RHEP rotation in attracting those healthcare professionals to practice in rural areas of the state. Also, the RHEP rotation experience did play a role in providing opportunities for employment for those who chose to practice in the area where their RHEP rotation was completed. Ways to increase the recruitment and retention should be considered such as increasing financial incentive awards, making them tax free or adding money to them to cover income taxes.

Recommendations

1. The Legislative Auditor recommends the Rural Health Advisory Panel be continued.

2. The Performance Evaluation and Research Division should continue to research ways to improve the recruitment and retention of healthcare professionals in rural areas of the state.

Issue 2

There Is No Explicit Statutory Authority that Allows the Use of RHEP Funds to Purchase Fixed Assets and to Have Those Assets Titled to Non-State Entities.

Some of RHEP's funding has been used to purchase vehicles and buildings for the purpose of facilitating the RHEP program. The question arises, does RHEP's statute allow for the purchase of such items? A legal opinion from the Office of Legislative Services states that the statute does not give explicit authority to allow for such purchases, however, a liberal interpretation of the statute could allow for such purchases (see Appendix B). It should be noted that on November 17, 2003, the Rural Health Advisory Panel passed a moratorium on capital purchases. This includes the purchase of vehicles and buildings, but does not include the purchase or upgrading of computers or other information technology used for student or resident training. This also does not include the modification or upkeep of current facilities, including Learning Resources Centers and/or housing used by students and residents in training. (see Appendix C).

Another area of concern is who should hold title to such items mentioned in the above paragraph. Currently buildings and vehicles purchased with RHEP funds are being titled to entities that are not state government agencies but are related to the RHEP consortiums that use these assets. The same legal opinion also indicates that there is no explicit statutory authority allowing for such assets to be titled to non-state entities. Therefore, the Legislature may wish to clarify the relevant statute(s) to either allow or disallow the purchase of assets such as automobiles and buildings and to specify who can receive the title to such purchases. RHEP has an Addendum to the Affiliation Agreement between the West Virginia Higher Education Policy Commission and Lead Agency. The Addendum (see Appendix D) clearly provides that title to real property and equipment that is purchased with RHEP funds "shall vest in the WVRHEP Lead Agency" upon its purchase. However, despite the property being titled to the Lead Agency, the Addendum specifies an agreement that the Lead Agency must use the property as specified by the Higher Education Policy Commission as dictates in the Addendum. The Addendum also specifies how the property can be relinquished completely to the Lead Agency to be used for the Lead Agency's exclusive and unrestricted use.

The cost of these purchases have amounted to $131,614 spent on seven vehicles and $827,431 spent on nine buildings for a total of $959,045.

The cost of these purchases have amounted to $131,614 spent on seven vehicles and $827,431 spent on nine buildings for a total of $959,045 (see Table 6).

Table 6 Capital Purchases Made With RHEP Funds		
Consortium/ Lead Agency	**Vehicles**	**Buildings**
Country Roads/Monroe County Health Center (Owned by the County)	1998 Ford Windstar Wagon $25,445 in 6/98. Vehicle is titled to Monroe County Health Center Board of Trustees.	
Eastern WV RHEC/Grant Memorial Hospital (Owned by the County)	2 vehicles purchased for $27,830 total in 9/01. Vehicles are titled to Grant Memorial Hospital.	Petersburg LCR(converted to male student housing) $63,936 on 6/94. Building is on land titled to Grant County for Grant Memorial Hospital d/b/a Rural Health Program.
		Martinsburg Office Suite $200,005 on 6/01. Building is titled to Grant County Memorial Hospital d/b/a Rural Health Program.
		Petersburg Building $196,309 on 6/02, used for male student housing. Building is titled to Grant County Memorial Hospital d/b/a Rural Health Program.
		Martinsburg house $160,000 on 4/03 used for student housing (replaces 2 apartments that cost $15,200/year). Building titled to Grant County Memorial Hospital d/b/a Rural Health Program.
Little Kanawha 501(c)3 status in 1997	Vehicle purchase $22,287 in 12/00 Vehicle is titled to Little Kanawha Area Rural Health Initiative Inc.	Remodeling of donated house $19,850 in 97, used as student housing as of 2001. Building is titled to Little Kanawha Area Rural Health Initiative, Inc.
Mountain Health-Grafton/ Grafton City Hospital		Grafton building $62,834 in 9/94 used for LRC and RHEP offices. Building is titled and attached to Grafton City Hospital.
Mountain Health-Braxton/ Braxton County Hospital (owned by county)		Braxton Co. Building $99,497 in 94, used as offices, LRC and meeting rooms. Building is titled to Braxton County Building Commission and set on property owned by the said Commission.
Rural Mountain/ Rainelle Medical Center, Inc.	Vehicle purchase $24,492 in 5/03 Vehicle is titled to Rainelle Medical Center, Inc.	
Southern Counties/ Boone County Memorial Hospital		Storage building on hospital property $25,000 in 99. Building is titled to Boone County Memorial Hospital.
Western Counties/ Pleasant Valley Hospital, Inc.	Vehicle purchase $14,140 in 2/03 Vehicle titled to Pleasant Valley Hospital, Inc.	

Table 6 Capital Purchases Made With RHEP Funds		
Consortium/ Lead Agency	**Vehicles**	**Buildings**
Winding Roads/ Roane Family Health Care Center, Inc.	Vehicle purchase $17,440 in 4/02. Vehicle titled to Winding Roads Health Consortium and Family Health Center.	
TOTAL	**$131,614**	**$827,431**

Conclusion

Over the last few years, there have been purchases of automobiles and buildings for the purpose of facilitating the RHEP program. Only a liberal interpretation of the RHEP enabling statute would suggest that purchases of fixed assets are permissible. RHEP recently adopted a new policy in November 2003 that places a moratorium on the purchase of capital assets. The other area of concern brought about by these purchases is that they are being titled to the lead agency or related agency, which are not state agencies. There is no explicit statutory authority allowing non-state entities to have title to such assets. Therefore, the title to these purchases should be in the name of the appropriate state agency since the purchases were made with state funds. The Legislature should consider clarifying the RHEP enabling statute to either allow or disallow for such purchases and to specify who can receive the title to such assets.

Recommendations

3. The Legislature should consider amending §18B-16 to clarify if purchases of automobiles, buildings or similar items can be made with funding designated for rural health education and who can receive title to such assets.

4. The Rural Health Advisory Panel should no longer permit the purchasing of vehicles and buildings with funds appropriated for the Rural Health Educational Partnerships program until further clarification of statutory language is made by the Legislature.

5. All vehicles and buildings that have been purchased with funding appropriated to the Rural Health Educational Partnerships should have their titles transferred to the appropriate state agency until further clarification of statutory language is made by the Legislature.

Appendix A: Transmittal Letter

WEST VIRGINIA LEGISLATURE

Performance Evaluation and Research Division

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John Sylvia
Director

December 19, 2003

Hilda R. Heady, MSW
Executive Director
WV Rural Health Education Partnerships
1159 HSN PO Box 9003
Morgantown, WV 26505-9003

Dear Ms. Heady:

This is to transmit a draft copy of the Preliminary Performance Review of the Rural Health Advisory Panel. This report is scheduled to be presented during the January 11-13 interim meeting of the Joint Committee on Government Operations. We will inform you of the exact time and location once the information becomes available. It is expected that a representative from your agency be present at the meeting to orally respond to the report and answer any questions the committee may have.

We have scheduled an exit conference to discuss any concerns you may have with the report on January 5, 2004 at a time of your convenience. We need your written response by noon on January 7, 2004, in order for it to be included in the final report. If your agency intends to distribute additional material to committee members at the meeting, please contact the House Government Organization staff at 340-3192 by Thursday, January 8, 2004 to make arrangements.

We request that your personnel treat the draft report as confidential and that it not be disclosed to anyone not affiliated with your agency. Thank you for your cooperation.

Sincerely,

John Sylvia

John Sylvia

Joint Committee on Government and Finance

Appendix B: Legal Opinion

WEST VIRGINIA LEGISLATURE
Joint Committee on Government and Finance

Building 1, Room E-132
1900 Kanawha Boulevard, East
Charleston, WV 25305-0610
(304) 347-4800
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Aaron Allred
Legislative Manager

January 7, 2004

John Sylvia, Director
Performance Evaluation & Research Division
Building 1, Room W-314
Charleston, WV 25305

RE: Request for legal opinion regarding the Rural Health Advisory Panel.

Dear Mr. Sylvia:

This is in response to your request for a legal opinion as to the following:

- *Is there anywhere within WVC §18B-16 that allows for the purchase of capital items such as buildings and automobiles for the purpose of facilitating the Rural Health Initiative?*

In reviewing this question, it appeared to me that there were two distinct issues involved, i.e.:

- Whether the Rural Health Advisory Panel, created by WVC §18B-16-6, is authorized to expend state funds appropriated for the purposes of implementing the "Rural Health Initiative" on the purchase of capital assets, including buildings and automobiles?

and

- Whether it is permissible for the Rural Health Advisory Panel, or a Rural Health Education Partnership Consortium established under RHAP's authority, to vest title to real or personal property purchased with state funds in the names of non-state entities, such as local Lead Agencies that contract with the various rural health education partnership consortia?

I examined WVC §18B-16-1 *et seq.*, the "Rural Health Initiative of 1991," which first authorized "Rural Health Education Partnerships." The stated purpose of this legislation was to "enable the health professions schools to serve the rural and primary health care needs of the state," which, according to Legislative findings, requires a "cooperative initiative among educators, physicians, mid-level providers, allied health care providers and rural communities." (WVC §18B-16-2) To achieve this purpose, the act authorizes the establishment of "primary health care education sites," (WVC §18B-16-4) which are defined as "rural health care facilities established for

the provision of educational and clinical experiences." (WVC §18B-16-3) The Rural Health Advisory Panel and the Vice Chancellor for Health Sciences play an important role in establishing the "primary health care education sites" by analyzing prospective sites under specific criteria that are set by statute. (WVC §18B-16-6 and -7) The Panel serves in an advisory capacity to the Vice Chancellor, who then submits his recommendations to the "Board of Trustees" (now the Higher Education Policy Commission or "HEPC") which alone is authorized to establish "primary health care education sites" and to contract with each site, subject to the laws that apply to publicly funded partnerships with private, non-profit entities. (WVC §18B-16-7)

Specifically, the Vice Chancellor for Health Sciences is authorized to coordinate and approve the provision of faculty members, students, interns and residents at the sites; to prepare the budget for the rural health initiative; submit the budget to the [HEPC]; and distribute the funds which were appropriated by the Legislature for the Rural Health Initiative. Other than these powers, and the implied powers stemming from the general all-purpose legislative grant of authority to "perform such other duties as may be prescribed by [the act] or as may be necessary to effectuate the provisions of [the act]," (WVC §18B-16-5) I found no provision in the law that would explicitly authorize the purchase of capital assets such as buildings or automobiles with state funds appropriated for purposes of the Rural Health Initiative, nor did I find any explicit authority for vesting title in any property purchased with such state funds in the name of local Lead Agencies or other non-state entities.

Although it could be argued that the broad grant of authority to the Vice Chancellor to "do what is necessary to effectuate the provisions of the act" implies the power to purchase capital assets that serve in furtherance of the act's goals, I believe that the statute should be amended to provide explicitly for this authority and to provide for the proper vesting of title to such property with the appropriate state agency or a consortium partner, so long as contractual provision is made for the proper use and disposition of the property, as approved by the HEPC. I expect such an amendment would also set forth the particulars needed to provide for appropriate maintenance and upkeep of property, adequate insurance coverage, and reversion of title to the appropriate state agency in the event that the property will no longer be used for the Rural Health Initiative, or other permissible disposition.

Please let me know if you have questions or concerns about this matter.

Sincerely,

Susan K. Coghill
Attorney, Legislative Services

Appendix C: Policy and Procedures

West Virginia Rural Health Education Partnerships

Policy and Procedures

Title of Policy:	Purchase of Capital Assets
Formulated By:	Executive Director, WVRHEP Finance Committee
Approved By:	WVRHEP Advisory Panel
Approved Date:	November 17, 2003
Effective Date:	November 17, 2003
Implementation Responsibility:	Lead Agency Administrators Site Coordinators
Oversight Responsibility:	Executive Director, WVRHEP WVRHEP Fiscal Officer and Finance Committee

Policy Statement:

The program has made every attempt to follow state guidelines concerning the operation of the program including the acquisition and depreciation of capital assets to further the mission of the partnership. In the absence of state guidelines, federal guidelines have been followed, particularly concerning the depreciation of capital assets. Due to the financial crisis in the state and until further notice, no consortium will be permitted to make capital purchase with RHI funds. This includes the purchase of vehicles and building, but does not include the purchase or upgrading of computers or other information technology used for student or resident training. This also does not include the modification or up keep of current facilities, including Learning Resources Centers and/or housing used by students and residents in training.

This policy will remain in effect until further action is taken by the Panel.

J. Michael Mullen MSW Chancellor, Higher Education Policy Commission	Hilda R. Heady, Executive Director WVRHEP

Appendix D: Affiliation Agreement

WEST VIRGINIA RURAL HEALTH EDUCATION PARTNERSHIPS
ADDENDUM TO THE AFFILIATION AGREEMENT
BETWEEN THE
WEST VIRGINIA HIGHER EDUCATION POLICY COMMISSION
AND
Lead Agency / 501c3
a representative of the
WVHREP Consortium

I. Insurance coverage - The WVRHEP Lead Agency shall, at a minimum, provide proof of equivalent insurance coverage for real property and equipment acquired with WVRHEP funds as provided to property owned by the WVRHEP Lead Agency.

II. Real property – The Higher Education Policy Commission shall prescribe requirements for the WVRHEP Lead Agency concerning the use and disposition of real property acquired in whole or in part under awards. Unless otherwise provided by statute, such requirements, at a minimum, shall contain the following:

A. Title to real property shall vest in the WVRHEP Lead Agency subject to the condition that the WVRHEP Lead Agency shall use the real property for the authorized purpose of the project as long as it is needed and shall not encumber the property without approval of the Higher Education Policy Commission.

B. The WVRHEP Lead Agency shall obtain written approval by the Higher Education Policy Commission for the use of real property in other federally or state sponsored projects when the WVRHEP Lead Agency determines that the property is no longer needed for the purpose of the original project.

C. When the real property is no longer needed as provided in paragraphs (A) and (B), the WVRHEP Lead Agency shall request disposition instructions from the Higher Education Policy Commission. The Higher Education Policy Commission shall observe one or more of the following disposition instructions.

1. The WVRHEP Lead Agency may be permitted to retain title without further obligation to the Higher Education Policy Commission after it compensates the Higher Education Policy Commission for that percentage of the current fair market value of the property attributable to Higher Education Useful Life.

2. The WVRHEP Lead Agency may be directed to sell the property under guidelines provided by the Higher Education Policy Commission and pay the Higher Education Policy Commission for that percentage of the current fair market value of the property attributable to Higher Education Useful Life (after deducting actual and reasonable selling and fix-up expenses, if any, from the sales proceeds). When the WVRHEP Lead Agency is authorized or required to sell the property, proper sales procedures shall be established that provide for competition to the extent practicable and result in the highest possible return.

3. The WVRHEP Lead Agency may be directed to transfer title to the property to the Higher Education Policy Commission or to an eligible third party provided that, in such cases, the WVRHEP Lead Agency shall be entitled to compensation for its attributable percentage of the current fair market value of the property.

WEST VIRGINIA RURAL HEALTH EDUCATION PARTNERSHIPS
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a representative of the
WVHREP Consortium

III. Equipment

A. Title to equipment acquired by a WVRHEP Lead Agency with WVRHEP funds shall vest in the WVRHEP Lead Agency, subject to conditions of this section.

B. The WVRHEP Lead Agency shall not use equipment acquired with WVRHEP funds to provide services to non-WV State outside organizations for a fee that is less than private companies charge for equivalent services, unless specifically authorized by WV State Code, for as long as the Higher Education Policy Commission retains an interest in the equipment.

C. The WVRHEP Lead Agency shall use the equipment in the project or program for which it was acquired as long as needed, whether or not the project or program continues to be supported by the Higher Education Policy Commission and shall not encumber the property without approval of the Higher Education Policy Commission. When no longer needed for the original project or program, the WVRHEP Lead Agency shall use the equipment in connection with its other state-sponsored activities, in the following order of priority:

1. Activities sponsored by the Higher Education Policy Commission which funded the original project, then
2. Activities sponsored by other State agencies.

D. During the time that equipment is used on the project or program for which it was acquired, the WVRHEP Lead Agency shall make it available for use on other projects or programs if such other use will not interfere with the work on the project or program for which the equipment was originally acquired. First preference for such other use shall be given to other projects or programs sponsored by the Higher Education Policy Commission that financed the equipment; second preference shall be given to projects or programs sponsored by other State agencies.

E. When acquiring replacement equipment, the WVRHEP Lead Agency may use the equipment to be replaced as trade-in or sell the equipment and use the proceeds to offset the costs of the replacement equipment subject to the approval of the Higher Education Policy Commission.

F. The WVRHEP Lead Agency's property management standards for equipment acquired with Higher Education Policy Commission funds shall include all of the following.

1. Equipment records shall be maintained accurately and shall include the following information:

a. A description of the equipment.

b. Manufacturer's serial number, model number, or other identification number.

c. Source of the equipment, including the award number.

d. Whether title vests in the WVRHEP Lead Agency or the Higher Education Policy Commission.

e. Acquisition date and cost.

f. Information from which one can calculate the percentage of Higher Education Policy Commission participation in the cost of the equipment (not applicable to equipment furnished by the Higher Education Policy Commission).

g. Location and condition of the equipment and the date the information was reported.

h. Unit acquisition cost.

i. Ultimate disposition data, including date of disposal and sales price or the method used to determine current fair market value where a WVRHEP Lead Agency compensates the Higher Education Policy Commission for its share.

2. A physical inventory of equipment shall be taken and the results reconciled with the equipment records at least once every two years. Any differences between quantities determined by the physical inspection and those shown in the accounting records shall be investigated to determine the causes of the difference. The WVRHEP Lead Agency shall, in connection with the inventory, verify the existence, current utilization, and continued need for the equipment.

3. A control system shall be in effect to insure adequate safeguards to prevent loss, damage, or theft of the equipment. Any loss, damage, or theft of equipment shall be investigated and fully documented; and the WVRHEP Lead Agency shall promptly notify the Higher Education Policy Commission.

4. Adequate maintenance procedures shall be implemented to keep the equipment in good condition.

5. Where the WVRHEP Lead Agency is authorized or required to sell the equipment, proper sales procedures shall be established which provide for competition to the extent practicable and result in the highest possible return.

G. When the WVRHEP Lead Agency no longer needs the equipment, the equipment may be used for other activities in accordance with the following standards. For equipment with a current per unit fair market value of $5000 or more, the WVRHEP Lead Agency may retain the

equipment for other uses provided that compensation is made to the Higher Education Policy Commission or its successor. The amount of compensation shall be computed by applying the percentage of WVRHEP participation to the cost of the original project or program. If the WVRHEP Lead Agency has no need for the equipment, the WVRHEP Lead Agency shall request disposition instructions from the Higher Education Policy Commission. The Higher Education Policy Commission shall determine whether the equipment can be used to meet the agency's requirements. If no requirement exists within that agency, the availability of the equipment shall be reported by the Higher Education Policy Commission to determine whether a requirement for the equipment exists in other State agencies. The Higher Education Policy Commission shall issue instructions to the WVRHEP Lead Agency no later than 120 calendar days after the WVRHEP Lead Agency's request and the following procedures shall govern.

1. If so instructed or if disposition instructions are not issued within 120 calendar days after the WVRHEP Lead Agency's request, the WVRHEP Lead Agency shall sell the equipment and reimburse the Higher Education Policy Commission an amount computed by applying to the sales proceeds the percentage of WVRHEP participation in the cost of the original project or program. However, the WVRHEP Lead Agency shall be permitted to deduct and retain from the Higher Education Policy Commission share $500 or ten percent of the proceeds, whichever is less, for the WVRHEP Lead Agency's selling and handling expenses.

2. If the WVRHEP Lead Agency is instructed to ship the equipment elsewhere, the WVRHEP Lead Agency shall be reimbursed by the Higher Education Policy Commission by an amount which is computed by applying the percentage of the WVRHEP Lead Agency's participation in the cost of the original project or program to the current fair market value of the equipment, plus any reasonable shipping or interim storage costs incurred.

3. If the WVRHEP Lead Agency is instructed to otherwise dispose of the equipment, the WVRHEP Lead Agency shall be reimbursed by the Higher Education Policy Commission for such costs incurred in its disposition.

4. The Higher Education Policy Commission may reserve the right to transfer the title to the Higher Education Policy Commission or to a third party named by the Higher Education Policy Commission when such third party is otherwise eligible under existing statutes. Such transfer shall be subject to the following standards.

a. The equipment shall be appropriately identified in the award or otherwise made known to the WVRHEP Lead Agency in writing.

b. The Higher Education Policy Commission shall issue disposition instructions within 120 calendar days after receipt of a final inventory. The final inventory

shall list all equipment acquired with grant funds and federally-owned equipment. If the Higher Education Policy Commission fails to issue disposition instructions within the 120 calendar day period, the WVRHEP Lead Agency shall apply the standards of this section, as appropriate.

c. When the Higher Education Policy Commission exercises its right to take title, the equipment shall be subject to the provisions for State owned equipment.

IV. **Property trust relationship** - Real property, equipment, intangible property and debt instruments that are acquired or improved with Higher Education Policy Commission funds shall be held in trust by the WVRHEP Lead Agency as trustee for the beneficiaries of the project or program under which the property was acquired or improved. HEPC may require WVRHEP Lead Agencies to record liens or other appropriate notices of record to indicate that personal or real property has been acquired or improved with Higher Education Policy Commission funds and that use and disposition conditions apply to the property.

APPROVED:

WEST VIRGINIA HIGHER EDUCATION POLICY COMMISSION

By:_____
J. Michael Mullen, PhD
Chancellor

Date:_____

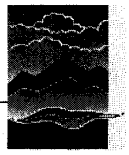
Lead Agency/501c3

By:_____
Name,
Lead Agency Administrator/Board Chairman

Date:_____

Appendix E: Agency Response

West Virginia Rural Health Education Partnerships:
The Vision for Rural Health Education in West Virginia



Memorandum

To: **John Sylvia, Director, PERD**
Brian Armentrout

From: **Hilda R. Heady, Executive Director, WVRHEP**

Date: **January 7, 2004**

Re: **WVRHEP written response to 2003 PERD Report**

In preparing our response to the drafted 2003 PERD report on WVRHEP sent via e-mail on December 19, I want to thank the PERD staff for their diligence and objectivity in this effort. Overall we feel the report is positive and reflects the information we have sent you in response to your questions. As the agency representative, I would like to share some general observations with you prior to making specific comments to the issues in the report. Our responses are supported by three pieces of research: (1) the WWVRHEP Graduate Survey conducted in the fall of 2003; (2) the Student Evaluation of Rural Field Experience (SERFE) which is completed by trainees following their rotations and is part of the on-going program evaluation; and (3), the financial incentives study conducted in 2001 and published this year in the national Journal of Rural Health.[1]

1. The independent survey done by PERD is enhanced by the data from the survey completed by WVRHEP of the same population of health care professionals. WVRHEP surveyed 341 individuals with a response rate of 56%. The WVRHEP Graduate survey received IRB approval[2], included more questions, and explored more variables than did the PERD survey.
2. Given the health outcomes and shortage problems we face here in WV, we have to combine strategies and do all that we can at all levels of the health professions training pipeline to maximize our opportunities for training, recruiting, and retaining our own graduates. This pipeline begins with health careers programs in secondary school through the Health Sciences and Technology Academy and similar programs and follows through to supporting health professionals in rural practice. While WVRHEP represents just one part of this pipeline addressing these chronic problems, it is a strategic and critical part of the state's pipeline.
3. WVRHEP is an infrastructure specifically built for the community-based training of health professionals. In the early '90's it was physically impossible for rural providers to accommodate large numbers of health professions students. Both Marshall and WVU maintain rural clinician support programs, however, these programs had and continue to have modest enrollment. WVRHEP is a partnership of communities and health professionals' schools and as such is part of our higher education system. This part of our higher education system now handles 600 to 700 students per year.
4. WVRHEP is a combination of educational strategies applied throughout the pipeline. These strategies result in health care providers who: a) are interested in rural practice, b) have the skills and abilities needed by the patients in greatest need, c) aren't afraid of rural practice, d) aren't overly encumbered by loans and financial concerns; and, e) are continually supported to stay in rural practice.

[1] Jackson J., Shannon, C.K, Pathman, D.E., Mason, E., Nemitz, JW, "A Comparative Assessment of West Virginia's Financial Incentive Programs for Rural Physicians", Journal of Rural Health, Vol. 19, No. 5, Supplemental 2003 329-339.
[2] IRB means Institutional Review Board and is a process to review and approve research plans. The review is designed to protect research subjects and assure that the approach meets research standards and is in compliance with federal regulations.

From our survey of graduates, our student evaluations (SERFE) and our own experience over the past 11 years, what is clear is that we are encouraging more WV graduates into primary care, even at a time when national trends are going down AND even during our own malpractice crisis. We are also instilling more confidence in those physicians who go into rural practice because they see more of the realities of rural practice.

The state needs to do more, however, to get more medical residents to complete rural rotations, and develop more rural residency tracks within our existing primary care residency programs.

In summary, education and training, and certainly rural rotations represent just one piece of the puzzle in finding solutions to this problem. Economic development, medical liability issues, and a host of personal issues impact recruitment and retention at all times. To achieve this mission for the state, we cannot limit our view to singular solutions to our chronic shortages. We must invest in all health profession disciplines, in medical school level training, and in residency level training.

From the PERD draft: "Issue 1 Rural Rotations of Health Sciences Students Increased Healthcare Resources in Rural Areas of the State, but Rural Rotations Have a Modest Impact in Encouraging Students to Establish Their Practices in Rural Areas."

The WVRHEP data indicates that the rural rotations have had more than a modest impact in encouraging students to go into rural practice. WVRHEP wishes all reviewers to note that students have to be attracted to both primary care and rural practice to succeed in recruiting an individual to serve the rural poor. Further, there is a complex pathway leading to a life-long career in rural underserved areas and the state needs strategies that intersect this pathway at many points. We respectfully submit that WVRHEP data supports these conclusions:

- **WVRHEP changes the ways in which students view primary care and rural practice.**
- **WVRHEP has influenced career decisions of those who complete rural rotations even during a period consumed by negative publicity regarding West Virginia's medical liability and reimbursement issues.**
- **WVRHEP may also increase the retention of rural practitioners by assisting isolated rural practitioners to maintain academic affiliations through their role as a preceptor.**

WVRHEP maintains an evaluation team consisting of members from Marshall University, the West Virginia School of Osteopathic Medicine, and West Virginia University. The WVRHEP Evaluation Team regularly surveys WVRHEP participants to gather program evaluation and policy development information. This Team routinely reviews student rotation evaluation data, makes improvements to TRACKER (the WVRHEP database), and develops all surveys and research survey plans that are submitted to a participating school's Institutional Review Board for approval. The WVRHEP Evaluation Team has measured the impact of rural rotations on the career decisions (i.e., recruitment) of health sciences students primarily in two ways:

1. Students are requested to complete an evaluation of each WVRHEP rotation. This evaluation is referred to as the *Student Evaluation of Rural Field Experience (SERFE).* The question that probably best assesses the impact of WVRHEP on career decisions is the question: "Did your rotation increase, decrease, or leave unchanged your interest in rural health?" Following is a table that depicts two years of medical student responses to this question:

Time Period and number of trainees responding	Medical student response to: "Did your rotation increase, decrease, or leave unchanged your interest in rural health?"		
	Increased	Left Unchanged	Decreased
July 1 - Dec. 31, 2001 n = 168	38%	58%	4%
Jan. 1 – June 30, 2002 n= 163	39%	56%	5%
July 1 – Dec. 31, 2002 n = 178	29%	62%	9%
Jan. 1 – June 30, 2003 n = 196	32%	62%	6%

2. In August 2003, the WVRHEP Evaluation Team initiated a 17-question survey (several questions multi-part) of all WVRHEP graduates known to be in rural practice as of July 2003. The survey consisted of a mailing followed by phone calls to non-responding practitioners and a re-mailing of the survey and cover letter at their request *or* the completion of the survey over the phone preceded by a script approved by the IRB. The Director of Research trained all the personnel who conducted the follow-up phone calls. The WVRHEP Graduate Survey had 192 out of 341 surveys returned, a response rate of 56%. Of the 192 respondents, 47 were physicians. The survey results indicate that:

   - WVRHEP is making an impact on those health professionals who have not finalized their practice decision. Thirty-one percent of the respondents said that their commitment to rural practice was solidified by their WVRHEP experience. While 58% of all health professions stated they had already decided to go into rural practice, 42% decided to go into rural practice influenced in part by their WVRHEP training experiences.
   - WVRHEP rotation may have a greater impact on location of practice than did the location of the practitioner's hometown. The WVRHEP Graduate Survey found that only 22 of the 47 physician-respondents or **47%** are practicing in the same county or an adjoining county to where they completed high school whereas **64%** (30 of the 47 physicians) are practicing in the same county or adjoining county to where they completed an WVRHEP rotation.
   - Only 3 or 10% of the 29 physicians who did a rural residency rotation are practicing in a county (or adjoining county) other than one of their WVRHEP counties, i.e., *26 of the 29 residents who did a rural residency rotation went back to a county where they did an WVRHEP rotation.*
   - A statistically significant correlation exists between greater time in practice and being an WVRHEP preceptor, therefore precepting students may have an impact on retention of rural practitioners.

Results from the WVRHEP Graduate Survey:
Factors Determining the Decision to Practice in a Rural Area

	Percentage Responding		
Response	Physicians* (number of answers)	Other Health Sciences Professionals** (number of answers)	All Health Science Professions (number of answers)
I was committed to rural practice before I began my health professions program.	**68% (32)**	**55% (80)**	**58% (112)**
I would **not** be in rural practice today if I had not had the WVRHEP (or RHI/Kellogg) experience	**4% (2)**	**10% (14)**	**8% (16)**
My commitment to rural practice was solidified by my WVRHEP (or RHI/Kellogg) experiences.	**23% (11)**	**34% (49)**	**31% (60)**

***Includes Medical Doctors (MDs) and Doctors of Osteopathy (DOs), also 8 respondents selected more than one of the survey choices.**
****Includes Nurse Practitioners, Physician Assistants, Dentists, Dental Hygienists, Pharmacists and Physical Therapists.**

Counties covered by the WVRHEP program

The RHI Act and current WVRHEP policy prohibits WVRHEP rural rotations in larger non-underserved cities. The intent of this is to appropriately inhibit students from completing rural rotations in areas that are not underserved and from doing rotations similar to their current training on campus and in teaching hospitals. We encourage the legislature to provide guidance to the Rural Health Advisory Panel on site designation. Counties acceptable for WVRHEP placements should not be decided purely on geography, rather on need. The intent of WVRHEP is to increase both the number and quality of practitioners serving those West Virginians with greatest need in underserved rural areas of the state. To this end, continued local control by WVRHEP Consortia Boards is essential to meet regional needs.

The WVRHEP Schools Committee is actively reviewing the criteria for WVRHEP site selection and is expected to complete their recommendations for the Rural Health Advisory Panel by July 2004. On November 17, 2003, the following drafted list was developed: 1) Federal Medically Underserved Area (MUA) or Health Professional Shortage Area (HPSA); 2) quality of student placements; 3) sites serving vulnerable populations (i.e.: developing sites at Free Clinics and Local Health Departments statewide); 4) areas with difficulty recruiting particular types of providers (i.e.: WVRHEP consortia boards could request adjustments in the mix of student placements); 5) sites away from the traditional university teaching setting; and, 6) different types of practice (i.e.: solo providers, group practices, community clinics, home care, etc).

Table 2 in the PERD draft shows the numbers of rotations by county. While there are some counties excluded from the WVRHEP program in the past (Brooke, Doddridge, Hancock, Mercer, Wetzel and Wood) these counties were excluded for one or more of these reasons:

1. Some of these counties are not designated as health professions shortage areas or have fewer partial areas so designated
2. The number of rural counties that have few or no rotations recorded are counties that do not have preceptors willing to take students, and/or
3. The leadership in these counties did not respond to the solicitation to participate when the program first began.

In November 2003, the Little Kanawha Area Consortium Board requested that Doddridge County be included as part of that consortium. Further, in 2003, both Mercer and Wetzel Counties were added to the WVRHEP counties by other consortium boards. The WVRHEP Program now covers 50 of 55 rural counties through community service, community based research and interdisciplinary training. It should also be noted that in these more rural counties, for example Doddridge, trainee led community service projects have been completed in these counties even though clinical rotations might not occur in those counties. This notwithstanding, the program does continue to struggle with the challenge of increasing the number of clinical rotations in the more rural counties with modest preceptor resources.

Services Provided By WVRHEP Rotations

The PERD report notes that the WVRHEP rotations provide a myriad of health care services that are focused towards the development of effective health promotion and disease prevention. These services include a broad range of services and average over 100,000 participants per year. WVRHEP began tracking these services in 1995-96 and since that time a total of 865,857 rural West Virginians have been served in these programs. Also since 1995, WVRHEP has tracked dental services and the cost of these services performed by dental students and dental hygienists. Since then, these trainees have provided over $6 million in uncompensated care. In 2003 WVRHEP began tracking these services by the West Virginia Healthy People 2010 Objectives addressed by the trainee provided services.

Examples of these services include the CARDIAC project, health screenings of cholesterol, blood sugar, osteoporosis, far analysis, and blood pressure. WVRHEP agrees with these statements from the PERD report, "Future physicians and other health care professionals get the chance to experience working in rural areas and confront different challenges that exist in that environment. If this program were amended to not being mandatory for all health sciences students or terminated altogether, the students participating in the WVRHEP rotations would most likely be attending classes on campus or doing internships. More notably, the health care services provided by the WVRHEP rotations would be either reduced or no longer exist." The chart below indicates the numbers of rural people served by trainees over the past academic year.

Community Services Provided by WVRHEP Students June 1, 2002 to May 31, 2003

Consortium and Counties Served	General Public	Adults	Children	Total
Kanawha Valley Health Consortium (Underserved areas of Kanawha)	1,704	1,432	4,761	7,897
Cabwaylingo Health Education Consortium (Cabell, Wayne and Lincoln)	2,220	12	242	2,474
County Roads Consortium (Summers and Monroe)	652	1,317	1,692	3,661
Eastern WV Rural Health Education Consortium (Grant, Hardy, Hampshire, Mineral, Pendleton and Tucker)	4,123	1,716	8,713	14,552
(Berkeley, Jefferson and Morgan)	4,169	1,318	2,665	8,152
Little Kanawha Area Consortium Calhoun, Ritchie, Gilmer, Pleasants, Tyler and Wirt)	1,438	734	3,999	6,171
Mountain Health Consortium (Barbour, Lewis, Randolph and Upshur)	2,408	1,389	4,068	7,865
(Braxton and Clay)	3,085	234	5,306	8,625
(Taylor, Harrison, Preston and Marion)	10,115	1,126	6,787	18,028
Rivers and Bridges Consortium (Fayette and Raleigh)	1,465	1,513	4,119	7,097
Rural Mountain Consortium (Greenbrier and Pocahontas)	2,539	427	916	3,882
Rural Ohio Valley Education Resources (ROVER) Consortium (Marshall and Ohio)	404	2,329	5,430	8,163
Southern Counties Consortium (Boone and Logan)	464	12	24	500
(McDowell, Mingo and Wyoming)	200	117	607	924
Webster-Nicholas Education Consortium (Webster and Nicholas)	188	99	722	1,009
Western Counties Consortium (Lincoln, Mason, Putnam, Wayne and rural portions of Cabell)	5,344	1,328	4,684	11,356
Winding Roads Health Consortium (Roane and Jackson)	6,051	2,726	4,888	13,665
Total	**46,569**	**17,829**	**59,623**	**124,021**

Possible Ways to Increase Recruitment Retention of Healthcare Professionals

In response to findings in this section, the WVRHEP Recruitment and Retention Committee offers its support to PERD in continuing to research the effectiveness of loan repayment programs and other financial incentives for rural practice. This is an issue the Committee has studied in coordination with the Division of Recruitment, Bureau for Public Health, which administers the State Loan Repayment Program, and WVRHEP staff who conducted an in-depth study of West Virginia financial incentive programs. These programs play a key role in recruitment and retention – 41 percent of the state's physician graduates, 1991-2000, in rural areas of the state received one or more state financial incentives. All the partners recognize the importance of making these awards more competitive. The first step, increasing the $10,000 rural scholarship for medical students to $20,000 under the Health Sciences Scholarship Program, was authorized by the Legislature in 2002.

For several years, the State Loan Repayment Program (SLRP) has had only $200,000 in annual funding, including a 50% match from the National Health Service Corps (NHSC). The Division of Recruitment offers up to $40,000 in loan repayment for 2 years of service, so only 4 to 6 awards can be made each year. This year, the Division expanded the program to $300,000 by identifying an additional $50,000 in state matching funds. This expansion may add 3 to 4 more awards. The Division has made additional awards for loan repayment ($20,000 for one year) under the Recruitment and Retention Community Project, which is state funded and requires a 50% local match. *The demand for both these programs exceeds current funding levels.*

There are two important issues to consider regarding financial incentives offered through the State Loan Repayment Program:

(1) *Awards to offset the tax obligation.* Although the Division and the Recruitment and Retention Committee have discussed this option, it was determined that, unless additional state funds can be dedicated to loan repayment, this would further reduce the number of awards to rural providers. The NHSC stipulates that *only state funds* can be used to offset tax obligations on State Loan Repayment Programs, not federal matching funds. It should also be pointed out that awards to offset tax obligations are taxable by the Internal Revenue Service.

(2) *Increasing the amount of loan repayment.* The NHSC stipulates that under the State Loan Repayment Program, the maximum amount of loan repayment a state can offer is $35,000 per year (e.g., Kentucky offers $70,000 for 2 years). A higher amount can be made in high-need shortage areas, but the excess funds must be paid from *non-federal sources*. The NHSC further requires that "SLRP contracts cannot be provided on terms that are more favorable... than the most favorable terms... under the federal NHSC Loan Repayment Program."

Response to Conclusion Section to Issue 1:

Sentence 6 of the Conclusion of the PERD Report states, "However, it should be noted that the area where the healthcare professional is from and/or that they already planned on practicing in a rural area is a more significant factor than WVRHEP rotation in attracting those healthcare professionals to practice in rural areas of the state." As stated above, only 22 of the 47 physicians or 47% are practicing in the very county or an adjoining county where they completed high school. Additionally, 58% of all respondents said that they were "committed to rural practice before I began my health professions program", leaving 42% of the rural practitioners who were NOT committed to rural practice before their health profession program.

The conclusions about any programs influencing R&R in this state are overshadowed by factors unmentioned here, particularly for physicians – those affecting the practice climate in this state (malpractice insurance, reimbursement, etc.). Thus, any conclusions should be cautious, knowing that these unmentioned and unknown factors are not measured. Those that are measured in evaluations of programs such as WVRHEP still remain influenced by these unknowns.

Recommendation

1 The Legislative Auditor recommends the Rural Health Advisory Panel be continued.

2 The Performance Evaluation and Research Division should continue to research ways to improve the recruitment and retention of healthcare professionals in rural areas of the state.

WVRHEP agrees with these recommendations and would like to add: PERD is welcomed as an active participant in researching ways to improve health professional recruitment and retention. The best forum might be the already constituted Recruitment and Retention Committee within the WVRHEP structure, charged in statue to over see such activities. This Committee is made up of state agencies, rural providers, and others who meet regularly to discuss policy issues and programs administering financial incentive programs, rural rotations, and graduate medical education issues. PERD staff would be welcomed to this committee and/or attend and contribute as actively as is appropriate for their investigative role. At a minimum, PERD is welcomed to be on the WVRHEP and Recruitment and Retention Committee mailing list.

The WVRHEP Partners and PERD have the capacity to do more definitive surveys on the factors that influence rural choice. One survey could include a cross-section of WVRHEP graduates, both urban and rural practitioners that may allow better isolation of those factors that have predicted for rural choice. Other joint initiatives could include; an investigation of community health and/or economic benefits of WVRHEP; a comparative study of retention for WVRHEP preceptors; community efforts in recruitment; and relative influence of factors affecting retention in rural WV.

Issue 2: There is no explicit statutory authority that allows the use of WVRHEP funds to purchase fixed assets and to have those assets titled to non-state entities.

WVRHEP agrees that there is no provision in statute which allows for the purchase of fixed assets, however, there is no prohibition in statute as to items that may be purchased with RHI funds. Rather, the statute allows discretion with the Vice Chancellor developing budgets that are approved by the Higher Education Policy Commission (HEPC) and the Finance Committee of the Rural Health Advisory Panel, discretion permitted in the statute. It is on the basis of this discretion and in the face of level and decreased funding since 1995 that fixed assets were allowed as a means to use the state funds as economically prudent as possible to best meet the mission of the RHI Act. As noted in the PERD report, the Rural Health Advisory Panel passed a policy on November 17, 2003 to address this issue. (Appendix C)

In the RHI Act the Legislature intended this to be a "cooperative initiative" [WV Code 18B-16-2(d) & (e)] to provide "increased use of underserved areas of the state in the educational process" [WV Code18B-16-4(k)] The Rural Health Advisory Panel and its WVRHEP Partnership represents an effort to provide maximum higher education opportunities of high quality to the state in the most economical manner.

The Act does make clear the role of the lead agencies as contractors for the purposes of providing training opportunities in rural communities for health professional trainees. As contractors, lead agencies adhere to policies of the Rural Health Advisory Panel regarding the use and management of these funds. The manner in which the original budgets were constructed, and subsequently revised, identified specific components only as a way to test the adequacy and fairness of the distribution of funds. The beauty of the WVRHEP program, as it was originally conceived, was to construct partnerships drawing on the unique resources of each partner. WVRHEP was also designed to provide assistance to the local partners, which it does, both financially and from a manpower perspective.

Each year, HEPC enters into affiliation agreements as contracts with the lead agencies of each WVRHEP consortia. The affiliation agreements include the granting of state funds for the express purpose of contracting with these entities to implement the program. These affiliation agreements also

include addenda that list all current assets for each consortium. Each addendum clearly outlines the depreciation schedule and the method of transfer of property should a lead agency elect to discontinue with the program.

Building and maintaining a statewide network to support the training of all state supported health professions students requires the wise and prudent use of resources to house trainees, provide learning space, and facilitate the learning of these students. Community based lead agencies and community members take very seriously their role to support these trainees and to make the best use of state funds for this purpose. On this issue, rural community leaders and agency administrators have worked together to best use dwindling state resources to meet the mission of the Act. The lead agencies have viewed their relationship to the state funded WVRHEP program as a contractor. The following sections of the RHI Act are used as policy guidance concerning this issue:

- 18B-16-7 [ESTABLISHMENT AND OPERATION OF PRIMARY HEALTH CARE EDUCATION SITES]
- 18-5-3 [AUTHORITY TO CONTRACT FOR PROGRAMS SERVICES AND FACILITIES]

Table 6 in the PERD report draft lists all the vehicle and building purchases made to implement the program. This is information provided to PERD by the WVRHEP program staff. The total figure of $861,078 should be reduced by the purchases made with Kellogg grant funds in the early years of the program. This should be viewed as donations to the state rather than expenses to the state. Therefore the $33,647 used for the LRC, offices and student housing in Winding Roads should not be included in this total figure resulting in a total of $827,431.

Recommendations

3 The Legislature should consider amending '18B-16 to clarify if purchases of automobiles, buildings or similar items can be made with funding designated for rural health education.

4 The Rural Health Advisory Panel shall no longer permit the purchasing of vehicles and buildings with funds appropriated for the Rural Health Educational Partnerships program until further clarification of statutory language is made by the Legislature. [3]

5 All vehicles and buildings that have been purchased with funding appropriated to the Rural Health Educational Partnerships shall have their titles transferred to the appropriate state agency.

[3] The Rural Health Advisory Panel passed WVRHEP Policy 2003-05 on November 17, 2003 establishing a moratorium on fixed asset purchases until this issue is resolved.