

California Healthcare Workforce Policy Commission (CHWPC)

400 R Street, Room 468

Sacramento, CA 95811

Wednesday, May 29, 2013

Call to Order: 8:35 a.m.

Adjourned: 2:50 p.m.

COMMISSION MEMBERS PRESENT	COMMISSION MEMBERS ABSENT
Rosslynn Byous, DPA, PA-C Elizabeth Dolezal - Chair Kathyann Marsh, RN, MSN Tracey Norton, DO Andrea Renwanz-Boyle, Ph.D., RN-BC Deborah Rice, MN, RN, FNP-C– Vice Chair Mario San Bartolome, MD, MBA Katherine Townsend, Ed.D., MSN Ashby Wolfe, MD, MPP, MPH	William Henning, DO Laura Lopez Angie Millan, RN, MSN, FAAN Cathryn Nation, MD Bonnie Wheatley, Ed.D., MPH, MA
	STAFF TO COMMISSION PRESENT
	Lupe Alonzo-Diaz, M.P.Aff Liz Martin Manuela Lachica Melissa Omand Barbara Zendejas
	ADDITIONAL OSHPD STAFF
	Robert P David Elizabeth Wied Debra Gonzalez

ITEM NUMBER	TOPIC	DISCUSSION	ACTION ITEM OR DISCUSSION
1.	Call to Order	Meeting called to order at 8:35am	
2.	Introduction of CHWPC	Each member of the CHWPC introduced themselves, indicated whom they statutorily represent and which government authority appointed them.	
3.	Chair Remarks	Chair Dolezal gave a brief overview on the agenda for the Policy meeting and emphasized the California Endowments' positive impact on Song-Brown, the Request For Application (RFA) and Evaluation Criteria for Family Practice (FP) and Family Nurse Practitioner/Physician Assistant (FNP/PA) Special Programs, and CalREACH.	
4.	Approval of February 12 th -13 th , 2013 Minutes	February 12th-13th, 2013 minutes are hereby incorporated as Attachment A	Motion made (Wolfe) and seconded (Townsend) to approve the February 12-13, 2013 minutes as presented.

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5.	OSHPD Director's Report	<p>Director David reported on the following items in the Director's Report:</p> <p><u>Affordable Care Act:</u> Director David stated the main emphasis for California at this time is the implementation of the Affordable Care Act with a great focus on the healthcare workforce. Director David will look heavily to the recommendations made by the CHWPC to help align with OSHPD's direction regarding primary care workforce development.</p> <p><u>May Revise:</u> In the Governor's May Revision, the Legislature approved the grant for the California Endowment for \$52 Million over three years for OSHPD's health care workforce programs.</p>	
6.	Executive Secretary's Report	<p>Ms. Lupe Alonzo-Diaz, M.P. Aff., Deputy Director of the HWDD reported on the following items in the Executive Secretary's Report.</p> <p><u>The California Endowment</u> The Endowment has expressed interest in funding the Song-Brown program and the Health Professions Education Foundation. The Grant proposal is expected to be submitted to their November 19th and 20th board meeting. They are interested in funding Song-Brown for three (3) years at \$7 million per year. For year one (FY 2013), \$3.5 million for Base and Capitation funding and \$3.5 million for Special Programs. Priority for funding the first year goes to Family Practice, Family Nurse Practitioner and Physician Assistants. The California Endowment has four parameters: career pathways, underserved communities, technology, and the 14 Building Healthy Communities.</p> <p><u>CalREACH</u> June 28th is the Go Live date for Song-Brown funded programs.</p>	

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6.	Executive Secretary's Report	<p><u>Healthcare Workforce Pilot Project (HWPP)</u> California Emergency Medical Services Authority (ESMA) is interested in submitting an application under the HWPP to test expanded skill sets for paramedics.</p>	
7.	Approval of Medical Service Study Area Reconfiguration	<p>Debra Gonzalez, GIS Specialist for the Healthcare Workforce Development Division presented Medical Service Study Area (MSSA) re-configurations for the counties of Imperial, Kern, Los Angeles, Orange, Riverside, San Bernardino, Marin, Monterey, San Diego, San Mateo, and Alameda for approval by the Commission.</p> <p>MSSA re-configurations are hereby incorporated as Attachment B</p> <p>Ms. Gonzalez also presented the annual Primary Care Shortage Areas (PCSA) and the Registered Nurse Shortage Areas (RNSA) annual update.</p> <p>PCSA annual update is hereby incorporated as Attachment B.1 RNSA annual update is hereby incorporated as Attachment B.2</p>	<p>Motion (Townsend) to adopt the MSSA re-configurations as presented, and seconded (Norton)</p> <p>Motion (Townsend) to adopt PCSA annual updates and seconded (Byous)</p> <p>Motion (Townsend) to adopt annual RNSA updates and seconded (Marsh)</p>
8.	Presentation on education and employment of foreign born/educated physicians	<p>Commissioner Wolfe presented an overview of how International Medical Graduates (IMG) receive training in California.</p> <p>Workforce: IMG physicians is hereby incorporated as Attachment C</p>	
9.	Approval of FP and FNP/PA Special Program RFA and evaluation criteria	<p>Manuela Lachica and Melissa Omand presented the proposed FP and FNP/PA Special Program application and evaluation criteria for approval by the CHWPC</p>	<p>Motion (San Bartolome) to adopt the FP and FNP/PA Special Program RFA and evaluation criteria for each (Byous)</p>

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9.	Approval of Family Practice and Family Nurse Practitioner/Physician Assistant Special Program Request of Application and Evaluation Criteria, - Cont.	<p>Family Practice and Family Nurse Practitioner/Physician Assistant Special Program Application and Evaluation Criteria is hereby incorporated as Attachment D</p>	<p>Motion (Marsh) to adopt \$125,000-\$150,000 award for FP or FNP Special Programs seconded (Boyle)</p> <p>Motion (Marsh) for a 50/50 split base of the \$7million between FP and FNP/PA programs seconded (Townsend)</p>
10.	Progress on Policy Work Plan	<p>Manuela Lachica reviewed the California Healthcare Workforce Policy Commission Policy Work Plan for 2012-2013</p> <p><u>Goal I. Fiscal Accountability, Transparency of SB funds:</u></p> <p>Commissioners discussed developing post-evaluation documents for awardees. Staff will send final copies of current progress and final reports to Commission members to review and provide feedback.</p> <p>Commissioners discussed developing recommendations regarding funding decisions. Staff will provide a cheat sheet at each meeting outlining funding available, funding tiers, and minimum funding for Special Program applicants.</p> <p><u>Goal II – Aligning Statutory Priorities:</u></p> <p>Commissioners discussed updated the Underrepresented Minority (URM) definition. Staff is to provide draft URM language to the Commission.</p> <p><u>Goal III – Planning and Evaluation of Policy Direction:</u></p> <p>Options for funding programs based on a geographic spread. Lupe Alonzo-Diaz stated she would discuss this with the Director of</p>	

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		OSHPD, Robert David.	
10.	Progress on Policy Work Plan - continued	<p>Melissa Omand provided an update to the Commission on the status of CalREACH.</p> <p>Staff is currently testing applications the vendor has designed; staff will begin to review the draft of the evaluation worksheet to determine how the data will be transferred prior to Commissioner use.</p>	
11.	Update on Health Care Reform (HCR) Activities	<p>Lupe Alonzo-Diaz presented an update on HCR activities:</p> <p><u>Mental Health Services Act (MHSA) – Workforce Education and Training</u></p> <p>OSHPD is in the process of developing the next Five Year Plan which guides the state's local & regional investment of MHSA funds, approximately \$115M.</p> <p>Seven (7) community forums have been completed; OSHPD is now looking for qualitative & quantitative feedback on statewide administered programs.</p> <p>Health Workforce Development Council (Council) – Each organization is taking a lead or supportive role to implement some of the 125 recommendations developed by the Council. Another discussion item was how to integrate the work that OSHPD is doing with the Mental Health component into the work that the Council is doing.</p>	Discussion only
12.	Public Comment	No public comment provided.	
13.	Future Agenda Items	<p>Commission requested the California Academy of Physician Assistants provide an overview of the recent PA survey results</p> <p>Commission would like an overview of Health care workforce issues to include a presentation by Mitchell Katz, MD.</p>	

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		Discussion on Other Considerations evaluation criteria, "Has the program increased the number of new clinical training sites meeting Song-Brown criteria?" How does this impact programs that have limited clinical training sites?	
14.	Adjourn	Meeting adjourned at 2:50 p.m.	Elizabeth Dolezal

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COMMISSION MEMBERS PRESENT	COMMISSION MEMBERS ABSENT
Elizabeth Dolezal - Chair Roslynn Byous, DPA, PA-C Lauri Hoagland, FNP Laura Lopez Kathy Marsh, RN, MSN Angie Millan, RN, MSN, FAAN Tracey Norton, DO Andrea Renwanz Boyle, Ph.D., RN-BC Katherine Townsend, Ed.D., MSN Ashby Wolfe, MD, MPP, MPH	William Henning, DO Cathryn Nation, MD Deborah Rice, FNP Mario San Bartolome, MD, MBA Bonnie Wheatley, Ed.D., MPH, MA
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	ADDITIONAL STAFF FROM OSHPD:
	Robert David Sergio Aguilar Debra Gonzalez

AGENDA ITEM	TOPIC	DISCUSSION	ACTION ITEM OR DISCUSSION
1.	Call to Order	Meeting called to order at 8:35 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 Registered Nurse Education Program they would recuse themselves from.	<u>Recusals</u> Dolezal: None Byous: Riverside Community College Lopez: None Townsend: Western Governors University Wolfe: None Norton: None Marsh: University of San Diego Millan: None Renwanz-Boyle: None

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3.	Chair's Remarks	This is the first meeting in which the CHWPC utilized the new scoring process in tandem with the newly streamlined applications. Also, the format in which we conduct public comment has changed. Previously, the CHWPC held all public comment until the end of the meeting. From this point forward the CHWPC will entertain public comment on specific issues, where it's appropriate. Public comment will be held to three minutes using the stop light provided by staff.	
4.	Approval of November 2, 2012 Minutes	Approval of minutes from CHWPC meeting held November 1, 2012 in Sacramento, California.	Motion Made (Townsend) and seconded (Wolfe) to approve the November 2, 2012 minutes as presented.
5.	OSHPD Director's Report	<p>Director David, reported on the following in his Director's report:</p> <p><u>State of California Budget –</u> Governor Brown released his proposed budget in January and with that is a major change to the State's fiscal year outlook. The passage of the Governors proposition in November restores funding to K-12 programs as well as higher education and avoids major cuts. OSHPD is not funded by the general fund but by a special fund; no major impact is expected to OSHPD other than the proposed elimination of mandatory employee furlough days starting July 1, 2013.</p> <p><u>Health Care Reform -</u> The Affordable Care Act is starting to take shape in California, and will be reality a year from now; 2014 will be the year for Healthcare Workforce. In California, there will be an estimated 2 million people with a health insurance card, many with MediCal cards and where will the providers be to take care of this huge influx of patients? Health workforce will be a big focus in the legislature especially where Scope of Practice is concerned. Senator Hernandez, head of the Senate Health Committee has talked extensively about Scope of Practice.</p>	

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5.	OSHPD Director's Report - continued	The Governor has called a special session of the legislature to deal with Health Care Reform issues, much of which will be around implementing MediCal eligibility expansion but may include a broader discussion about healthcare workforce. I wouldn't be shocked if this department received additional funding, a greater discussion will be held at the next CHWPC meeting on this issue.	
6.	Executive Secretary's Report	<p>Ms. Lupe Alonzo-Diaz, M.P.Aff., Executive Secretary for the CHWPC discussed the following in her report:</p> <p><u>Partnerships:</u> Through the Healthcare Workforce Pilot Projects the Office is looking at partnering with the Emergency Medical Services Authority on a Community Paramedicine project. The partnership includes identifying regions throughout the state that would be interested in focusing on community paramedicine. The idea behind the partnership is that paramedics have a very specific skill however their scope of practice limits where and how they can practice that skill. The goals of the project are to improve individual and community health, reduce unnecessary hospitalizations and Emergency Department visits, and reduce healthcare costs.</p> <p>Members of the Healthcare Workforce Development Council, the California Workforce Investment Board and OSHPD are re-convening the Career Pathways Sub-Committee to develop career pathways for mental health professions.</p>	

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6.	Executive Secretary's Report – continued	<p><u>Funding:</u> Since the July 1 transfer of the Department of Mental Health's workforce programs to OSHPD the Agency has been focused on honoring the commitment to workforce investment especially where the public mental health system is involved. That commitment includes the release of a \$2M request for funding to fund psych residency programs. It is anticipated that two awards in the amount of \$1M each may be awarded.</p> <p>The Governor's Budget, released in January includes a one-time request of \$196,000 for OSHPD to hire a consultant to help develop a local and regional needs assessment in the public mental health system.</p> <p>The grant proposal submitted for \$1.5M to United Healthcare in 2012 was not awarded. Constructive feedback stated the other awarded grantees were able to leverage existing funds.</p> <p>The California Endowment has made a commitment to support the implementation of Federal Health Care Reform and have committed \$225M. OSHPD is currently in negotiations for \$22M to be specifically tied to workforce. Song-Brown is one of the programs in negotiation to receive funding.</p> <p><u>CalREACH:</u> CalREACH is OSHPD's electronic application monitoring system and is expected to roll-out before 30 June 2013. The Health Careers Training Program within our Healthcare Workforce Development Division will be the first program to go-live on February 19.</p>	<p>Commissioner Marsh asked how the implementation of Cal-REACH will affect announcements to the public on the release of applications. Ms. Alonzo-Diaz replied that awareness would be through community outreach, emails to the program directors, word-of-mouth, and assistance from the CHWPC. Manuela Lachica also commented that the change of dates to the cycles has been posted on the OSHPD website and Family Practice residency directors have been emailed regarding the changes.</p>

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6.	Executive Secretary's Report – continued	<p><u>Clearinghouse:</u> Clearinghouse has several factsheets: Registered Nurses, Licensed Vocational Nurses, Osteopathic and Allopathic Physicians & Surgeons, Physician Assistants, Respiratory Care Practitioners, and Psychiatric Technicians. On February 17th, Clearinghouse will roll out factsheets for Dentist and Dental Hygienist.</p> <p>OSHPD has partnered with the Employment Development Division and will roll out state-wide labor projections for 2012-2022 starting in March.</p> <p>September marks the 40th anniversary of the Song-Brown program! The team is working on a plan for the next meeting to honor the past work and accomplishments of the Song-Brown program.</p>	
7.	Presentation by Commissioner Angie Millan	<p>Commissioner Angie Millan presented on the Institute of Medicine Report "The Future of Nursing, Leading Change, Advancing Health."</p> <p>Future of Nursing, Campaign for Action presentation is hereby incorporated as Attachment B</p>	
8.	Registered Nurse Education – Capitation and Special Program Presentations	<p>Presentation of Associate Degree Nursing Programs:</p> <ol style="list-style-type: none"> 1. Glendale Community College 2. Los Angeles Harbor College 3. Modesto Junior College 4. Reedley College – Withdrawn 5. Fresno City College 6. Mt. San Jacinto Community College 7. Hartnell College 8. College of the Canyons 9. Riverside City College 10. Mt. San Antonio College 11. Rio Hondo College 12. Pierce College 	

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8.	Registered Nurse Education – Capitation and Special Program Presentations - continued	Presentation of Bachelor of Science in Nursing and Master’s Degree in Nursing Programs: 13. Point Loma Nazarene University 14. California State University, Stanislaus 15. Western University of Health - no presentation 16. Simpson University 17. California State University, Fresno	
9.	Recess	Meeting recessed at 3:55 p.m.	

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ACTION ITEM	TOPIC	DISCUSSION	ACTION ITEM OR DISCUSSION
3.	Registered Nurse Education – Capitation and Special Program Presentations	Continued presentation of Bachelor of Science in Nursing/Master’s Degree in Nursing Programs: 18. California State University, Long Beach 19. University of San Diego, Hahn 20. California State University, Bakersfield 21. California State University, Chico 22. Western Governor’s University 23. University of California, Irvine	
4.	Physician Assistant Mental Health Special Program Presentations	Physician Assistant Mental Health Special Program Presentations: 1. University of California, Davis 2. Moreno Valley College – no presentation 3. Touro University	
5.	Funding Discussion and Decision	Nursing programs were ranked by the CHWPC in the following order: <u>ADN Programs – Capitation:</u> Riverside City College 1 Fresno City College 2 College of the Canyons 3 Mt San Antonio College 4 Rio Hondo College 5 Los Angeles Harbor College 6 Mt San Jacinto College 7 Modesto Junior College 8 Pierce College 9 <u>BSN-MSN Programs – Capitation:</u> California State University, Stanislaus 1 University of California, Irvine 2 University of San Diego 3 California State University, Fresno 4 California State University, Bakersfield 4 Western University of Health Sciences 6 California State University, Long Beach 6 Simpson University 8	Motion made by (Norton) and seconded by (Townsend) to distribute Capitation funding as follows: California State University, Stanislaus \$240,000.00 Riverside City College \$200,000.00 University of California, Irvine \$192,000.00 College of the Canyons \$160,000.00 Fresno City College \$160,000.00 USD, Hahn School of Nursing \$144,000.00 Mt. San Antonio College \$120,000.00

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7.	Mental Health Service Act (MHSA) Workforce Education and Training (WET) 5-Year Plan Overview	<p>Sergio Aguilar, Healthcare Reform Analyst provided the CHWPC with an overview of the Mental Health Service Act and the Workforce Education and Training (WET) 5-year plan.</p> <p>Mental Health Services Act (MHSA) Workforce Education and Training (WET) Program Overview is hereby incorporated at Attachment D</p>	<p>Mr. Aguilar asked the Commissioners questions regarding the WET Five-Year Plan. Feedback on the questions are as follow:</p> <p>1. What are the most significant mental health workforce development challenges? What actions are needed to address the most significant mental health workforce development challenges?</p> <p>Byous-Finding training sites for students to acquire skills. Once skills are acquired, are jobs available? Communities could use loan repayment for these students.</p> <p>Boyle-Recruiting in a workforce that's representative of the community they're trying to serve.</p> <p>Hoagland-Mental Health and Substance abuse are interfacing problems yet these services aren't always connected. Individuals who need mental health treatment don't have a place to stay and receive treatment; migration from county to county with no system to keep track of records.</p> <p>Marsh-Students show interest in the mental health field but can't afford to pay their bills upon graduation so they go into another specialty.</p>

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7.			<p>Lopez-We need to think outside the box as to where the people are who have mental health issues. Think shelters, community centers; maybe we can get people in there to help.</p> <p>Norton- Family physicians practicing rural medicine have many resources. Family medicine as the foundation can gather the staff and resources. Need electronic health records.</p> <p>Wolfe-In the urban areas there are inadequate resources, such as medical insurance not covering mental health services. The MDs struggle with coordination between the patient and social worker. Workforce development is needed to communicate between team members.</p> <p>Public Comment 1-There are multiple issues. Until the reimbursement is there for PA's in mental health, it's going to be an uphill battle. Main obstacles are funding, reimbursement, and job availability.</p> <p>Public Comment 2-Barriers in clinical training sites such as only physicians can train PA's so there is a bottle neck of PA's who want to be trained and work.</p>

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7.	Mental Health Service Act (MHSA) Workforce Education and Training (WET) 5-Year Plan Overview – Cont'd		<p>Public Comment 3-It's great if the money is given to the programs, but their hands are tied if there isn't a collaboration between the counties health facilities and within the state.</p> <p>2. What are the barriers to expanding the capacity of postsecondary education for mental health workforce programs? What actions are needed to expand the capacity of postsecondary education in order to meet the mental health workforce needs?</p> <p>Townsend-Lack of clinical sites for Mental Health. Provide students with the skill to learn in practice.</p> <p>Wolfe-Use nursing and physician pipeline strategies for mental health recruitment. Better tracking.</p> <p>Boyle-Faculty shortages, and lack of funding and pipeline to help address this issue. Unable to recruit, retain and educate if you don't have the clinicians. Plans are needed to get the future educators in place. Money is an issue.</p> <p>Norton-Providers are truly impacted. Reinvent the training sites.</p> <p>Lopez-Helping foreign medical personnel gain their US certification so we can benefit from their skill set.</p>

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7.	Mental Health Service Act (MHSA) Workforce Education and Training (WET) 5-Year Plan Overview – Cont'd		<p>Public Comment 1- Recruitment from high school all the way to placement. From a program standpoint, they can focus their admission process and give priority to those interested in Mental Health. You can do all the right things, but if there is no end point, it would be futile. Need positive role models and mentors.</p> <p>3. What are the barriers to include diverse, racial and ethnic community members in the mental health provider networks?</p> <p>Public Comment 1-Use of community colleges to meet pre-requisites. Norton-Mental Health providers for non-English speakers or specific ethnic relations.</p> <p>4. What are the barriers to including cultural competency in the mental health workforce training and education programs?</p> <p>Marsh-Language is a huge barrier. Need more students that speak other languages. Hoagland-Placement of medication. Lopez-Different cultures see mental health in different ways. Need to incorporate cultural acceptance to mental health program. Public Comment 1-Still much to learn and always room for improvement, but this is the place we are succeeding at.</p>

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7.	Mental Health Service Act (MHSA) Workforce Education and Training (WET) 5-Year Plan Overview – Cont'd		<p>Public Comment 2-Training current providers to ensure they are receiving the newest training available in order to be the most effective.</p> <p>5. What actions are needed to include diverse, racial and ethnic community members in the mental health provider network, and include cultural competency in the mental health workforce training and education programs?</p> <p>Public Comment 1-Training program models could be replicated into continuing education curriculums that are at the state and national level.</p> <p>Hoagland-Conversation should take place around the state with community leadership.</p> <p>Wolfe-Collaborating with the licensing boards and professional organizations, highlighting to those stakeholders what's important and why. How can the state better coordinate? How can it get done?</p> <p>Sergio Aguilar stated they will have forums in eleven different communities and with different local networks on what they feel should be provided in the 5-Year Plan. For those that are unable to attend a forum, there will be a Webinar followed-up with an on-line survey.</p>

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7.	Mental Health Service Act (MHSA) Workforce Education and Training (WET) 5-Year Plan Overview – Cont'd		There is a long list of questions that will be asked to the communities and framed to fit within that particular area. The questions asked to the Commission today are within the CHWPC specific scope of assignment. They will have an opportunity to answer all the questions, should they choose, through the on-line survey
8.	Update on Work-plan objectives	Manuela Lachica, Program Director for the Song-Brown Program updated the CHWPC on work-plan objectives, the program director survey on special projects and graduate student assistant project.	
9.	Public Comment		Dr. Troidl stated he will send a letter to Director David, expressing his concern, regarding the lack of partnership between CHWPC and the California Healthcare Workforce Development Council. He stated he will send a second letter expressing concern over Commissioner compensation.
10.	Adjournment	Meeting adjourned at 4:10 p.m.	

influences the areas healthcare providers eligibility for federal programs designed to assist clinics financially and provides incentives for physicians and other healthcare professionals to practice in areas of high unmet medical need.

These MSSAs meet the federal requirement for consideration as a rational service area for health professional shortage area and Medically Underserved Area/Population (MUA/P) designations. The reconfiguration process increased the number of MSSAs from the 487 MSSAs in 1990 to the current number of 541 MSSAs (an increase of 54 MSSAs). As a result of these efforts, the State has greatly improved its eligibility for federal funds.

On November 4, 2004, the Commission adopted the California Primary Care (CPC) Shortage Areas (formerly Areas of Unmet Need). The CPC Shortage Areas are defined by two criteria: the percentage of population below the federal poverty level (100 percent) and the primary care physician:population ratio.

An analysis of the CPC Shortage Areas data (See appendix, Table 1) indicates the following:

- 63 percent of the State's total population resides in CPC Shortage Areas
- 75 percent of the population in CPC Shortage Areas meets the federal definition of 100 percent below poverty
- 75 percent of the State's African-American population resides in CPC Shortage Areas
- 76 percent of the State's Hispanic American population resides in CPC Shortage Areas
- 67 percent of the population under age 5 lives in CPC Shortage Areas
- 62 percent of the population between 18 – 64 lives in CPC Shortage Areas

THE VALUE OF THE SONG-BROWN PROGRAM

Song-Brown providers deliver primary care services in 100 percent of the University of California's teaching hospitals, 42 percent of County facilities and a multitude of community health centers (see appendix). During fiscal year 2003-2004, Song-Brown funded providers served approximately 350,000 patients in predominantly underserved areas.

In contrast to the approximately 10 percent of California physicians who practice in medically underserved areas, 39 percent of trainees in Song-Brown select to serve in communities defined as underserved, which are often the communities in which they trained.

POTENTIAL ALTERNATIVE FUNDING

1. Assess a 12 percent fee against the professional licenses of allopathic physicians, osteopathic physicians and physician assistants. Such a fee could generate approximately \$4.5 million dollars per year.

To: California Healthcare Workforce Policy Commission**Date:** May 3, 2013**From:** Debra Gonzalez, Research Program Specialist I
Office of Statewide Health Planning and Development
Healthcare Workforce Development Division**Subject:** Primary Care Shortage Areas (Update)

The results displayed in this report are from the Primary Care Shortage Area (PCSA) analysis completed in April 2013. The data used are from the U.S. Census 2010 and physician data 2012 from the Office of Statewide Health Planning and Development (OSHPD).

Background and Methodology

On January 26, 2004, the California Healthcare Workforce Policy Commission (Commission) formally adopted a means to create the Primary Care Shortage Areas (PCSA) designation. In April 2006, the Office of Statewide Health Planning and Development (OSHPD) staff presented the Commission with information suggesting an update to the map to include current data on (1) physicians, (2) poverty and (3) population.

The Commission uses PCSAs as one of many factors to determine Song-Brown funding for Family Practice, Family Nurse Practitioner-Physician Assistant and Mental Health-Physician Assistant programs. PCSAs themselves do not determine funding or funding levels. PCSAs are used as a means to help the Commission rank applications based on the number of program graduates and training sites inside areas of unmet need. PCSAs are an applied rule base defining shortages of physicians, as compared to the other designations (Federal Health Professional Shortage Areas) that are applicant-based and require prior knowledge that a shortage might exist.

Medical Service Study Areas (MSSAs) are used in determining Primary Care Shortage Areas and are the defined geographic analysis unit for OSHPD. MSSAs are reproduced on the decadal census and the boundaries are formally approved by the California Healthcare Workforce Policy Commission. The US Department of Health and Human Services, Health Resources and Services Administration (HRSA) formally recognizes California's MSSAs as Rational Service Areas (RSAs) for purposes of designating health professional shortage areas and medically underserved areas or populations for California. Two factors from a MSSA are evaluated for a PCSA: (1) percent below 100% federal poverty level and (2) physician-to-population ratio. The percent below 100% federal poverty level score and physician-to-population ratio score added together constitutes a PCSA score. A score of greater than or equal to five is a PCSA designation. The physician-to-population ratio score is assigned a score of five if no providers are identified in the MSSA. (See Table 1 for score values.)

PCSA Equation:

$$\text{PCSA Score} = \sum (\text{Percent Below 100\% Federal Poverty Level Score}) + (\text{Physician-to-Population Ratio Score})$$

Where: PCSA Score \geq 5 = **PCSA Designation**

The process for identifying the PCSA Score uses the rule base listed in Table 1.

Table 1. Methodology for Designation of Primary Care Shortage Areas

Percent Below 100% Federal Poverty Level		Physician-to-Population Ratio	
	Score		Score
5.0% or Less	0	Lower than 1:1,000	0
5.1 – 10.0%	1	1:1,000 to 1:1,500	1
10.1 – 15.0%	2	1:1,500 to 1:2,000	2
15.1 – 20.0%	3	1:2,000 to 1:2,500	3
20.1 – 25.0%	4	1:2,500 to 1:3,000	4
25.1% or Greater	5	Higher than 1:3,000	5
		No Providers ¹	5

¹The score 5 is applied if no providers are identified in the MSSA.
 (Percent Below 100% Federal Poverty Level Score) + (Physician-to-Population Ratio Score)=
 PCSA Score. Any MSSA with a PCSA score of 5 or greater is defined as a PCSA.

Assessment

The Commission adopted a formal method and rule base for calculating and measuring Primary Care Shortage Areas in 2004. OSHPD revised the PCSA scores in 2006 and 2010 with updated data. In 2010, the update used 2007 demographic data and 2009 physician counts data.

OSHPD proposes to revise the PCSA scores with 2010 U.S. Census data for demographics and 2012 physician counts data. The proposed revision to the PCSA scores is based on updated data only.

The data used for this update include:

1. InfoUSA 2012 provider count data on the locations of practicing primary care physicians in the State. These data are aggregated by MSSAs to obtain a count of primary care physicians by MSSA.
2. U.S. Census, American Community Survey 5 Year estimated population, demographic and poverty data by 2010 census tracts, aggregated to the 2000 MSSA boundaries. ("ACS 2006 – 2010 5 Year Estimate"). MSSA geometries are not changed based on the MSSA reconfiguration project for this analysis with the exception of Inyo County. Inyo County had two MSSAs that were single census tracts which were merged by the U.S. Census, therefore eliminating one MSSA.

Results

Table 2 summarizes and compares the number of MSSAs designated in the prior update to the current update. It shows the population total for the MSSAs designated and the percentage of California population designated for each update. There are 21 less designated MSSAs, in the current update.

Table 2. Summary of Existing PCSA Update and Proposed Update

Category	Prior Update	Current Update
Number of MSSAs Designated as PCSA*	319	298
Population in MSSAs Designated by PCSA	19,078,790	16,758,276
Percent of California Population Designated	52%	47%

*There are 540 total MSSAs in California.

The PCSA score changed for 83 MSSAs between the prior update and the current update due to changes in the percent of residents below 100% Federal poverty level and physician-to-population ratios. Table 3 summarizes these changes and the impact to the respective PCSA designation (gain or loss).

Table 3. Summary of changes to MSSAs by Score criteria

# of MSSAs	Percent Below Poverty	Physician to Population Ratio	# Gaining PCSA Designation	# Losing PCSA Designation
8	Increased	Increased	8	0
4	Increased	No Change	4	0
4	Increased	Decreased	0	4
3	Decreased	Increased	3	0
10	Decreased	No Change	0	10
12	Decreased	Decreased	0	12
16	No Change	Increased	16	0
26	No Change	Decreased	0	26
83		Total	31	

Table 4 lists all MSSAs that meet the recommended criteria for the current update. It also lists the MSSAs designated as PCSAs in the prior update, which do not meet the current update criteria. The current PCSA designations are presented in a map at the end of this document.

Table 4. MSSA PCSA Designation Status per Current Update

Category	Table	# of MSSAs	Total Population
Newly Designated MSSAs	Table 4a	31	1,915,840
No Longer Designated MSSAs	Table 4b	52	3,526,924
Remaining Designated MSSAs	Table 4c	266	14,839,177
Remaining Undesignated MSSAs	Table 4d	191	15,528,652
	Total	540	35,810,593

Total California estimated Population is 35,810,593.

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Table 4a. Newly Designated MSSAs

County	MSSA	Population	Percent Poverty Score	Physician Population Ratio Score	PCSA Score
Alameda	1.1	51,731	1	5	6
Alameda	2l	111,763	0	5	5
Alameda	2m	116,000	2	5	7
Fresno	35a	134,125	1	4	5
Fresno	35f	77,710	4	3	7
Kern	64	33,289	2	3	5
Los Angeles	77.5	23,374	1	5	6
Los Angeles	78.2ii	86,640	2	5	7
Los Angeles	78.2o	123,863	1	5	6
Mendocino	92	2,617	5	0	5
Mendocino	93.2	6,108	3	3	6
Mendocino	93.3	1,815	1	5	6
Monterey	104	1,142	4	1	5
Orange	115.2b	131,963	0	5	5
Orange	116c	120,151	2	3	5
Orange	116t	80,961	1	5	6
Riverside	135d	114,714	2	5	7
San Bernardino	142	2,659	5	5	10
San Bernardino	144.1	5,321	2	5	7
San Francisco	162a	96,949	4	1	5
San Francisco	162d	123,574	2	5	7
San Joaquin	166	64,311	3	4	7
San Joaquin	169c	83,061	2	3	5
San Luis Obispo	172	51,096	5	0	5
Sierra	191	3,366	2	5	7
Solano	203.1	32,809	1	5	6
Tehama	221	34,711	4	1	5
Tuolumne	234.1	1,713	1	5	6
Tuolumne	236	25,236	2	5	7
Ventura	241b	122,757	3	2	5
Yolo	245	50,311	3	5	8
Total Population		1,915,840			

Table 4b. No Longer Designated MSSAs

County	MSSA	Population	Percent Poverty Score	Physician Population Ratio Score	PCSA Score
Alameda	1.2	36,228	1	0	1
Alameda	2a	73,765	4	0	4
Alameda	2c	81,109	4	0	4
Alameda	2i	88,393	1	0	1
Alameda	2n	114,392	2	2	4
Butte	7.1	90,919	4	0	4
Calaveras	12	45,769	1	2	3
Contra Costa	18f	93,907	4	0	4
El Dorado	23.1	65,964	0	4	4
Fresno	35b	93,425	2	1	3
Humboldt	38	4,907	4	0	4
Humboldt	44	6,127	3	1	4
Kern	66c	143,087	3	0	3
Los Angeles	78.2f	89,809	2	0	2
Los Angeles	78.2ff	96,491	3	1	4
Los Angeles	78.2g	112,132	4	0	4
Los Angeles	78.2hhh	90,704	3	0	3
Los Angeles	78.2kk	107,175	3	1	4
Los Angeles	78.2pp	101,651	1	3	4
Los Angeles	78.2t	93,166	1	3	4
Los Angeles	78.2ww	98,941	2	2	4
Madera	80	95,114	4	0	4
Merced	97.1	69,178	4	0	4
Modoc	98	5,731	3	1	4
Monterey	105	15,500	2	1	3
Plumas	123.2	1,845	0	2	2
Riverside	126	14,432	3	1	4
Riverside	129.2	50,281	2	2	4
Riverside	131b	208,777	1	2	3
Riverside	135g	88,076	2	1	3
Sacramento	139g	123,077	3	1	4
Sacramento	139k	82,275	4	0	4
San Bernardino	148	6,428	1	3	4
San Bernardino	151d	85,161	1	3	4
San Diego	152	9,436	2	2	4

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County	MSSA	Population	Percent Poverty Score	Physician Population Ratio Score	PCSA Score
San Diego	153.2	15,826	1	2	3
San Diego	160	69,236	1	3	4
San Diego	161j	111,549	4	0	4
San Diego	161n	78,931	1	3	4
San Diego	161t	91,207	1	1	2
San Joaquin	168	24,118	1	0	1
San Mateo	175.1	23,444	1	3	4
Santa Barbara	179	54,051	2	0	2
Santa Barbara	180.1	126,213	2	1	3
Santa Barbara	181a	88,896	4	0	4
Santa Clara	183d	67,155	4	0	4
Siskiyou	194	4,745	2	2	4
Stanislaus	213	37,120	2	2	4
Trinity	224	7,394	2	2	4
Trinity	226	744	4	0	4
Tulare	233	138,128	3	1	4
Yuba	247	4,795	3	0	3
Total Population		3,526,924			

Table 4c. Remaining Designated MSSAs

County	MSSA	Population	Percent Poverty Score	Physician Population Ratio Score	PCSA Score
Alameda	2d	113,433	5	0	5
Alameda	2h	104,062	2	5	7
Amador	5	4,882	1	5	6
Amador	6	6,082	1	5	6
Butte	7.2	5,946	0	5	5
Butte	7.3	5,163	1	5	6
Butte	7.4	5,259	0	5	5
Butte	9	13,648	3	2	5
Butte	10	46,769	4	1	5
Butte	11	4,858	4	5	9
Colusa	16.1	5,280	2	5	7
Colusa	16.2	2,220	2	5	7
Colusa	16.3	5,188	4	5	9
Contra Costa	18b	74,183	2	5	7

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County	MSSA	Population	Percent Poverty Score	Physician Population Ratio Score	PCSA Score
Contra Costa	18d	94,963	3	2	5
Contra Costa	18g	77,239	1	5	6
El Dorado	22	9,221	1	5	6
El Dorado	23.2	23,834	1	5	6
Fresno	25	20,615	5	4	9
Fresno	26	6,566	5	5	10
Fresno	27	9,308	4	1	5
Fresno	28	8,097	5	4	9
Fresno	29	34,477	4	5	9
Fresno	30	87,438	5	4	9
Fresno	31	90,536	2	5	7
Fresno	32	59,441	5	4	9
Fresno	35c	81,366	5	0	5
Fresno	35d	99,848	5	5	10
Fresno	35e	87,625	5	5	10
Glenn	36.1	13,375	3	5	8
Glenn	36.2	3,356	4	2	6
Humboldt	40	23,468	2	4	6
Imperial	46	3,380	5	5	10
Imperial	47	11,897	4	5	9
Imperial	48	77,707	3	5	8
Imperial	49	37,572	4	5	9
Imperial	50	27,295	4	1	5
Inyo	54	2,316	1	5	6
Inyo	55	3,259	3	5	8
Kern	57.1	7,745	1	5	6
Kern	57.2	18,509	4	5	9
Kern	58.1	18,635	4	3	7
Kern	58.2	23,518	5	5	10
Kern	59	3,744	4	5	9
Kern	60	54,786	5	3	8
Kern	61	40,654	5	5	10
Kern	62	29,433	2	4	6
Kern	63	15,675	3	3	6
Kern	65	41,154	4	5	9
Kern	66b	135,672	5	5	10
Kings	67	15,007	5	5	10
Kings	68	18,016	4	1	5

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County	MSSA	Population	Percent Poverty Score	Physician Population Ratio Score	PCSA Score
Kings	69	100,858	3	2	5
Lake	70.2	8,265	3	5	8
Lake	71.1	18,013	5	1	6
Lake	71.2	9,435	2	5	7
Lake	71.3	12,353	2	5	7
Lassen	74	1,721	2	5	7
Lassen	75	1,895	2	5	7
Los Angeles	76.2	24,269	1	5	6
Los Angeles	77.2	17,775	4	5	9
Los Angeles	77.3	15,640	2	5	7
Los Angeles	77.4	10,725	1	5	6
Los Angeles	76.1b	111,656	1	4	5
Los Angeles	77.1a	93,677	3	5	8
Los Angeles	77.1c	102,082	5	1	6
Los Angeles	78.2a	80,328	3	5	8
Los Angeles	78.2aaa	82,926	5	1	6
Los Angeles	78.2b	146,918	5	5	10
Los Angeles	78.2bb	98,348	3	5	8
Los Angeles	78.2bbb	88,264	4	5	9
Los Angeles	78.2bbbb	76,757	3	5	8
Los Angeles	78.2c	116,007	4	5	9
Los Angeles	78.2cc	103,753	4	5	9
Los Angeles	78.2ccc	105,549	4	3	7
Los Angeles	78.2cccc	102,639	1	5	6
Los Angeles	78.2d	91,148	4	2	6
Los Angeles	78.2ddd	81,832	4	2	6
Los Angeles	78.2e	132,804	4	4	8
Los Angeles	78.2fff	98,263	5	5	10
Los Angeles	78.2ffff	86,852	5	0	5
Los Angeles	78.2ggg	97,090	5	5	10
Los Angeles	78.2gggg	87,039	1	5	6
Los Angeles	78.2h	94,815	5	5	10
Los Angeles	78.2hhhh	94,066	4	5	9
Los Angeles	78.2i	123,532	4	5	9
Los Angeles	78.2iii	92,063	3	5	8
Los Angeles	78.2iiii	109,412	2	3	5
Los Angeles	78.2jjj	110,527	5	5	10
Los Angeles	78.2jjjj	104,206	2	5	7

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County	MSSA	Population	Percent Poverty Score	Physician Population Ratio Score	PCSA Score
Los Angeles	78.2k	112,643	4	5	9
Los Angeles	78.2l	81,266	5	5	10
Los Angeles	78.2ll	127,020	3	5	8
Los Angeles	78.2mmm	88,575	5	5	10
Los Angeles	78.2n	107,736	1	4	5
Los Angeles	78.2nnn	105,231	5	5	10
Los Angeles	78.2oo	91,929	4	2	6
Los Angeles	78.2ooo	80,579	3	5	8
Los Angeles	78.2p	108,061	4	5	9
Los Angeles	78.2ppp	100,742	3	5	8
Los Angeles	78.2qq	115,427	2	3	5
Los Angeles	78.2qqq	95,519	3	3	6
Los Angeles	78.2r	76,965	4	5	9
Los Angeles	78.2rr	110,012	1	5	6
Los Angeles	78.2s	91,173	5	5	10
Los Angeles	78.2ss	114,052	3	3	6
Los Angeles	78.2sss	87,516	3	2	5
Los Angeles	78.2uuu	84,826	4	5	9
Los Angeles	78.2v	106,413	1	4	5
Los Angeles	78.2vv	86,304	2	5	7
Los Angeles	78.2vvv	112,880	1	5	6
Los Angeles	78.2y	93,822	2	4	6
Madera	79.1	28,510	2	4	6
Mariposa	85	16,822	2	3	5
Mariposa	86	769	1	5	6
Mendocino	87.1	3,042	5	1	6
Mendocino	87.2	7,549	1	4	5
Mendocino	90	3,355	3	5	8
Mendocino	93.4	3,484	4	5	9
Mendocino	93.5	2,128	3	5	8
Merced	94	56,907	4	2	6
Merced	95	39,568	3	5	8
Merced	96	48,103	4	5	9
Merced	97.2	25,398	5	1	6
Merced	97.3	7,997	4	1	5
Modoc	99	1,290	4	1	5
Modoc	100	2,261	3	5	8
Mono	102	5,812	1	5	6

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County	MSSA	Population	Percent Poverty Score	Physician Population Ratio Score	PCSA Score
Monterey	106	3,069	1	5	6
Monterey	107	42,163	3	3	6
Monterey	108	54,817	2	5	7
Monterey	109.1	40,126	2	5	7
Napa	111.2	6,004	1	5	6
Napa	112.3	18,527	1	5	6
Orange	116b	112,449	4	2	6
Orange	116g	115,621	3	5	8
Orange	116i	114,671	3	4	7
Orange	116k	108,065	1	5	6
Orange	116q	111,909	2	5	7
Orange	116v	100,939	0	5	5
Placer	118	15,782	0	5	5
Placer	120	6,082	2	5	7
Plumas	122	2,594	2	4	6
Riverside	127	2,082	4	5	9
Riverside	128	96,494	5	5	10
Riverside	129.3	30,412	2	5	7
Riverside	129.4	127,164	3	2	5
Riverside	130	12,133	2	5	7
Riverside	132	138,534	3	4	7
Riverside	133.1	160,898	2	5	7
Riverside	133.2	23,855	2	5	7
Riverside	133.3	22,826	5	5	10
Riverside	134	131,504	2	5	7
Riverside	131a	134,412	2	4	6
Riverside	135a	100,045	4	4	8
Riverside	135b	159,262	2	4	6
Riverside	135e	162,038	1	5	6
Sacramento	136	109,127	1	5	6
Sacramento	137	5,216	1	5	6
Sacramento	138	18,864	0	5	5
Sacramento	139a	178,361	1	5	6
Sacramento	139c	119,658	3	5	8
Sacramento	139f	116,697	5	0	5
Sacramento	139j	119,307	5	1	6
San Benito	140	52,768	2	3	5
San Bernardino	143	6,647	4	3	7

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County	MSSA	Population	Percent Poverty Score	Physician Population Ratio Score	PCSA Score
San Bernardino	144.2	40,737	3	3	6
San Bernardino	144.3	19,199	3	5	8
San Bernardino	145.2	49,689	4	5	9
San Bernardino	145.3	4,322	2	5	7
San Bernardino	146	23,977	3	5	8
San Bernardino	147	19,897	2	4	6
San Bernardino	150	12,216	2	5	7
San Bernardino	145.1a	170,197	3	2	5
San Bernardino	145.1b	105,530	3	5	8
San Bernardino	151b	95,453	1	5	6
San Bernardino	151c	123,594	3	2	5
San Bernardino	151e	175,823	0	5	5
San Bernardino	151g	124,134	5	1	6
San Bernardino	151h	131,508	3	5	8
San Bernardino	151k	115,016	5	5	10
San Bernardino	151l	132,409	1	5	6
San Diego	153.1	6,922	2	5	7
San Diego	154	2,328	1	5	6
San Diego	155	31,135	1	4	5
San Diego	157	14,706	1	5	6
San Diego	158.2	11,533	0	5	5
San Diego	159	6,477	4	5	9
San Diego	156a	108,585	2	3	5
San Diego	156b	105,899	1	4	5
San Diego	156f	96,991	1	5	6
San Diego	161a	130,874	3	2	5
San Diego	161c	71,865	5	0	5
San Diego	161d	92,976	4	5	9
San Diego	161g	92,295	4	4	8
San Diego	161h	81,637	4	2	6
San Diego	161i	80,318	1	5	6
San Diego	161l	80,359	2	5	7
San Diego	161m	84,866	1	5	6
San Diego	161u	81,761	1	5	6
San Diego	161v	110,757	1	4	5
San Francisco	162e	78,222	1	5	6
San Francisco	162f	78,730	3	5	8
San Joaquin	164.2	48,730	1	5	6

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County	MSSA	Population	Percent Poverty Score	Physician Population Ratio Score	PCSA Score
San Joaquin	165	4,805	1	5	6
San Joaquin	167	35,340	2	5	7
San Joaquin	169a	95,566	4	4	8
San Joaquin	169b	131,836	5	0	5
San Luis Obispo	173	48,164	2	5	7
San Luis Obispo	174	35,099	1	5	6
San Mateo	175.2	3,960	1	5	6
San Mateo	175.3	36,729	0	5	5
Santa Barbara	177	18,300	1	5	6
Santa Barbara	178.2	7,065	1	5	6
Santa Barbara	180.2	7,343	3	5	8
Santa Clara	183e	115,834	2	5	7
Santa Clara	183g	113,704	1	5	6
Santa Clara	183h	126,752	2	5	7
Santa Clara	183k	101,998	1	5	6
Santa Cruz	185.2	3,979	1	5	6
Santa Cruz	185.4	11,288	1	5	6
Santa Cruz	185.5	27,582	1	5	6
Shasta	186	32,258	3	2	5
Shasta	187	1,370	1	5	6
Shasta	188.1	4,893	2	5	7
Shasta	188.2	6,262	2	3	5
Shasta	189.1	4,684	3	5	8
Shasta	189.3	20,808	3	5	8
Shasta	190	7,199	2	3	5
Siskiyou	193	2,030	4	5	9
Siskiyou	196	1,383	5	5	10
Siskiyou	198	2,398	4	3	7
Siskiyou	199	1,559	3	2	5
Siskiyou	200	1,826	3	2	5
Solano	201	20,729	1	4	5
Solano	203.2	7,447	1	5	6
Sonoma	205.2	27,717	1	5	6
Sonoma	206	13,969	1	5	6
Sonoma	207	23,320	2	5	7
Sonoma	209.2	12,497	1	5	6
Stanislaus	211	53,918	2	5	7
Stanislaus	212.2	15,383	3	5	8

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County	MSSA	Population	Percent Poverty Score	Physician Population Ratio Score	PCSA Score
Stanislaus	212.3	24,765	3	5	8
Stanislaus	214	43,561	3	4	7
Stanislaus	215c	86,704	5	0	5
Sutter	217	2,574	1	5	6
Sutter	218	9,874	4	5	9
Tehama	219	3,932	4	5	9
Tehama	220	4,454	4	5	9
Tehama	222	17,951	4	5	9
Trinity	223	2,161	3	5	8
Trinity	225	2,689	3	5	8
Tulare	227.1	31,540	5	5	10
Tulare	227.2	18,443	5	5	10
Tulare	228.1	15,813	4	1	5
Tulare	228.2	41,809	5	4	9
Tulare	229	4,644	2	5	7
Tulare	230	72,102	3	3	6
Tulare	231	95,985	5	2	7
Tulare	232	5,607	2	5	7
Ventura	240c	86,367	1	5	6
Ventura	241a	106,772	2	4	6
Yolo	243	4,543	1	5	6
Yolo	246.2	3,508	3	5	8
Yuba	248	4,498	3	5	8
Yuba	249	60,190	4	3	7
Total Population		14,839,177			

Table 4d. Remaining Undesignated MSSAs

County	MSSA	Population	Percent Poverty Score	Physician Population Ratio Score	PCSA Score
Alameda	2b	104,466	1	0	1
Alameda	2e	75,450	2	1	3
Alameda	2f	99,039	1	2	3
Alameda	2g	94,258	1	0	1
Alameda	2j	84,306	1	1	2
Alameda	2k	99,129	0	0	0
Alpine	3	1,176	2	1	3

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County	MSSA	Population	Percent Poverty Score	Physician Population Ratio Score	PCSA Score
Amador	4	22,974	1	0	1
Butte	8	40,958	2	2	4
Colusa	15	7,626	2	0	2
Contra Costa	17	48,099	1	3	4
Contra Costa	18a	84,509	1	0	1
Contra Costa	18c	86,517	1	1	2
Contra Costa	18e	122,478	1	2	3
Contra Costa	18h	128,556	0	1	1
Contra Costa	18i	106,446	0	0	0
Contra Costa	18j	96,657	0	0	0
Del Norte	19	25,321	4	0	4
El Dorado	23.3	48,677	1	1	2
El Dorado	24	30,140	3	0	3
Glenn	37	11,204	3	1	4
Humboldt	39	69,157	4	0	4
Humboldt	42	25,521	3	1	4
Inyo	53	12,859	2	0	2
Kern	66a	100,091	3	1	4
Kern	66d	112,950	1	0	1
Lake	70.1	15,530	3	0	3
Lassen	72	19,708	3	1	4
Lassen	73	1,147	0	0	0
Los Angeles	78.1	3,938	2	0	2
Los Angeles	76.1a	114,607	0	3	3
Los Angeles	77.1b	98,645	2	2	4
Los Angeles	78.2aa	96,559	0	0	0
Los Angeles	78.2aaaa	112,367	2	0	2
Los Angeles	78.2dd	105,584	1	1	2
Los Angeles	78.2dddd	102,462	1	3	4
Los Angeles	78.2ee	94,355	2	0	2
Los Angeles	78.2eee	79,651	1	0	1
Los Angeles	78.2eeee	107,841	2	1	3
Los Angeles	78.2gg	95,032	2	0	2
Los Angeles	78.2hh	82,626	1	1	2
Los Angeles	78.2j	121,226	1	1	2
Los Angeles	78.2jj	122,536	1	2	3
Los Angeles	78.2kkk	123,824	1	0	1

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County	MSSA	Population	Percent Poverty Score	Physician Population Ratio Score	PCSA Score
Los Angeles	78.2kkkk	80,754	2	0	2
Los Angeles	78.2lll	105,780	2	0	2
Los Angeles	78.2m	98,589	2	0	2
Los Angeles	78.2mm	98,776	1	0	1
Los Angeles	78.2nn	79,711	2	1	3
Los Angeles	78.2q	99,048	2	0	2
Los Angeles	78.2rrr	100,701	1	2	3
Los Angeles	78.2tt	108,577	1	0	1
Los Angeles	78.2ttt	125,723	1	1	2
Los Angeles	78.2u	90,741	1	0	1
Los Angeles	78.2uu	83,447	1	0	1
Los Angeles	78.2w	113,910	3	0	3
Los Angeles	78.2www	125,674	1	0	1
Los Angeles	78.2x	123,028	2	0	2
Los Angeles	78.2xx	113,774	1	1	2
Los Angeles	78.2xxx	99,296	1	2	3
Los Angeles	78.2yy	79,097	1	0	1
Los Angeles	78.2yyy	119,842	2	0	2
Los Angeles	78.2z	74,533	2	0	2
Los Angeles	78.2zz	103,529	3	0	3
Los Angeles	78.2zzz	101,838	2	1	3
Madera	79.2	15,092	3	0	3
Marin	81	13,515	1	2	3
Marin	82	27,838	1	3	4
Marin	83a	105,116	0	0	0
Marin	83b	93,165	1	0	1
Mendocino	88	3,734	2	1	3
Mendocino	89	11,074	4	0	4
Mendocino	91	13,020	3	1	4
Mendocino	93.1	27,836	3	0	3
Mono	103	7,977	3	0	3
Monterey	109.2	146,090	3	0	3
Monterey	110	87,049	1	0	1
Napa	111.1	12,091	1	0	1
Napa	111.3	1,627	0	2	2
Napa	112.1	61,003	2	0	2
Napa	112.2	29,329	1	1	2

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County	MSSA	Population	Percent Poverty Score	Physician Population Ratio Score	PCSA Score
Nevada	113	78,125	1	1	2
Nevada	114	19,268	2	1	3
Orange	115.1	109,643	1	1	2
Orange	115.2a	108,474	0	0	0
Orange	115.2c	122,425	1	0	1
Orange	115.2d	74,561	1	1	2
Orange	116a	78,570	2	1	3
Orange	116d	134,408	1	0	1
Orange	116e	112,314	1	2	3
Orange	116f	101,572	2	1	3
Orange	116h	128,128	2	0	2
Orange	116j	76,441	1	0	1
Orange	116l	95,224	3	0	3
Orange	116m	134,667	1	0	1
Orange	116n	128,208	1	0	1
Orange	116o	86,324	1	0	1
Orange	116p	105,736	2	1	3
Orange	116r	122,309	2	0	2
Orange	116s	123,983	2	1	3
Orange	116u	85,166	1	3	4
Placer	117	11,664	1	3	4
Placer	119	113,334	1	1	2
Placer	121.1	129,584	1	0	1
Placer	121.2	57,135	1	2	3
Plumas	123.1	6,542	3	1	4
Plumas	124	5,197	2	0	2
Plumas	125	4,093	2	1	3
Riverside	129.1	98,679	1	1	2
Riverside	135c	84,208	3	0	3
Riverside	135f	119,257	1	2	3
Sacramento	139b	89,853	1	0	1
Sacramento	139d	74,421	2	0	2
Sacramento	139e	98,573	1	0	1
Sacramento	139h	147,145	1	0	1
Sacramento	139i	84,127	1	0	1
San Bernardino	149	55,796	3	1	4
San Bernardino	151a	118,516	1	1	2

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County	MSSA	Population	Percent Poverty Score	Physician Population Ratio Score	PCSA Score
San Bernardino	151f	143,194	3	0	3
San Bernardino	151i	99,126	2	0	2
San Bernardino	151j	97,378	1	1	2
San Diego	158.1	24,307	1	2	3
San Diego	156c	145,560	1	1	2
San Diego	156d	116,996	2	2	4
San Diego	156e	125,694	3	1	4
San Diego	161b	89,388	2	0	2
San Diego	161e	83,809	4	0	4
San Diego	161f	76,879	2	0	2
San Diego	161k	73,033	4	0	4
San Diego	161o	80,684	1	0	1
San Diego	161p	144,177	1	1	2
San Diego	161q	75,765	0	0	0
San Diego	161r	83,501	1	0	1
San Diego	161s	129,859	1	1	2
San Francisco	162b	87,908	1	0	1
San Francisco	162c	104,748	2	0	2
San Francisco	162g	114,835	1	0	1
San Francisco	162h	89,425	2	0	2
San Joaquin	163	92,996	1	2	3
San Joaquin	164.1	73,429	2	1	3
San Luis Obispo	170	34,821	1	1	2
San Luis Obispo	171	79,526	1	2	3
San Mateo	176a	91,777	1	0	1
San Mateo	176b	73,894	3	0	3
San Mateo	176c	78,207	1	1	2
San Mateo	176d	117,318	1	1	2
San Mateo	176e	93,347	0	3	3
San Mateo	176f	98,782	1	0	1
San Mateo	176g	77,984	0	2	2
Santa Barbara	178.1	17,040	1	1	2
Santa Barbara	181b	79,119	1	0	1
Santa Clara	182	102,191	1	2	3
Santa Clara	183a	118,425	1	0	1
Santa Clara	183b	119,752	1	2	3
Santa Clara	183c	86,848	0	4	4

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County	MSSA	Population	Percent Poverty Score	Physician Population Ratio Score	PCSA Score
Santa Clara	183f	110,305	0	3	3
Santa Clara	183i	108,532	0	4	4
Santa Clara	183j	81,948	3	0	3
Santa Clara	183l	117,432	1	0	1
Santa Clara	183m	98,997	1	0	1
Santa Clara	183n	121,517	1	2	3
Santa Clara	183o	116,354	1	3	4
Santa Cruz	184	52,700	3	0	3
Santa Cruz	185.1	107,299	2	0	2
Santa Cruz	185.3	43,755	1	2	3
Shasta	189.2	96,906	3	0	3
Siskiyou	195	16,188	3	0	3
Siskiyou	197	13,611	2	1	3
Solano	204	140,367	2	0	2
Solano	202a	90,202	1	0	1
Solano	202b	106,410	2	0	2
Sonoma	205.1	15,817	1	0	1
Sonoma	208	38,472	2	2	4
Sonoma	209.1	131,027	1	1	2
Sonoma	210.1	182,301	2	0	2
Sonoma	210.2	19,152	1	0	1
Stanislaus	212.1	71,252	2	0	2
Stanislaus	215a	79,773	2	0	2
Stanislaus	215b	89,472	2	1	3
Sutter	216	80,088	2	1	3
Tuolumne	234.2	20,285	2	0	2
Tuolumne	235	3,368	1	0	1
Ventura	237	65,111	2	1	3
Ventura	238	31,384	1	1	2
Ventura	239	102,177	0	2	2
Ventura	240a	89,109	0	1	1
Ventura	240b	108,346	1	0	1
Ventura	241c	86,812	2	0	2
Yolo	242	7,913	2	2	4
Yolo	244	64,105	4	0	4
Yolo	246.1	56,647	2	0	2
Total Population		15,528,652			

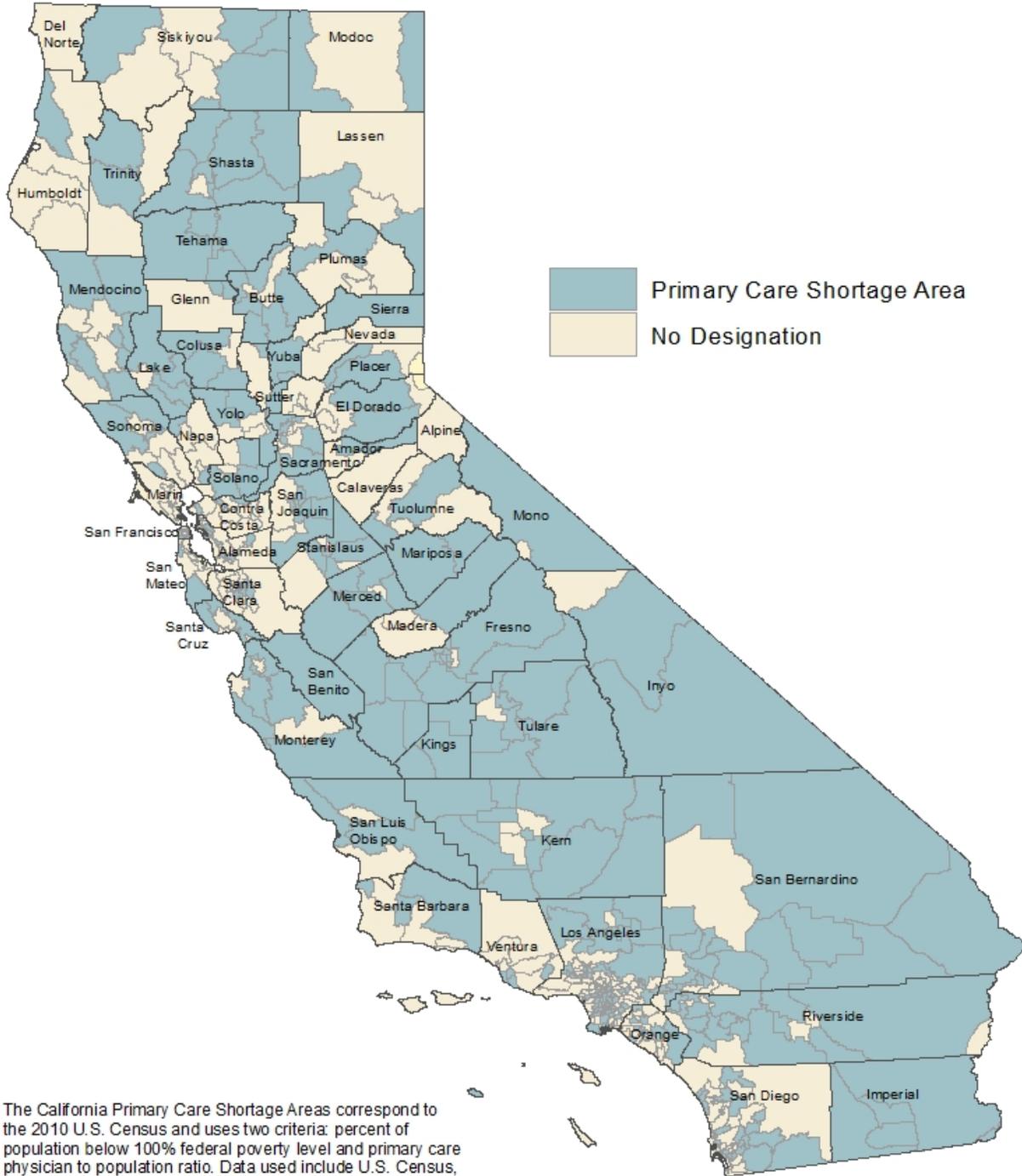
Recommendation

The Commission adopted a formal method for designating Primary Care Shortage Areas in 2004. OSHPD proposes to revise those PCSA scores with 2012 physician counts data and 2010 estimated data for demographics. The proposed revision is based on updated data only. OSHPD staff are not recommending changing the qualifying threshold criteria or methodology for calculating the PCSA designation. OSHPD staff recommend that the Commission adopt the updated PCSA scores based on new and current data using the existing criteria and methodology.

Recommended Motion

OSHPD recommends that the Commission adopt this paper as a formal motion, thereby revising the list of designated PCSAs with 2010 demographic and 2012 primary care physician data.

California Primary Care Shortage Areas



The California Primary Care Shortage Areas correspond to the 2010 U.S. Census and uses two criteria: percent of population below 100% federal poverty level and primary care physician to population ratio. Data used include U.S. Census, American Community Survey 5 yr population and poverty estimates and infoUSA 2010 Physicians.

To: California Healthcare Workforce Policy Commission **Date:** May 3, 2013

From: Debra Gonzalez, Research Program Specialist I
Healthcare Workforce Development Division
Office of Statewide Health Planning and Development

Subject: Registered Nurse Shortage Area Update

The results displayed in this report are from the Registered Nurse Shortage Area (RNSA) analysis completed in April 2013. The 2012 data used are from the Board of Registered Nursing (BRN) and the Office of Statewide Health Planning and Development (OSHPD).

Background

In February 2007, the California Healthcare Workforce Policy Commission (Commission) formally adopted staff recommendations for the creation of a Registered Nurse Shortage Area (RNSA). The method for determining the RNSA is a function of the number of licensed nurses (supply) and patient volume (demand). The previous analysis performed used 2010 data and was on a county basis.

Final RNSA designation is determined when a county (1) lacks a general acute care hospital (GAC) and a long-term care (LTC) facility or (2) is above the mean ratio of available nurses to patient volume. The ratio is the total number of bed days for GACs and LTC facilities multiplied by .08 and divided by the number of registered nurses (RNs) in the specific county. The mean is calculated by the sum of the ratio for each county divided by 58 the number of counties in California.

The counties with ratios greater than the mean are considered designated. The Commission uses the RNSA as only one of many factors to determine Song-Brown funding for nursing education programs. The RNSA does not in itself determine funding or funding levels. In February 2008, the Commission stipulated that this method be reviewed annually, rather than every two years to provide insight into the latest science and current literature affecting the nursing workforce.

The Commission needs a quantitative, repeatable and meaningful way of ranking applications whose past graduates and training facilities operate in areas of unmet need (e.g. Song-Brown nursing shortages). The adopted RNSA, using counties as the analytical unit, serves well under this rubric.

Methodology

Three factors are used in defining nursing shortages: (1) California counties as the geographic unit of analysis, (2) California registered nurse data of all active licenses by county from the Board of Registered Nursing (BRN)¹, and (3) the patient day and census data from all LTCs and GACs from OSHPD.²

¹ Source: 2012, Department of Consumer Affairs, Board of Registered Nursing, County Count Summary for Clear Licenses.

² Source: 2012, Office of Statewide Health Planning and Development, Healthcare Information Division (HID) Data Products. <http://www.oshpd.ca.gov/HID/DataFlow/index.html>

OSHPD maintains data on patient volume for GACs and LTCs. These data are maintained on the OSHPD Automated Licensing Information and Report Tracking System (ALIRTS) and available on the OSHPD website as data products. These GAC and LTC locations employ nearly 70% of the total nursing workforce in California. No current data exist on patient volume for the other 30% of the workforce.

OSHPD facility census³ data for 2012 were obtained by county. There are more licensed bed days in LTCs than GACs in California and LTCs only account for 5% of the registered nurse workforce.⁴ Therefore, a scale factor representing the percent of the nursing workforce at LTCs in this function was applied to ensure the census data were not skewed.⁵ A total census was created by summing the two numbers and a ratio was used of census divided by registered nurses for each of the 58 counties.

Ratio Equation:

$$\frac{\sum (\text{CensusDaysGAC} + [(\text{PatientDaysLTC}) * 0.08])}{\text{RNCount}}$$

Where:

CensusDaysGAC is the number of days a patient is occupying a bed in General Acute Care Hospitals in 2012

PatientDaysLTC is the number of days a patient is occupying a bed in Long-Term Care Facilities in 2012

RNCount is the number of licensed, active registered nurses per county in 2012

Limitations

This designation methodology has two limitations. First, only about 70% of the nursing workforce is accounted for in this function. The remaining 30% of the workforce is employed at schools, home health agencies, and other facilities, for which no ratio of average daily census or population served can be readily analyzed.⁶ Second, nurses and patients both travel outside county boundaries to give and receive care. However, we are unable to obtain data on commute patterns by occupation at this time due to confidentiality constraints regarding the release of healthcare providers' Social Security Numbers.

Other methodological approaches were explored by OSHPD staff and were indicated in a separate report on March 9, 2009, "Registered Nurse Shortage Area Alternative Methodologies."

³ Census Day Totals are a measure of service delivery. This value is the sum of the number of days that a given bed was occupied by a patient. Each night healthcare facilities take a census of patients in each bed. The census is kept by bed type (Acute Respiratory Care, Burn, Coronary Care, Intensive Care, Intensive Care – Newborn Nursery, Perinatal, Pediatric, Rehabilitation Center, and Unspecified General Acute Care). The GAC Census Days are the sum of the census for each of the nine GAC bed designations. A similar number is obtained for Long-Term Care Facilities.

⁴ 5% of the RN workforce is at LTC facilities, while 64% of the RN workforce is at GACs.

⁵ The scale factor is 0.08. This number is the percent of the workforce at LTC facilities, in our function. It is derived from 5 (percent of nurses employed at LTC facilities) / 64 (percent of nurses employed at GACs).

⁶ CA Workforce Initiative, Center for Health Professions, UCSF. 2001. *Nursing in CA: A Workforce Crisis*.

Assessment

No new data sources currently exist which would enhance or change the adopted approach. The results from the last adopted approach are displayed in a separate memo, “Registered Nurse Shortage Area Update” on April 21, 2011.

Results

This analysis was performed by using the current methodology of counties as the analytical unit. The mean ratio for counties was 43.81. In the county analysis, 27 counties were designated as RNSAs. Since the February 2011 Commission meeting, designation status has changed for one county. Lake County lost designation.

Alpine County and Sierra County are automatically designated since there are no counts for Long-Term Care Facilities (LTCs) or General Acute Care Hospitals (GACs). (See map on page 7)

Table 1 illustrates the RNSA listed alphabetically by county, where *LTCPatient* is the patient days for long-term care facilities, *GACCensus* is the patient census days for general acute care hospitals, *BRNCount* is the number of registered nurses per county from the BRN, *Ratio* is the ratio of each county derived from the Ratio Equation, and *Designated* is whether that particular county has been designated according to the mean. The mean is calculated by the sum of the ratio for each county divided by 58; the number of counties in California. Table 2 on Page 5 ranks the counties by ratio. A map is also included on Page 7 to show the county designations. *Note: the yellow highlighted row in Tables 1 and 2 indicate the County whose designation status has changed since the last RNSA update in February 2011.

Table 1 – RNSA Listed Alphabetically by County; Mean Designation Cutoff >43.81

County	LTCPatient	GACCensus	BRNCount	Ratio	Designated
Alameda	1,645,910	614,425	13,395	55.70	Yes
Alpine	0	0	8	0.00	Yes
Amador	41,203	7,601	285	38.24	No
Butte	339,968	118,438	2,399	60.71	Yes
Calaveras	33,702	5,114	461	16.94	No
Colusa	30,621	3,106	55	101.01	Yes
Contra Costa	883,902	353,087	11,621	36.47	No
Del Norte	26,419	8,001	225	44.95	Yes
El Dorado	77,411	31,736	2,227	17.03	No
Fresno	956,370	383,515	7,902	58.22	Yes
Glenn	26,132	1,116	99	32.39	No
Humboldt	123,317	46,655	1,425	39.66	No
Imperial	81,654	47,864	900	60.44	Yes
Inyo	28,135	2,742	183	27.28	No
Kern	513,581	324,497	5,343	68.42	Yes

County	LTCPatient	GACCensus	BRNCount	Ratio	Designated
Kings	97,692	36,654	922	48.23	Yes
Lake	77,721	14,154	466	43.72	No
Lassen	0	4,007	219	18.30	No
Los Angeles	11,848,304	4,765,336	72,615	78.68	Yes
Madera	135,636	105,901	885	131.92	Yes
Marin	309,820	84,641	3,441	31.80	No
Mariposa	0	793	134	5.92	No
Mendocino	78,367	21,442	760	36.46	No
Merced	229,511	54,677	1,207	60.51	Yes
Modoc	0	789	48	16.44	No
Mono	0	1,591	99	16.07	No
Monterey	312,561	148,503	2,942	58.98	Yes
Napa	239,097	59,194	2,199	35.62	No
Nevada	125,546	24,868	1,309	26.67	No
Orange	2,169,995	1,151,329	25,627	51.70	Yes
Placer	325,341	161,481	4,827	38.85	No
Plumas	18,400	4,089	168	33.10	No
Riverside	1,395,191	669,787	17,229	45.35	Yes
Sacramento	1,119,840	632,963	12,607	57.31	Yes
San Benito	0	7,286	342	21.30	No
San Bernardino	1,354,571	819,632	17,440	53.21	Yes
San Diego	2,598,381	1,219,544	29,484	48.41	Yes
San Francisco	423,018	539,950	7,623	75.27	Yes
San Joaquin	856,413	232,822	5,098	59.11	Yes
San Luis Obispo	268,719	80,014	2,955	34.35	No
San Mateo	418,002	190,364	8,314	26.92	No
Santa Barbara	340,205	128,987	2,833	55.14	Yes
Santa Clara	1,551,789	738,467	14,318	60.25	Yes
Santa Cruz	175,375	71,955	2,701	31.83	No
Shasta	269,647	103,601	2,202	56.85	Yes
Sierra	0	0	25	0.00	Yes
Siskiyou	19,055	8,300	407	24.14	No
Solano	257,725	132,092	5,637	27.09	No
Sonoma	464,794	137,574	5,075	34.43	No
Stanislaus	583,695	263,956	4,173	74.44	Yes
Sutter	126,470	11,567	750	28.91	No
Tehama	18,115	8,806	314	32.66	No
Trinity	0	1,923	73	26.34	No
Tulare	454,503	160,918	2,998	65.80	Yes
Tuolumne	42,756	19,942	625	37.38	No

County	LTCPatient	GACCensus	BRNCount	Ratio	Designated
Ventura	502,611	261,743	7,416	40.72	No
Yolo	229,850	18,865	1,407	26.48	No
Yuba	29,775	39,185	390	106.58	Yes

Table 2 – RNSA Listed by Ratio (for Counties); Mean Designation Cutoff >43.81

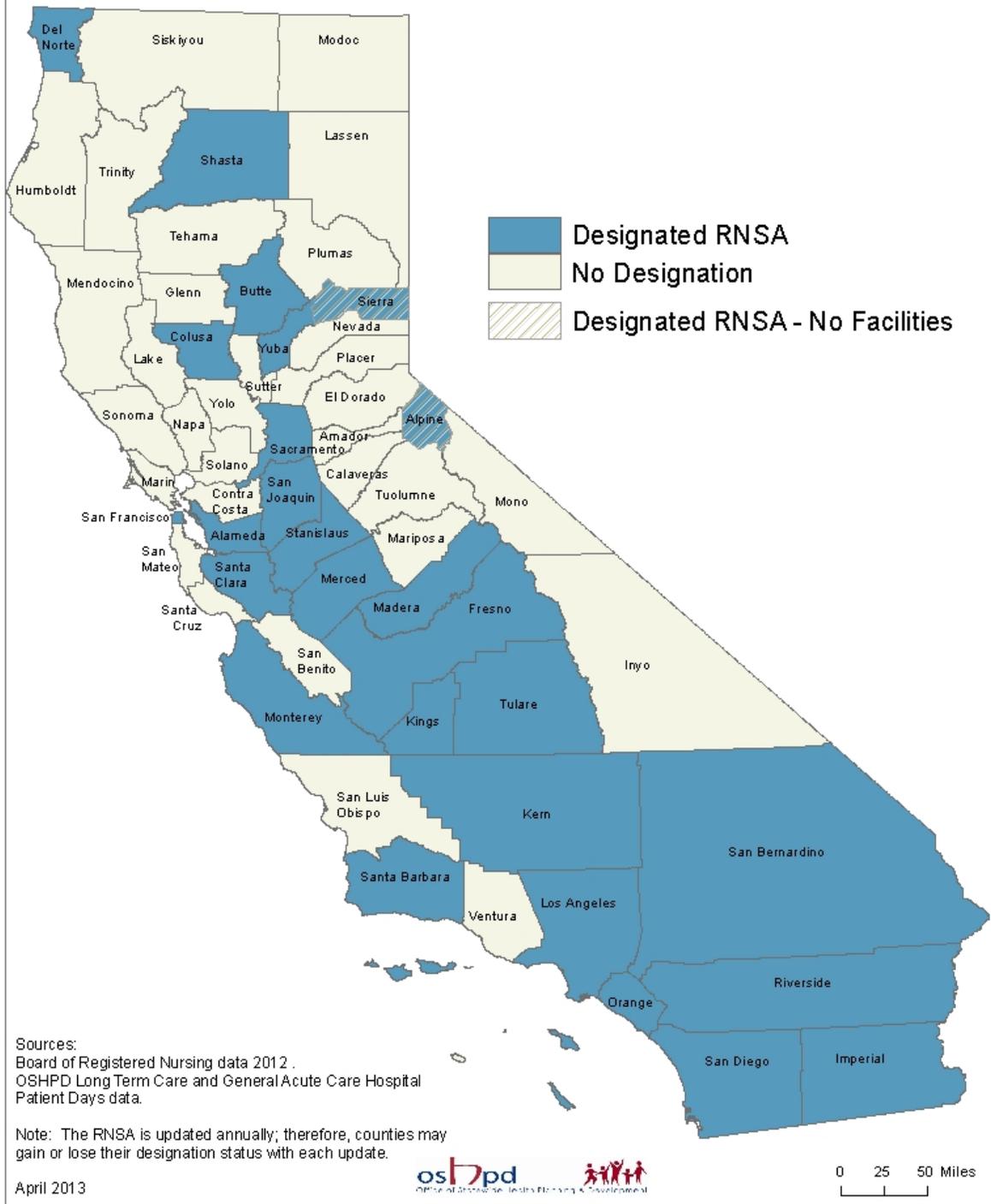
County	LTCPatient	GACCensus	BRNCount	Ratio	Designated
Mariposa	0	793	134	5.92	No
Mono	0	1,591	99	16.07	No
Modoc	0	789	48	16.44	No
Calaveras	33,702	5,114	461	16.94	No
El Dorado	77,411	31,736	2,227	17.03	No
Lassen	0	4,007	219	18.30	No
San Benito	0	7,286	342	21.30	No
Siskiyou	19,055	8,300	407	24.14	No
Trinity	0	1,923	73	26.34	No
Yolo	229,850	18,865	1,407	26.48	No
Nevada	125,546	24,868	1,309	26.67	No
San Mateo	418,002	190,364	8,314	26.92	No
Solano	257,725	132,092	5,637	27.09	No
Inyo	28,135	2,742	183	27.28	No
Sutter	126,470	11,567	750	28.91	No
Marin	309,820	84,641	3,441	31.80	No
Santa Cruz	175,375	71,955	2,701	31.83	No
Glenn	26,132	1,116	99	32.39	No
Tehama	18,115	8,806	314	32.66	No
Plumas	18,400	4,089	168	33.10	No
San Luis Obispo	268,719	80,014	2,955	34.35	No
Sonoma	464,794	137,574	5,075	34.43	No
Napa	239,097	59,194	2,199	35.62	No
Mendocino	78,367	21,442	760	36.46	No
Contra Costa	883,902	353,087	11,621	36.47	No
Tuolumne	42,756	19,942	625	37.38	No
Amador	41,203	7,601	285	38.24	No
Placer	325,341	161,481	4,827	38.85	No
Humboldt	123,317	46,655	1,425	39.66	No
Ventura	502,611	261,743	7,416	40.72	No
Lake	77,721	14,154	466	43.72	No
Del Norte	26,419	8,001	225	44.95	Yes

County	LTCPatient	GACCensus	BRNCount	Ratio	Designated
Riverside	1,395,191	669,787	17,229	45.35	Yes
Kings	97,692	36,654	922	48.23	Yes
San Diego	2,598,381	1,219,544	29,484	48.41	Yes
Orange	2,169,995	1,151,329	25,627	51.70	Yes
San Bernardino	1,354,571	819,632	17,440	53.21	Yes
Santa Barbara	340,205	128,987	2,833	55.14	Yes
Alameda	1,645,910	614,425	13,395	55.70	Yes
Shasta	269,647	103,601	2,202	56.85	Yes
Sacramento	1,119,840	632,963	12,607	57.31	Yes
Fresno	956,370	383,515	7,902	58.22	Yes
Monterey	312,561	148,503	2,942	58.98	Yes
San Joaquin	856,413	232,822	5,098	59.11	Yes
Santa Clara	1,551,789	738,467	14,318	60.25	Yes
Imperial	81,654	47,864	900	60.44	Yes
Merced	229,511	54,677	1,207	60.51	Yes
Butte	339,968	118,438	2,399	60.71	Yes
Tulare	454,503	160,918	2,998	65.80	Yes
Kern	513,581	324,497	5,343	68.42	Yes
Stanislaus	583,695	263,956	4,173	74.44	Yes
San Francisco	423,018	539,950	7,623	75.27	Yes
Los Angeles	11,848,304	4,765,336	72,615	78.68	Yes
Colusa	30,621	3,106	55	101.01	Yes
Yuba	29,775	39,185	390	106.58	Yes
Madera	135,636	105,901	885	131.92	Yes
Alpine	0	0	8	0.00	Yes
Sierra	0	0	25	0.00	Yes

Recommendation

Since the development and implementation of the current RNSA methodology, there has not been a formal method of measuring the nursing shortage. Staff recommends the continued use of the current methodology using the county mean as the analytical unit and adoption of this paper as a formal motion, thereby revising the list of designated RNSAs.

Registered Nurse Shortage Areas (RNSAs) By County Using the Mean as the Analytical Unit



Workforce: IMG physicians

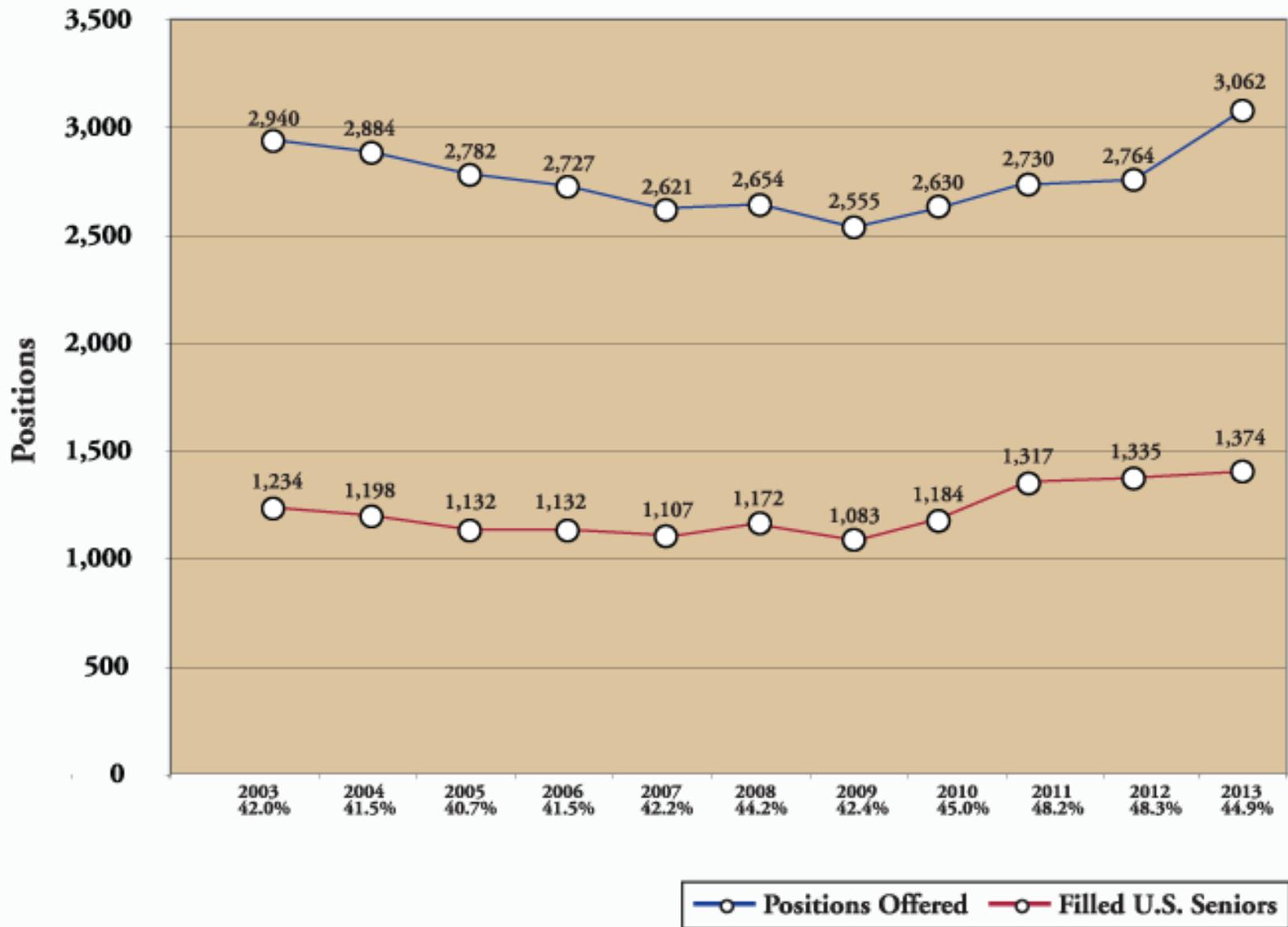
Ashby Wolfe MD, MPP, MPH

CHWPC

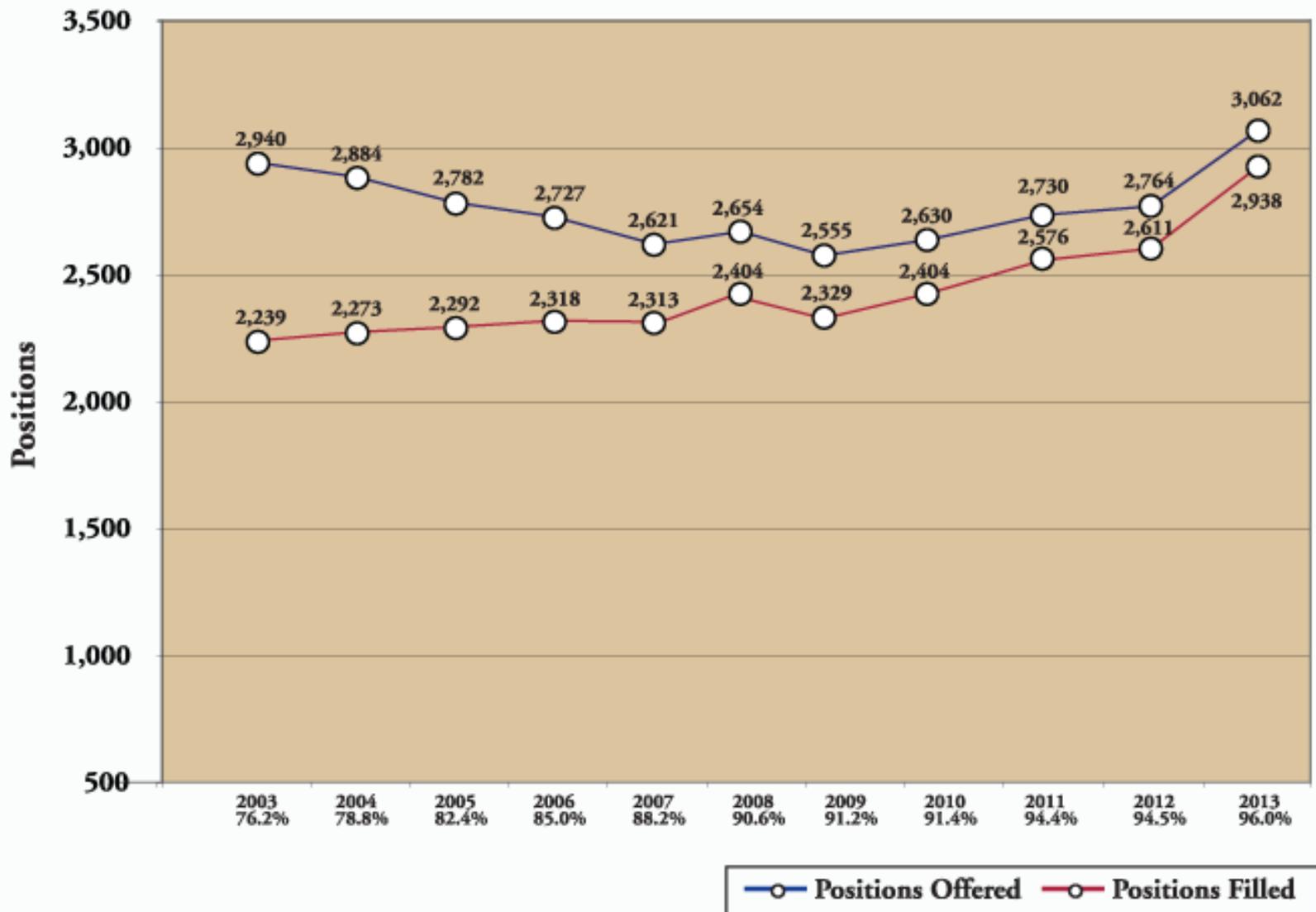
May 29, 2013

Family Medicine Match Statistics

- 2,938 positions filled out of 3,062 positions offered (96.0%)
- Two hundred and ninety-eight more family medicine positions (10.8%) were offered in 2013 compared with 2012
- Three hundred and twenty-seven more positions (11.1%) were filled in 2013 compared with 2012
- Thirty-nine more U.S. seniors (1,374 vs. 1,335) chose family medicine in 2013
- 2013 National Resident Matching Program (NRMP)



- AAFP National Residency Match Program Summary and Analysis
<http://www.aafp.org/online/en/home/residents/match.html>



- AAFP National Residency Match Program Summary and Analysis.
<http://www.aafp.org/online/en/home/residents/match.html>

International Medical Graduates

- Complete medical training in another country and would like to practice here in the US
- CA "approved school" confers direct eligibility
- July 2012 Match analysis
 - 1,209 (34.6%) of the 3,494 first-year family medicine residents were international graduates
 - 409 (11.7%) first-year residents were non-US citizen IMGs
 - 800 (22.8%) were US citizen IMGs
- Bieck *et al.* Results of the 2012 National Resident Matching Program: Family Medicine. *Fam Med* 2012;44(9):615-9.)

UCLA IMG program

- Goal: to provide bilingual (English/Spanish) family physicians for underserved rural and urban communities in California
- Focus on care of vulnerable populations
- Graduates are required to spend 24 to 36 months in an underserved community providing care to those immigrants and low-income patients who face financial and language barriers for care
- Service to the community after residency is a requirement for participation
- UCLA Department of Family Medicine <http://fm.mednet.ucla.edu/IMG/about/about.asp>

IMG Graduate Matches, 2007-2012

Natividad/Salinas	2
Stanislaus/Modesto	3
Kern/Bakersfield	2
Hanford/Loma Linda	4
UCSF/Fresno	6
San Joaquin	1
Kaiser/Fontana	1
Riverside County	7
Glendale Adventist	2
Presbyterian/Whittier	2
UCLA Family Medicine	8
USC/CA Hospital	8
Pomona Valley	4
Northridge Hospital	1
UCSD	2
Naval Hospital	1
JMMiami	1
TOTAL	54



Impact on HCWPC



California,
Primary Care,
Health Professional
Shortage Areas

**Family Nurse Practitioner/Physician Assistant
Proposed Special Programs Evaluation Criteria**

Section I		Statutory Criteria	Total Points Available
1	Placement of graduates in medically underserved areas. (% and # of graduates in areas of UMN)		15
1. a.	Counseling and placement program to encourage graduate placement in areas of unmet need.		5
1. b.	Cultural competency/culturally responsive care incorporated into the program curriculum		5
2	Attracting and admitting underrepresented minorities and/or economically disadvantaged groups to the program (% and # of URM students and graduates)		15
2. a.	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.		10
3	Location of the program and/or clinical training sites in medically underserved areas. (% and # training sites in areas of UMN)		15
3. a.	Percent of clinical hours in areas of unmet need		5
Total points possible for Section I			70
Section II		Other Considerations	
1	Does the proposed special program faculty possess the knowledge, skills and experience to deliver a primary care curriculum with an emphasis on health care disparities?		3
2	Does the training program structure its training to encourage graduates to practice as a health care team that includes family practice physicians as well as other health professions as evidenced by letters from the disciplines?		4
3	Does the proposed special program integrate different educational modalities into learning delivery models?		4
4	Does the proposed special program use technology assisted educational tools or integrate health information technology into the training model?		4
5	Has the training program developed coherent ties with medically underserved multi-cultural communities in lower socioeconomic neighborhoods as evidenced by letters of support?		4
7	Does the training program have an evaluation process to review the proposed special programs effectiveness and deficiencies such as those required by accrediting bodies successes and outcomes?		3
7.a.	How is the program addressing the deficiencies challenges identified by the accrediting bodies with the proposed special program?		3
8	Does the program utilize interdisciplinary and/or inter-professionals from the local community in the training program?		6
8.a.	Has the program increased the number of new clinical training sites meeting Song-Brown criteria?		3
3	Can proposed special program be replicated?		
3. a.	Does the program have a dissemination plan?		
-4	Has the program provided adequate information as to the sustainability of the proposed special program?		
4. a.	Are letters of support included to demonstrate sustainability?		
Proposed Other Consideration Criteria			
1	Is the proposed special program innovative and meet Song-Brown's goals of increasing FNP/PA's practicing in California?		3 4
2	Does the proposed special program include interdisciplinary training as part of their training model?		3 4
3	Does the training program have an evaluation process to review the proposed special program's successes and outcomes?		3
3. a.	How is the program addressing the challenges identified with the proposed special program?		3
Proposed Other Consideration Criteria The California Endowment			
4	Does the proposed special program include one of the social determinants of health as defined by The California Endowment? (e.g. poverty, employment, education and housing)		6 9
5	Does the proposed special program focus on increasing the number of health professionals from racial/ethnic and other underserved communities?		6 9
6	Is the proposed special program targeting any of the 14 Building Healthy Communities identified by The California Endowment? As evidenced by letters of support. http://www.calendow.org/communities/building-healthy-communities/		6-9
7	Does the proposed special program include activities to increase primary care career pathways?		6-9
Sub-total for Section II			50
Total Possible Score Section I and II			120