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INSTITUTION/AGENCY AGENDA
COLLEGE OF WESTERN IDAHO

SUBJECT
FY 2008 College of Western Idaho Budget Approval and Funds Transfer

REFERENCE

August, 2007	Finance Committee Chair report
November, 2007	Board released 2nd Installment of Appropriation

APPLICABLE STATUTE, RULE, OR POLICY
House Bill 283

BACKGROUND
House Bill 283 from the 2007 legislative session appropriated $5,000,000 to the Office of the State Board of Education in ongoing general funds for a newly formed community college district.

At the August 2007 Board meeting, the Finance Committee Chair reported that $300,000 was released to the College of Western Idaho (CWI) in compliance with Board policy. This action was approved by the Executive Committee. It was noted at the meeting that for any amount more than the $500,000, delegated authority would need to come to the full Board first.

At its November 2007 meeting, the Board approved the release of an additional $300,000 to CWI.

DISCUSSION
House Bill 283, Section 6 provides:

> The Legislature seeks to encourage local communities to establish new community college districts under existing law. As such, it is legislative intent that a newly formed community college district shall be eligible for up to $5,000,000 in ongoing General Fund moneys. The State Board of Education shall evaluate the business and operating plans of any newly created community college in determining the amount of General Fund moneys the college is eligible to receive. Any portion of the $5,000,000 which is not allocated to a new college shall be reverted to the General Fund. In the event that more than one (1) district is formed, and the Board determines that additional funding is necessary, the Board may request additional funding as a part of the annual budget process.

Therefore, the Board is required to evaluate the business plan and operating budget for CWI and determine the amount to remit to the College from the remaining $4.4 million.

IMPACT

The FY 2008 budget includes $5,000,000 in ongoing general funds and $20,000 interest income.

Non-credit classes are scheduled to commence January 2008, including short-term workforce training and adult basic education. Credit classes are scheduled to commence in fall of 2008.

ATTACHMENTS

Attachment 1: College of Western Idaho Business Plan Page 3

STAFF COMMENTS AND RECOMMENDATIONS

While the FY 2008 budget for CWI has been prepared using the best estimates possible, some agreements with Boise State University have not been finalized. Representatives from CWI will be available to present their business plan and answer questions.

Staff recommends approval.

BOARD ACTION

A motion to approve the FY 2008 operating budget and plan for the College of Western Idaho and to direct the Interim Executive Director for the Office of the State Board of Education to release to the College of Western Idaho $4.4 million in general funds currently appropriated in the general fund budget of the Office of the State Board of Education.

Moved by _____ Seconded by _____ Carried Yes _____ No _____

College of Western Idaho

Business Plan

November 2007

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EXECUTIVE SUMMARY

This business plan is intended to provide information regarding the establishment of the College of Western Idaho. On May 22, 2007, the voters of Ada and Canyon Counties voted to establish a community college district. A Board of Trustees was chosen and the executive management team has been hired and put in place.

The Board of Trustees and the management group will be going through a workshop exercise on November 13th to establish a vision and mission statement for the college. The Board and the management team are committed to establishing a comprehensive community college which will include academic/transfer courses and programs, professional-technical courses and programs, adult basic education, work-force training, and personal enrichment courses. The plan is to transfer the Larry G. Selland College of Applied Technology from Boise State University to the College of Western Idaho and it will provide the basis for everything except the credit/transfer programs. Boise State is also prepared to transfer to the college certain AA/AS programs which will be added to other degree and diploma programs developed by CWI.

The board of trustees voted to partner with Boise State University for accreditation and for the use of certain employees until the college is able to establish its own policies and procedures. An interagency agreement is being prepared so that the college can also contract for information technology and other services in the short-term from Boise State. The college will look at other partners for certain services as well. The college is committed to purchasing its own enterprise resource program (ERP) this fiscal year. The ERP will include systems for student tracking/financial aid, human resources/payroll, and finance. CWI plans to implement the systems, as soon as possible, to gain independence from all partners.

The College of Western Idaho will be developing a strategic plan, a facilities master plan, enrollment projections, and will be working with the community in meeting their educational/training needs.

The College of Western Idaho's programmatic plan is to contract with the Selland College of Boise State University to offer non-credit (workforce training and adult basic education) classes in January, 2008. Credit classes (both professional-technical and academic/transfer) will start in August, 2008 with registration beginning in April. The plan is to serve about 1200 professional-technical and 2000 academic/transfer credit students along with about 18,000 non credit students.

This plan is based on the best information currently available. Given the short time the college has been in existence and the deadline required for submittal of this document, it is important to stress that the timing of the offerings will depend upon the finalization of the interagency agreement with Boise State University and the various subsequent MOU's that will have to be negotiated. The other variable is the ability for BSU, as CWI's partner, to support the College of Western Idaho from an Information Technology standpoint on fairly short notice.

Because of the complicated nature of trying to establish an independent entity and at the same time partner to transition people, classes and programs from another institution, there may have to be modifications made to the plan. Regardless of whether the College of Western Idaho hires its own people or whether it has to contract for people and services, the funding is still very much needed and we formally request that the remaining $4.4 million be allocated to the College of Western Idaho.

SECTION I: Ownership

Address and contact information:

College of Western Idaho
5500 East University Way
Nampa, Idaho 83687

Phone: 208-562-3500
Web address: http://www.cwidaho.cc

CWI Trustees:

Name	Phone number	Email
Jerry Hess, Chairman	250-3804	JerryHess@cwidaho.cc
Mark Dunham, Vice Chairman	871-8884	MarkDunham@cwidaho.cc
Mary C. Niland, Secretary	989-8621	MCNiland@cwidaho.cc
Hatch Barrett	921-6955	HatchBarrett@cwidaho.cc
Guy Hurlbutt	921-6793	GuyHurlbutt@cwidaho.cc

CWI Executive Officers and Staff:

Interim President:		
Dennis E. Griffin, Ed.D.	562-3500	DennisGriffin@cwidaho.cc
Executive Vice President for Instruction and Student Services:		
Victor B. Watson, Ed.D.	562-3254	VictorWatson@cwidaho.cc
Vice President for Finance and Administration		
Cheryl A. Wright	562-3299	CherylWright@cwidaho.cc
Chief Technology Officer		
Brian Currin	426-4089	BrianCurrin@cwidaho.cc
Special Assistant to the Vice President of Finance		
Cathy Hampton	562-3300	CathyHampton@cwidaho.cc
Management Assistant		
Debbie Jensen	562-3232	DebbieJensen@cwidaho.cc

Process utilized to start the College of Western Idaho:
The development of House Bill 283: APPROPRIATION OF MONEYS FOR THE OFFICE OF THE STATE BOARD OF EDUCATION FOR FISCAL YEAR 2008, SECTION 6

Boise State University has been a strong advocate for the establishment of a community college in the Boise region. The Boise geographic area was the most populated area in the United States that did not provide its citizens the opportunity to access a comprehensive community college prior to the establishment of the College of Western Idaho. Boise State University, numerous community and state leaders, worked diligently along with Governor Butch Otter to develop a proposal to expand Idaho's community colleges.

The original suggestions for legislative reform involved reducing the super majority to form a community college district from 66 2/3% voter approval to 60%. A legislative committee studying community colleges during the summer of 2006, endorsed the recommendation for a reduced level for voter approval of a community college district. The legislative committee also spent significant time addressing the issue of State versus local control for community college governance.

Governor Otter encouraged local communities to establish new community college districts when he requested the state legislature allocate $5 million to the general fund for fiscal year 2008 to provide startup money for any community willing to establish a new community college District.

Micron Technology Inc. conducted a survey, which indicated 71% of those surveyed would support a community college in the Boise area. Additional advocates included the J. A. and Katherine Albertson Foundation which pledged to make a significant contribution if the community college district was established.

The state legislature in the House Bill 283, Section 6, as part of the State Board of Education appropriation bill passed the following legislation.

> *"The legislature seeks to encourage local communities to establish new community college districts under existing law. As such, it is legislative intent that a newly formed community college district shall be eligible for up to $5 million in ongoing General Fund money. The State Board of Education shall evaluate the business and operating plans of any newly created community college in determining the amount of General Fund monies the college is eligible to receive. Any portion of the $5,000,000, which is not allocated to a new college, shall be reverted to the General Fund. In the event that more than one (1) district is formed, and the Board determines that additional funding is necessary, the Board may request additional funding as part of the annual budget process."*

This legislation was instrumental in the approval of the community college district for Ada and Canyon Counties. The approval of the community college district established the third community college in the State of Idaho.

State Board of Education appointment of the College of Western Idaho Trustees:
One of the most important indicators that the citizens of Ada and Canyon Counties were strong advocates for the newly established community college district was the response by 102 people who applied to be a member of the initial Board of Trustees. The State Board of Education faced a daunting task as they narrowed the application pool from 102 to the final appointment of five individuals to serve on this inaugural board.

The College of Western Idaho Trustees were appointed by the State Board of Education on July 16, 2007. The Board of Trustees will serve through 2008. In the November, general election of 2008, each member will stand for election if they choose to do so. The terms will be staggered at this point in time with the length of terms to be determined by a lot draw.

The five Board of Trustees members are the official governing board for the College of Western Idaho. Their role in the establishment of this community college will remain significant many years into the future.

Description of a comprehensive community college:
The American Association of Community College's provides this perspective on America's community colleges.

> *"Community colleges are centers of educational opportunity. They are an American invention to put publicly funded higher education at close to home facilities, beginning nearly 100 years ago with Juliette Junior College. Since then they have been inclusive institutions that welcome all who desire to learn, regardless of wealth, heritage, or previous academic experience. The process of making higher education available to the maximum number of people continues to evolve at 1,173 public and independent community colleges."*

The evolution of the community colleges from the original Juliette Junior College has been an ever-expanding role to meet the educational needs of the communities the colleges serve. Today a comprehensive community college not only provides students the opportunity to complete the first two years of a baccalaureate degree, or to seek an associate degree or certificate in a chosen technical profession, but also provides students the opportunity to develop the educational skills they will need to succeed in higher education through developmental educational opportunities and adult basic education. Meeting the educational needs of the community is complex. Centers for business and industry, and community education opportunities are key in meeting this complex challenge. Community colleges are enhancing the high school educational experience by offering dual credit programs in the area high schools giving high school students a head start in completing their college education.

The College of Western Idaho is planning to meet each aspect of a comprehensive community college. The Board of Trustees is committed to this goal and will continually seek input from the community they serve to ensure that the College of Western Idaho is responsive in providing quality educational experiences for the citizens of this region.

Role and Mission of the College:
The Board of Trustees will be finalizing the vision and mission statements for the College of Western Idaho at a special meeting on November 13, 2007. Dr. Kathy Hagler will facilitate the process.

Success Factors:
Many factors play into the success of any community college, both tangible and intangible.

Tangible factors would include the following:

1. Sufficient funding to secure top quality faculty and staff.
2. Sufficient funding to provide modern teaching-learning facilities and equipment, to include distance learning technologies.
3. Dedicated and experienced administrative and student service staff.
4. Dedicated and experienced faculty who understand the community college concept and implement practices in keeping with that concept.
5. Supportive Trustees.

Intangible factors would include at least the following:

1. A supportive, engaged local community.
2. Staff who have been trained in and exemplify a "student first" attitude.
3. College goals that reflect the needs of the community.
4. College goals that reflect best practices in community college education.

SECTION II: Products and Services

Course Offerings:
Noncredit workforce training and adult basic education courses, especially GED, will be offered beginning in January 2008. Professional technical education (PTE) courses, as currently offered by Selland College of Applied Technology, plus general education/college transfer courses, including developmental courses will be offered beginning fall 2008.

The College of Western Idaho will expand course offerings and add additional professional technical programs in subsequent years, as the need becomes apparent.

The mode of delivery for classes will be lecture, lab, internships, hybrid electronic, internet individualized instruction, and electronic distance.

Tuition and Fees:
The initial tuition and fees for students will be one hundred eighteen dollars ($118) per credit hour.

Student and Community Services:
Financial Aid will initially be available to CWI students through BSU, the accreditation partner, as necessitated by federal regulations. Advisors will be available at the BSU main Campus, BSU West campus and the Canyon County Center. The projected costs budgeted for student services

in fiscal year 2008 is $370,359. Development and production of student handbooks, catalogs and class schedules will start soon after the Public Information Officer is hired. The fiscal year 2008 budget includes a total of $180,000 for design and production of the necessary student material.

Advising:
Academic and career counseling will be available at the BSU main, West and Canyon County campuses.

Development of Forms:
Admission forms are currently being developed. Some of the current BSU forms and processes are temporarily being used for advising and enrollment until the creation of CWI is finalized. CWI is required by the accrediting association to temporarily use the partner institute's registration and grade forms. These two forms will be developed as CWI moves along in the time lines set by the accrediting association.

Student housing, student activities and child care are not applicable at this time.

SECTION III: Possible Barriers for Meeting Student Enrollment Projections

Current PTE facilities are limited and create enrollment barriers. In order to meet the growing need for qualified employees in the Treasure Valley, CWI will need to build or lease facilities to house new and expanded PTE program offerings. PTE programs are often equipment intensive and require more room per student than general education classes. MOUs for use of BSU facilities will be developed in the near future. The current year budget for the use of BSU facilities is $138,541. The budget also includes $16,000 to lease office space for CWI administration. CWI staff will have to move to an off campus site in order to free up the current suite of offices for the fiscal year 2009 Department Chairs and Associate Vice President of Instruction.

The current general education facilities are adequate, but the potential future enrollment projections indicate new space will be needed in two to three years. CWI will need to partner with local school districts for open classroom space and will have to have added flexibility to the class schedules in order to meet demand.

Quality of instruction will be assured through MOUs between CWI and BSU as the accrediting partner, who will jointly review staff qualifications, evaluations and curriculum.

The current use of the BSU's information technology and student services systems provides CWI with the ability to move forward in fiscal year 2008. CWI is in the process of evaluating and purchasing relevant technology systems in order to be fully functional and independent. The budget of $1.7 million for the fiscal year 2008 purchase of the Enterprise Resource Program (ERP) is included under Academic Support. Once the funding is in place CWI will purchase the ERP in December 2007 or January 2008.

As shown in the fiscal year 2008 budget, the five million state appropriation for the community college provided for in House Bill 282, section 6 provides adequate funding for the immediate start up needs in fiscal year 2008. The five million dollar state appropriation for fiscal year 2008 will not create a barrier for the students. One of the biggest funding challenges for the near future will be the need to build new facilities that will enable CWI to move off of the BSU main campus and be able to expand to meet the near future demand. CWI needs to develop MOUs with BSU for facilities. The fiscal year 2008 budget has allowed for lease of the executive suite of offices and the conference room on the third floor of the BSU West academic building at $6 per square foot. The fiscal year 2009 budget includes a projected expense of approximately $2 million for occupancy costs for the space utilized by the Larry G Selland College on the main campus, the Canyon County Center and the BSU West Academic Building. Not having the MOUs in place is a potential barrier to the students.

SECTION IV: Potential Enrollment Growth and Competition:

One method of determining enrollment potential for the College of Western Idaho is to evaluate the percentage of the population in the CSI and NIC taxing districts compared to the student enrollment in credit offerings.

The 2006 Idaho Department of Labor statistics indicate that the total populations for the community college taxing districts were:

Ada County Population	359,035
Canyon County Population	173,302
Total Population for CWI Taxing District	**532,337**
Twin Falls County Population	71,575
Jerome County Population	20,130
Total Population for CSI Taxing District	**91,705**
Kootenai County Population	131,507
Total Population for NIC Taxing District	**131,507**

According to the State Board of Education, Student Headcount Report for Spring Semester 1997-2007 the 2006 student enrollments were:

CSI Student Credit Enrollment 2006	7,497
NIC Student Credit Enrollment 2006	4,119

The percentage of the taxing district population that enrolled in the community college credit offerings for the spring semester of 2006 were:

CSI student enrollment of 7,497 divided by the taxing district population of 91,705 equals **8.1%** of the population enrolling in the credit programs.

NIC student enrollment of 4,119 divided by the taxing district population of 131,507 equals **3.4%** of the population enrolling in the credit programs.

College of Western Idaho enrollment projections could easily fall within the range of 3.4% to 8.1% of the taxing district population enrolling in credit offerings once the total curriculum is developed and offered.

NIC	3.4% of the taxing district population
CSI	8.1% of the taxing district population
Average	5.75% of the CSI and NIC taxing districts population

Projected College of Western Idaho enrollment in credit offerings:

- 532,337 CWI taxing district population times the average percentage 5.75% equals **30,609** students
- 532,337 CWI taxing district population times CSI percentage 8.1% equals **43,119**[*] students
- 532,337 CWI taxing district population times NIC percentage 3.4% equals **18,009** students

The range of 18,009 students to 30,609 students does not include students who are accessing Adult Basic Education and non-credit community education and workforce training programs.

The State of Idaho is fortunate to have four state colleges/universities, two existing comprehensive community colleges, one technical college, and five private colleges/universities.

The potential competition heading associated with this section is somewhat misleading. The goal of the College of Western Idaho is to assist students in providing them the educational opportunities at a community college that will allow them to meet their ultimate educational goals. In actuality, the other educational institutions in the state of Idaho are viewed more as partners versus competitors in helping students meet their educational goals.

The issue of revenues based on enrollments is real. Knowing that other educational institutions in the state, and in some cases, outside of the state are vying for students to access their institution does develop competition.

As stated previously in this business plan, the metropolitan area of Boise, was the largest metropolitan area in the United States not to have a comprehensive community college physically located in the community. The College of Western Idaho, is preparing to meet what potentially could be an extremely large demand by students for community college services.

[*] This number reflects an amount based on a rural community college setting. In urban settings such as the Treasure Valley where potential students have numerous educational options in addition to the community college, a mature college would expect to enroll around four percent of the populous after ten or more years of operation.

The following table shows the various educational opportunities in the state of Idaho and includes Treasure Valley Community College.

TABLE 1: A COMPARISION OF DEGREES, PTE OFFERINGS, APPLICATION FEES, TUTION AND FEES, AND SEMESTER ENROLLMENTS OF IDAHO COLLEGES AND TREASURE VALLEY COMMUNITY COLLEGE, 2008

College Name	Location	Degrees Offered	PTE Programs	Application Fee	9 Month Tuition and Fees	Total Semester Enrollment
College Of Idaho	Caldwell	Bachelors	No	$50	$17,000	824
Boise Bible College	Boise	Bachelors	No	$25	$7,600	200
Boise State University	Boise	Bachelors, Master and Doctorate	Yes	$40	$4,410	18,876
BYU-Idaho	Rexburg	Associate and Bachelors	Yes	$35	LDS $3,060 Non-LDS $6,120	12,000
College of Southern Idaho	Twin Falls	Associate	Yes	None	$2,000	7,491
Eastern Idaho Technical College	Idaho Falls	Associate	Yes	$10	$1,728	1,410
Idaho State University	Pocatello	Associate, Bachelors, Masters, Doctorate	Yes	$40	$4,000	14,361
Lewis Clark State College	Lewiston	Associate, Bachelors	Yes	$35	$,4092	3,500
New Saint Andrews College	Moscow	Associate, Bachelors	No	$35	$7,800	200
North Idaho College	Coeur d'Alene	Associate	Yes	$25	$2,110	4,631
Northwest Nazarene	Nampa	Bachelors	No	$25	$19,700	1,735
University of Idaho	Moscow	Bachelors, Masters, Doctorate	No	$40	$4,414	11,739
Treasure Valley Community College	Ontario, Oregon	Associate	Yes	None	$3,420 for 3 quarters	12,000

Source: Idaho State Board of Education, Higher Education in Idaho booklet, 2008. Treasure Valley Community College Web Site, tvcc.cc.or.us

The higher educational institutions within 100 miles of the College of Western Idaho are:

- Boise State University
- Treasure Valley Community College
- College of Idaho
- Boise Bible College
- Northwest Nazarene University

These colleges enroll 33,635 students. This is a significant number, but in analyzing the enrollment figures 12,000 are enrolled in Treasure Valley Community College that is out of state leaving a balance of 21,635 students enrolled in Idaho colleges. Approximately 40% of the 21,635 students enrolled in Idaho Colleges in the Boise region are juniors, seniors or in graduate programs leaving only 12,981 who are currently enrolled as freshman or sophomores.

The College of Western Idaho will be assuming all of the community college functions currently offered by Boise State University including Professional Technical Education. The transfer of the PTE programs to the College of Western Idaho will be important in developing a strong student enrollment.

The only other college within a 100 miles radius of CWI that will offer an Associate Degree and Professional Technical Education is Treasure Valley Community College in Ontario, Oregon. The lower tuition rate and reduced commute distance will be positive factors for the College of Western Idaho.

The costs associated with attending The College of Idaho, Northwest Nazarene, Boise State University and the proprietary schools for the student seeking the first two years of their bachelors degree are significantly higher than the projected tuition and fees at the College of Western Idaho.

The role and mission of the College of Western Idaho as a comprehensive community college and the four-year liberal arts or research university roles and missions will provide the citizens of the region numerous options for achieving their educational goals.

As stated earlier, the concept of cooperation versus competition with the region's higher education institutions will be a positive approach to assisting students in meeting their educational goals.

SECTION V: Promotion of the College of Western Idaho

The Board of Trustees has appointed a subcommittee in charge of community relations. The Community Relations subcommittee has been actively seeking input from community leaders as well as keeping the communities informed of the community college's progress and plans.

The college is in the process of recruiting a Public Information Officer (PIO) and a Marketing Specialist. As soon as the Public Information Officer is on board, a comprehensive marketing plan will be developed and implemented.

The design, development, and production of the college catalog will be directed by the PIO in conjunction with BSU, the accreditation partner and the CWI marketing specialist. The CWI catalog will be produced in both traditional hard copies and electronically. Development of the class schedule will be handled in a similar manner but will include targeted placement of hard copies.

The Chief Technology Officer (CTO) has completed the initial development of the CWI web page. The CTO will hire a Systems Analyst/Developer in January, 2008 and will have an information technology team and Web team in place July 1, 2008.

Many of the necessary program brochures currently exist in the Larry G Selland College. These brochures and other publications will be updated to CWI. Other brochures will be developed by the Marketing Specialist with cognizant staff.

SECTION VI: Relationships and Formal Agreements

The College of Western Idaho has signed enrollment agreements with Boise State University to "loan" employees which the college desires to employ. These employees are under the operational control of the College of Western Idaho and report to management within CWI. This arrangement allows the employees to retain their benefits until the College of Western Idaho is able to set up its own system. Employees hired, who are not current Boise State employees, will be subject to Boise State's hiring policies and procedures and "loaned" to the College of Western Idaho, again, until the College of Western Idaho has developed its own human resources system.

In addition, the college has signed a Memorandum of Understanding (MOU) with Boise State University to partner with them relative to accreditation. Under this arrangement, the college's students will be able to receive federal financial aid. Within three to five years, the college will receive its own accreditation and the MOU with Boise State will end.

The College of Western Idaho will contract with Boise State for information technology (IT) services in the areas of finance, human resources/payroll, and student tracking until the college has its own IT system. The plan is for the college to purchase its own system as soon as possible and to become independent.

The Selland College of Applied Technology will be transitioned to the College of Western Idaho by the end of fiscal year 2008 and will become the Professional Technical unit with the College

of Western Idaho. During fiscal year 2009, certain AA/AS programs at Boise State will also be transitioned (e.g., criminal justice, respiratory therapy, general studies, nursing, etc.)

During fiscal year 2008, the College of Western Idaho will be paying for office space for the staff. In fiscal year 2009, the college will be paying Boise State for facility occupancy costs for offices, classrooms, and labs at the Canyon County Center, the BSU West Campus, and the BSU Main Campus all of which will house the College of Western Idaho programs.

SECTION VII: Personnel

CWI will have nineteen full time employees and one half time employee by April, 2008. The three executives in place are the President, Executive Vice President of Instruction and Student Services, plus the Vice President of Finance and Administration. The Chief Technology Officer and the Special Assistant to the Vice President of Finance are currently half-time professional staff and there is a full time management assistant. The two current half time staff will move to full time as of January 1. CWI will be adding a full time PIO and a half time Marketing Director, a Controller, and a Payroll Manager, as soon as possible. Between January and April 2008, CWI plans to hire a Dean of Student Services and three other Student Services personnel to be in place in early spring to register students for the fall semester. Other personnel needed in January will be a Systems Analyst/Developer, and one Administrative Manager. Three positions for security have been budgeted. Whether or not CWI needs security staff will be determined in future contracts with Boise State University.

CWI anticipates having 80.5 FTP by fall semester 2008. This does not include the number of employees currently in the Larry G Selland College of Applied Technology. Because the funding for the Selland College covers the current employees, the FTE and costs were not included in this plan or in the FY 2008 and FY 2009 proposed budgets presented to the CWI Board of Trustees on Oct 20, 2007 or to the State Board of Education on November 2, 2007. Future years budgets to the CWI Board of Trustees will include the funding and expenditures currently housed under the Larry G Selland College within Boise State University.

There are 20 full time faculty members, including one Dean, budgeted in fiscal year 2009 for personnel cost of $1.4 million. The fiscal year 2009 projection for part time faculty includes 50 adjuncts at a personnel cost of $605,495. Five support staff will be needed for the Dean and faculty budgeted at $220,000.

There will be fiscal year 2008 costs associated with recruiting and hiring the additional 65 employees along with developing all of the related personnel policies and procedures. Even though the bulk of additional employees will be hired in fiscal year 2009, funding must be available in fiscal year 2008 to have the employees in place in time to be fully functional for the start of classes in the fall of 2008.

The development of employee classifications, pay structure, job descriptions, employment policies, and determination of benefits will begin as soon as CWI hires a Controller and a Payroll Manager. The Controller will also take on the responsibilities for human resource issues at least

for the first few years. In fiscal year 2008, CWI employees continue to be covered under Boise State University's employee policies and benefit plans.

SECTION VIII: Management and Organization

Appendix 1 details the organizational chart for fiscal year 2008 and Appendix 2 has the organizational chart for fall 2008.

The CWI Board of Trustees has retained Eberle, Berlin, Kading, Turnbow & McKlveen Chartered as legal council, until the request for proposal for longer term representation has been completed. The 2008 budget projects $120,000 for legal services due to the necessity of reviewing policies and other legal issues related to the start-up of a community college.

Request for proposals for a search for an auditor for the college will be completed by December 30, 2007.

The Hartwell Corporation of Caldwell, Idaho serves as the college Idaho County Risk Management Program (ICRMP) agent. CWI is currently paying $1,000 annually for liability coverage on the trustees and current staff.

CWI chose US Bank Corporation to provide the college's main checking account. An investment account will be established at the State of Idaho's Treasurer's Office in the Local Government Investment Pool (LGIP), as soon as possible. The LGIP will be used for short term investments based on cash flow projections.

The Board of Trustees and the Executive staff plan to use consultants for several of the processes that need to be completed in the short period of time available to be ready for offering credit classes fall 2008. Some examples are: a consultant has been hired to facilitate the development of a Vision Statement, Mission Statement, and a strategic plan; CWI is negotiating with a second consultant to assist with the development of the necessary policies and procedures for the College of Western Idaho; two alternatives are being considered to assist with training for the Board of Trustees. The 2008 budget includes an expenditure of $100,000 for consultants, plus the budget for the Trustees includes funds for training and travel.

Both the Board of Trustees and the executive staff are utilizing key advisors and mentors. Leaders at the College of Southern Idaho, North Idaho College, and Boise State University have been extremely helpful on all levels. The support CWI has been shown from these institutions has been invaluable.

SECTION IX: Financial Projections

The difficulty in projecting financial needs for the current year and next year is primarily because memorandums of understanding and contracts with the Boise State University are not defined yet. Another important factor yet to be determined is an agreement for facilities. As of the formation of the budget, there have been no agreements on the short term or long term use of the land and current academic building at the BSU West campus, the Canyon County Center or facilities used by Larry G. Selland College on the BSU main campus.

CWI depended heavily on the research and benchmarking completed by Boise State University over the last two years in relation to the projected costs for fiscal year 2008 and fiscal year 2009. Stacy Pearson, CFO for BSU; Mike Mason, CFO for CSI; and Rolly Jurgens, CFO for NIC were all consulted on various segments of the budget preparation.

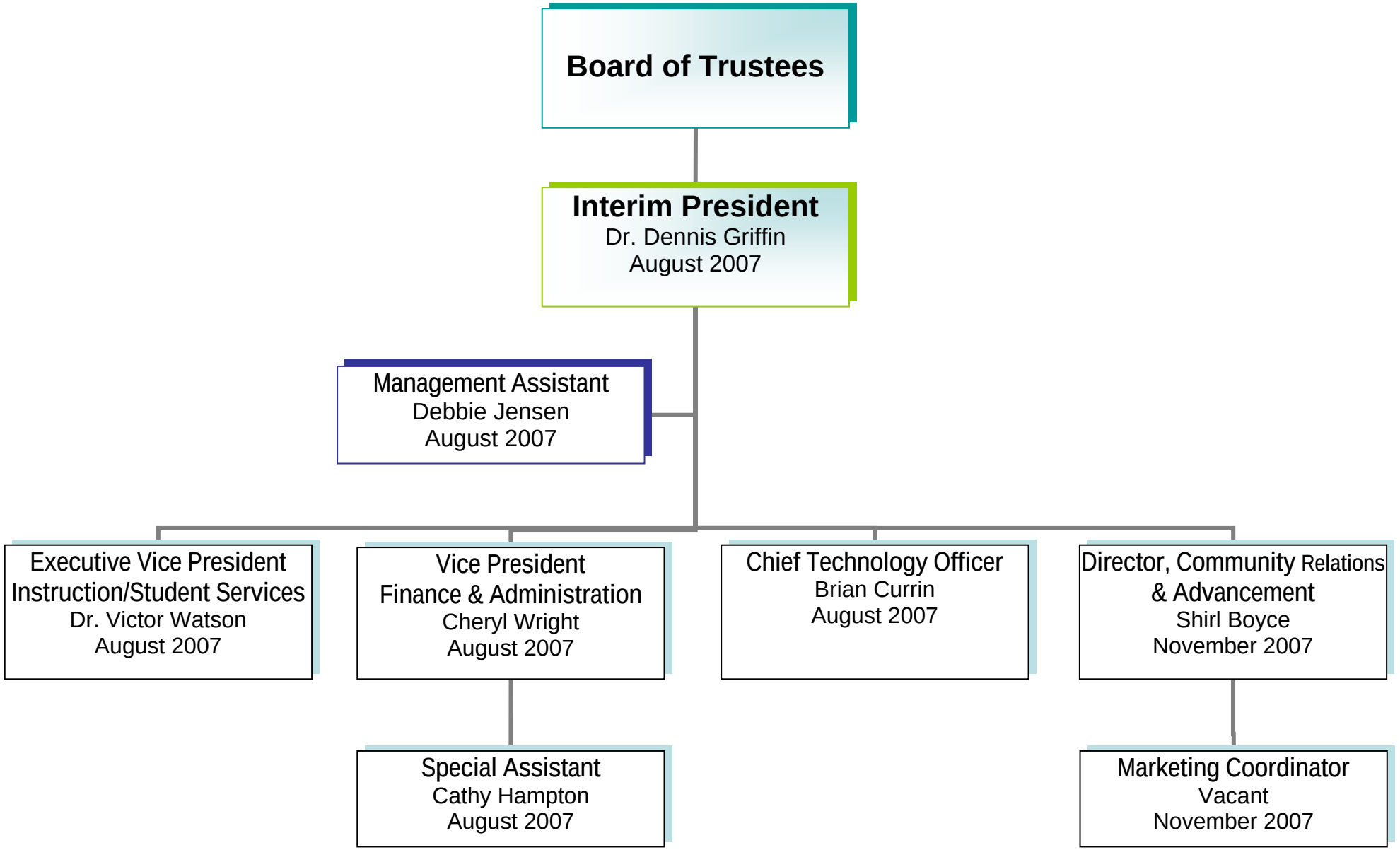
CWI will be filing the required L2 form with the Ada and Canyon County commissioners on or before September 1, 2008. The county commissioners use this form to establish the local tax levy. The Board of Trustees will finalize the processes involved to determine the amount that CWI will need to request from the counties. CWI will be operating as a comprehensive community college one semester before local tax revenue is received in January 2009.

SECTION X: Appendices List

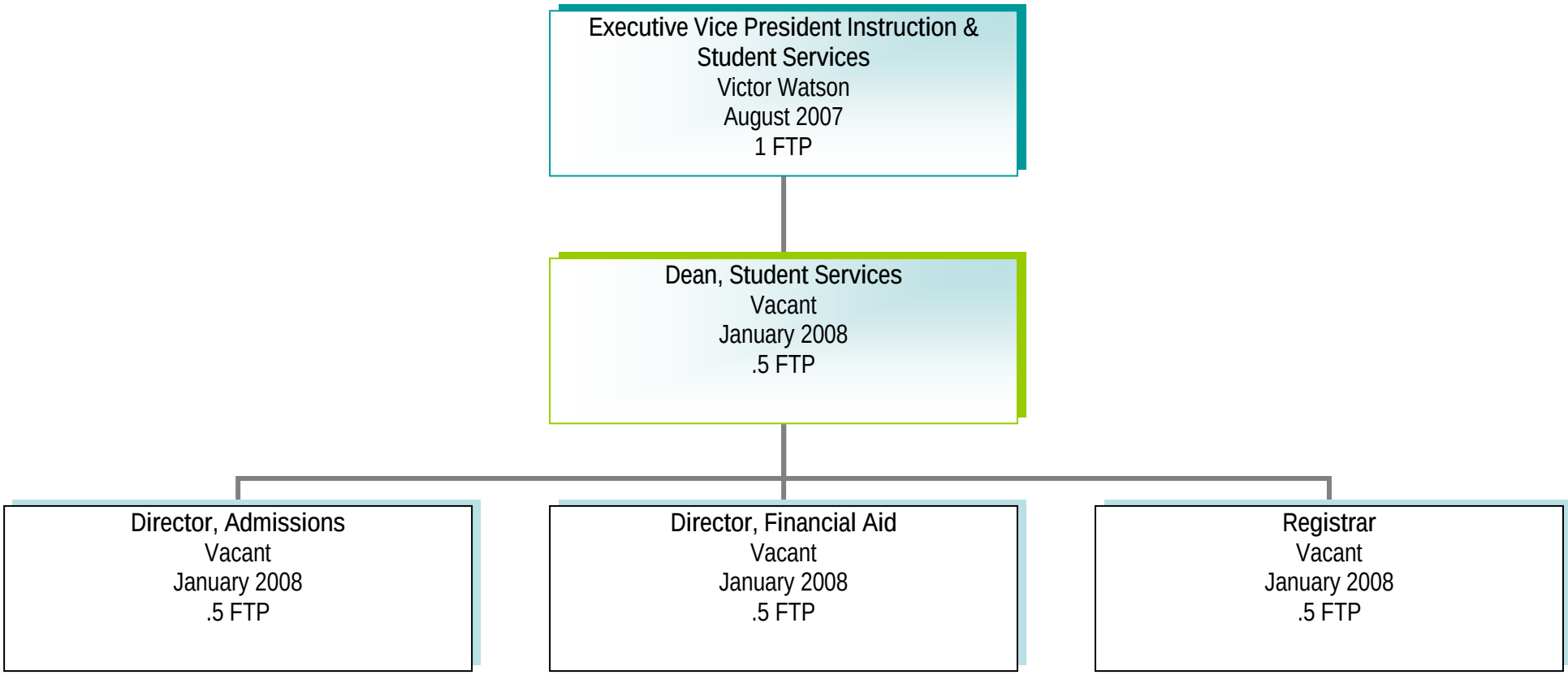
Appendix 1	Fiscal Year 2008 Organizational Chart
Appendix 2	Fall 2008 Organizational Chart
Appendix 3	Fiscal Year 2008 Budget Narrative and Budget
Appendix 4	Fiscal Year 2009 Budget Narrative and Budget
Appendix 5	Proposed Fee Schedule Under Current Legislation
Appendix 6	Proposed Fee Schedule if New Legislation Passes

APPENDIX 1

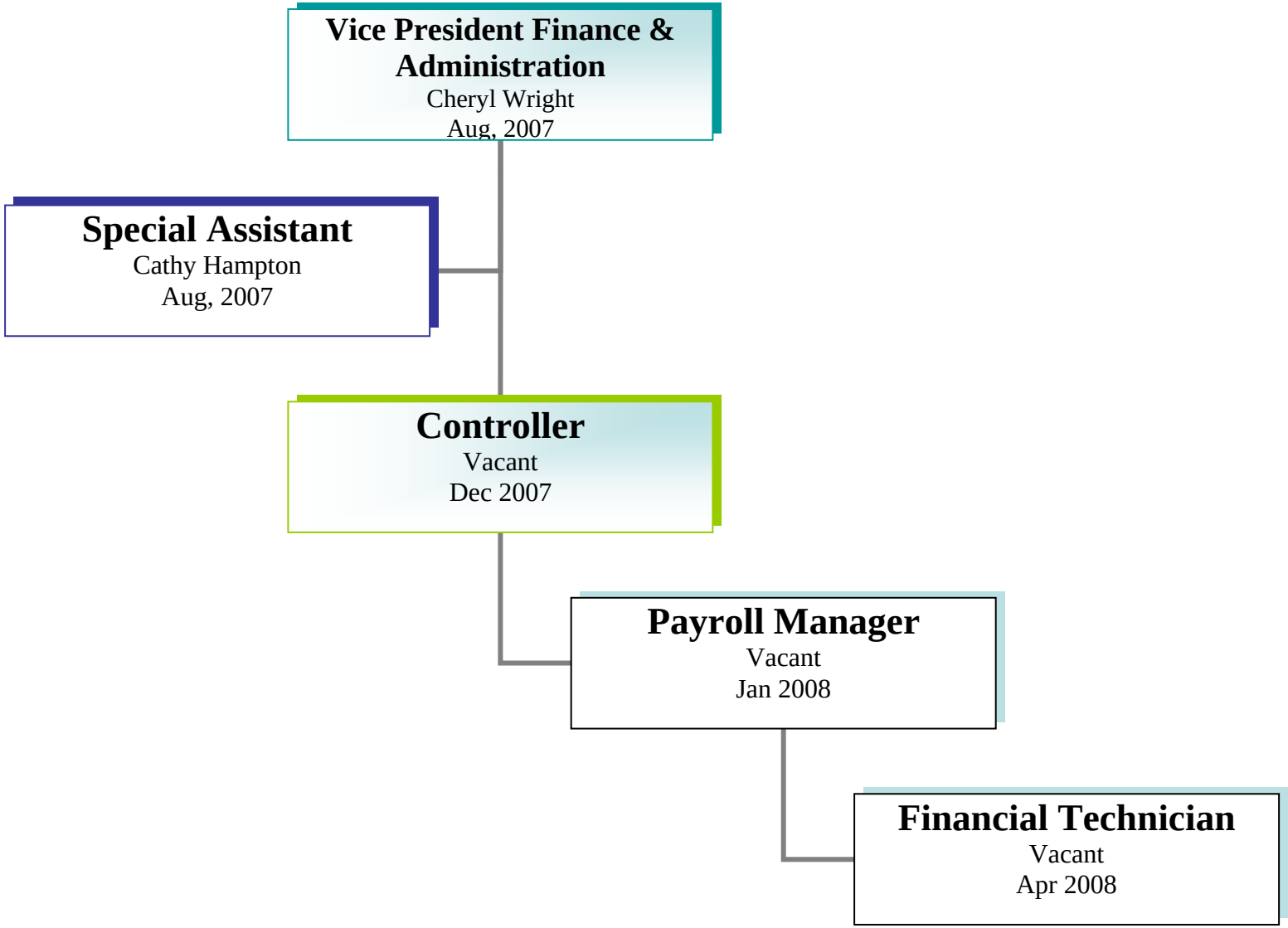
College of Western Idaho Organizational Chart FY08



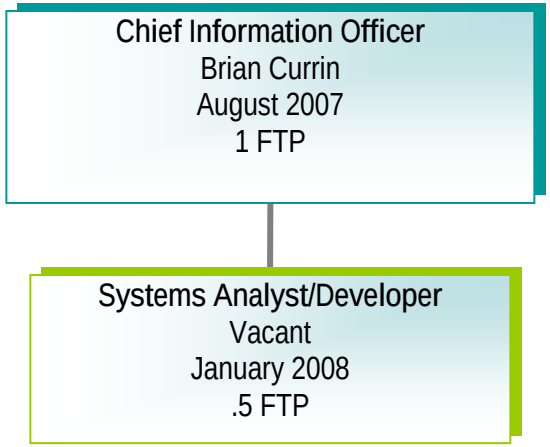
Executive Vice President, Instruction & Student Services
Organizational Chart
FY08



Finance & Administration Organizational Chart
FY08



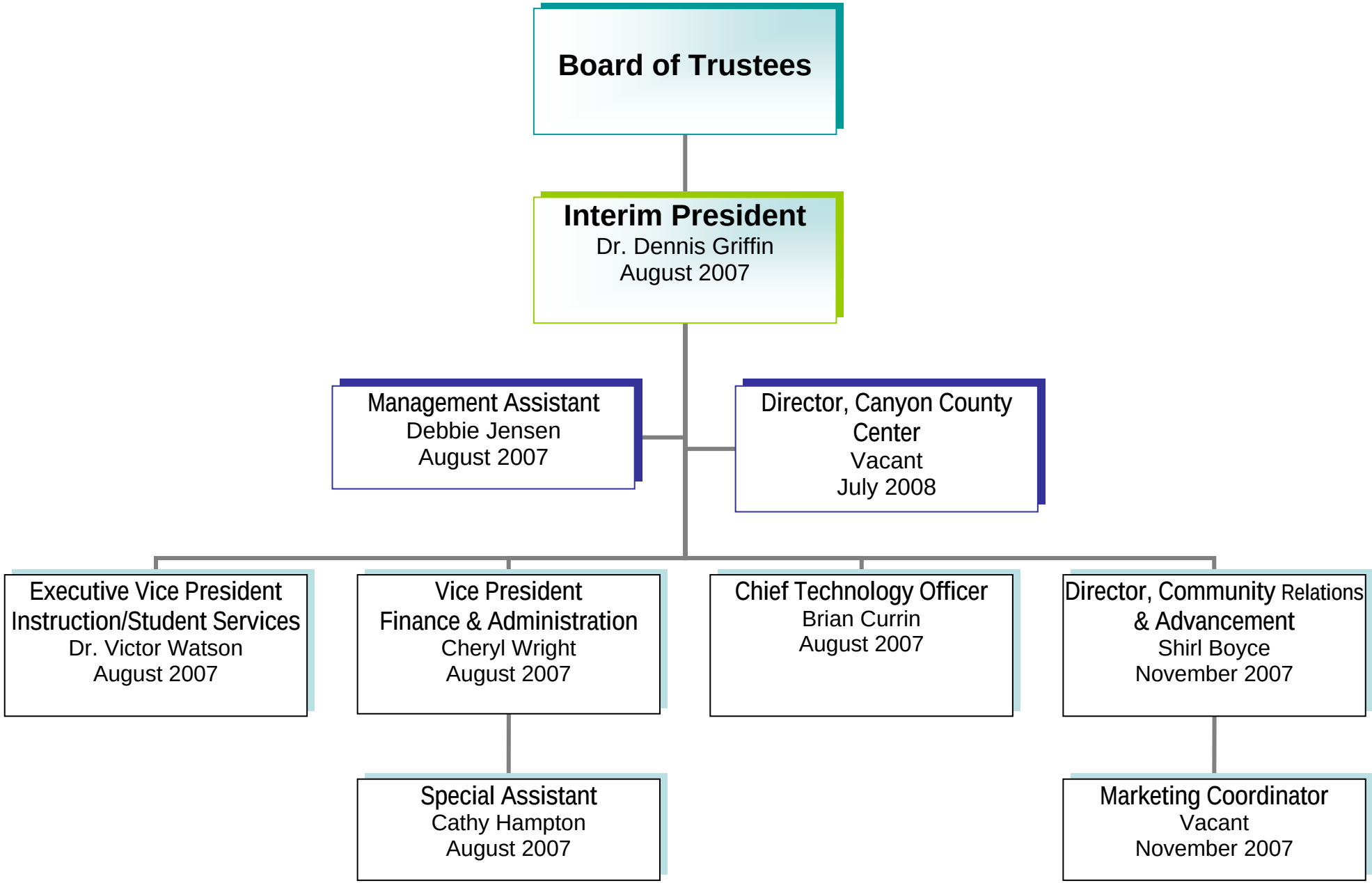
Information Technologies Organizational Chart
FY08



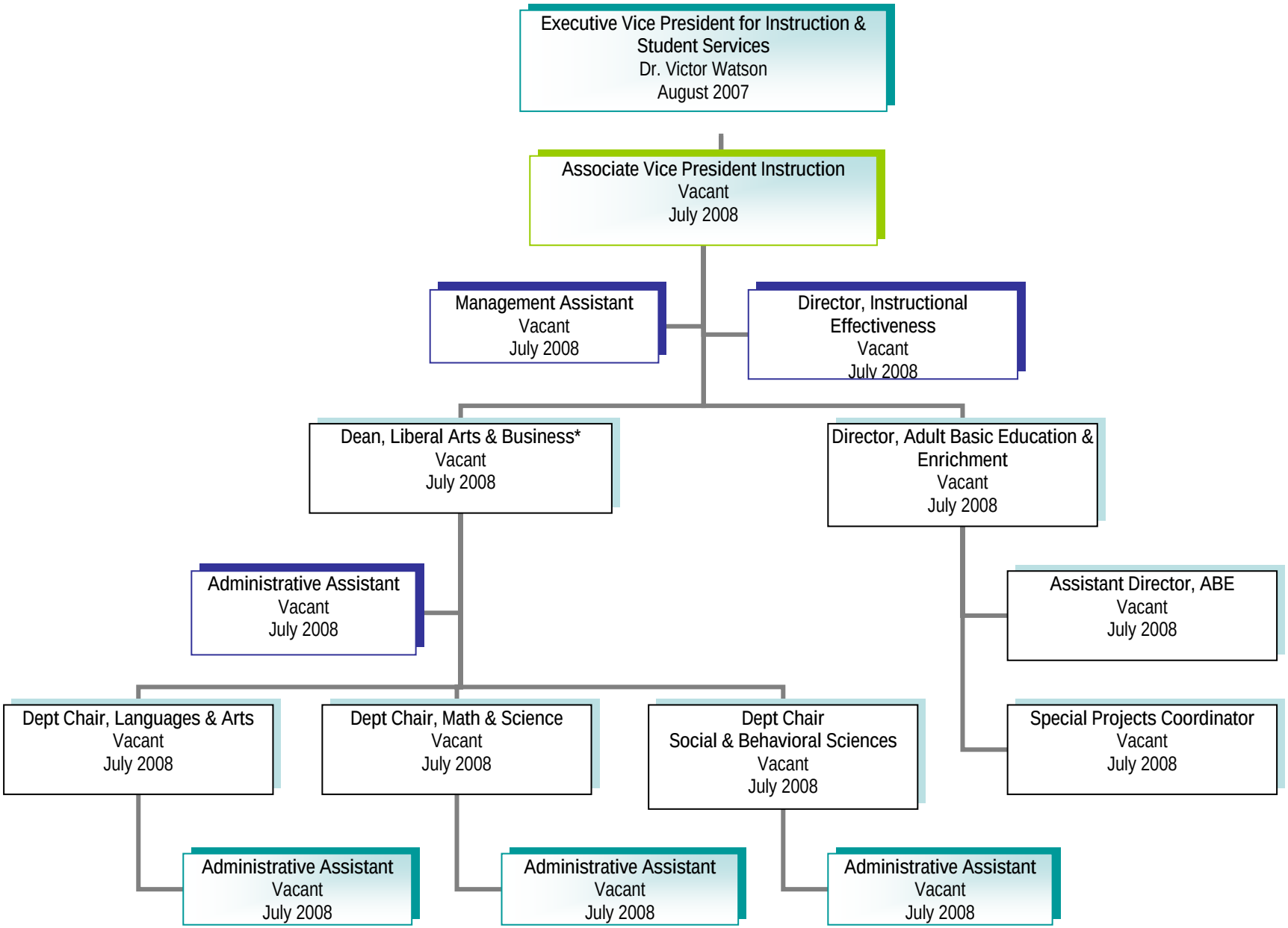
Community Relations & Advancement Organizational Chart
FY08

APPENDIX 2

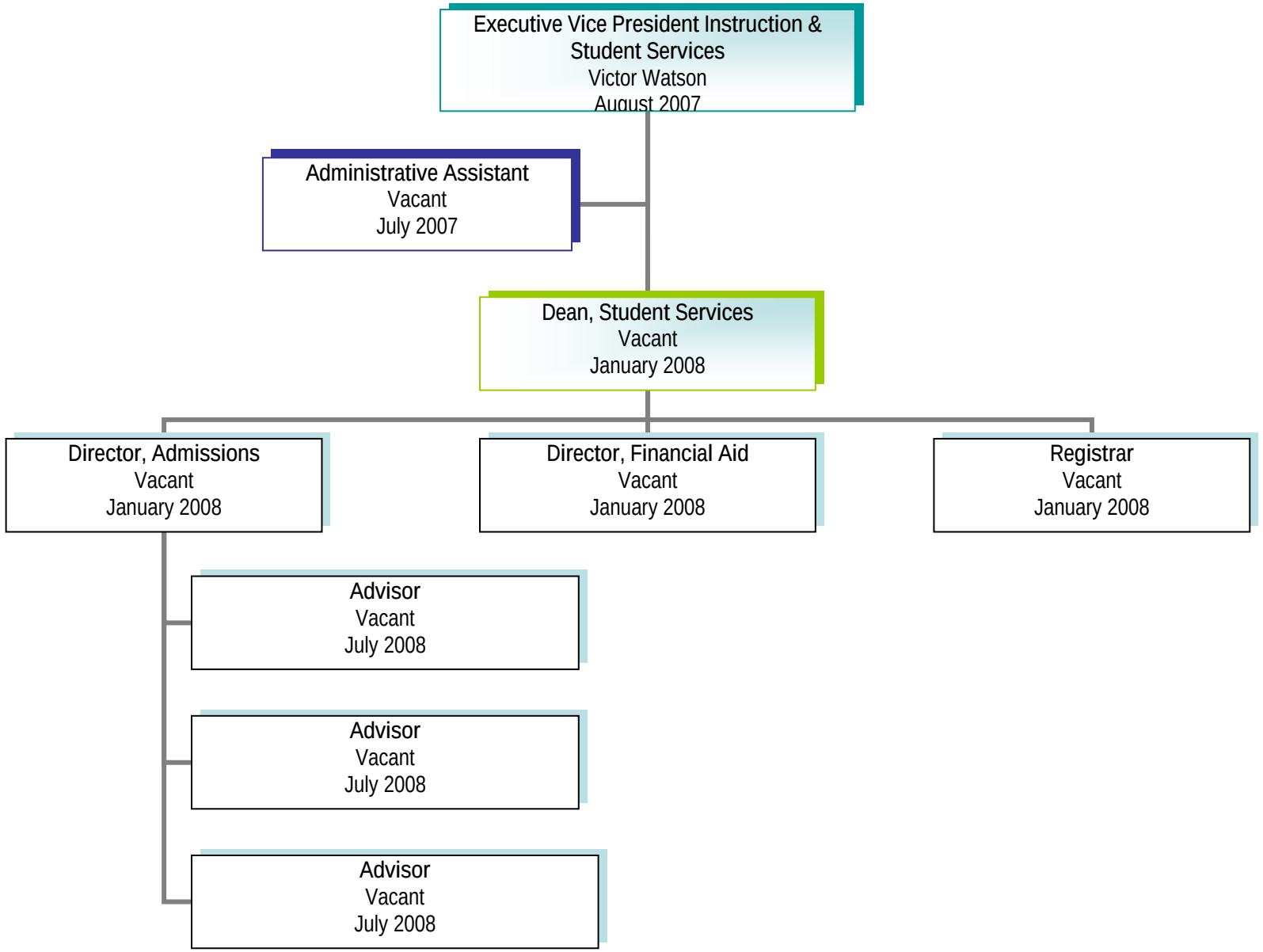
College of Western Idaho Organizational Chart FY09



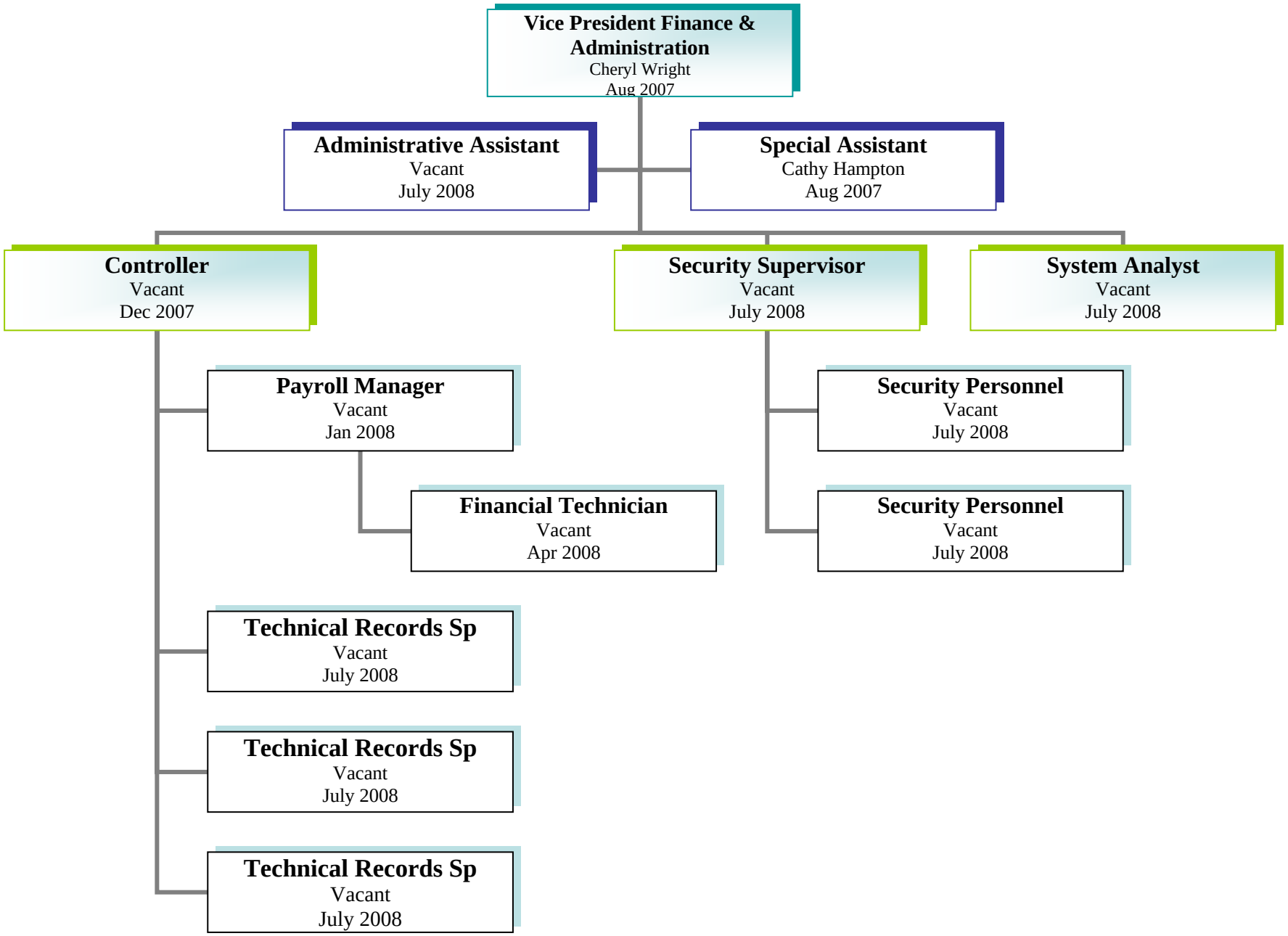
Executive Vice President, Instruction & Student Services Organizational Chart FY09



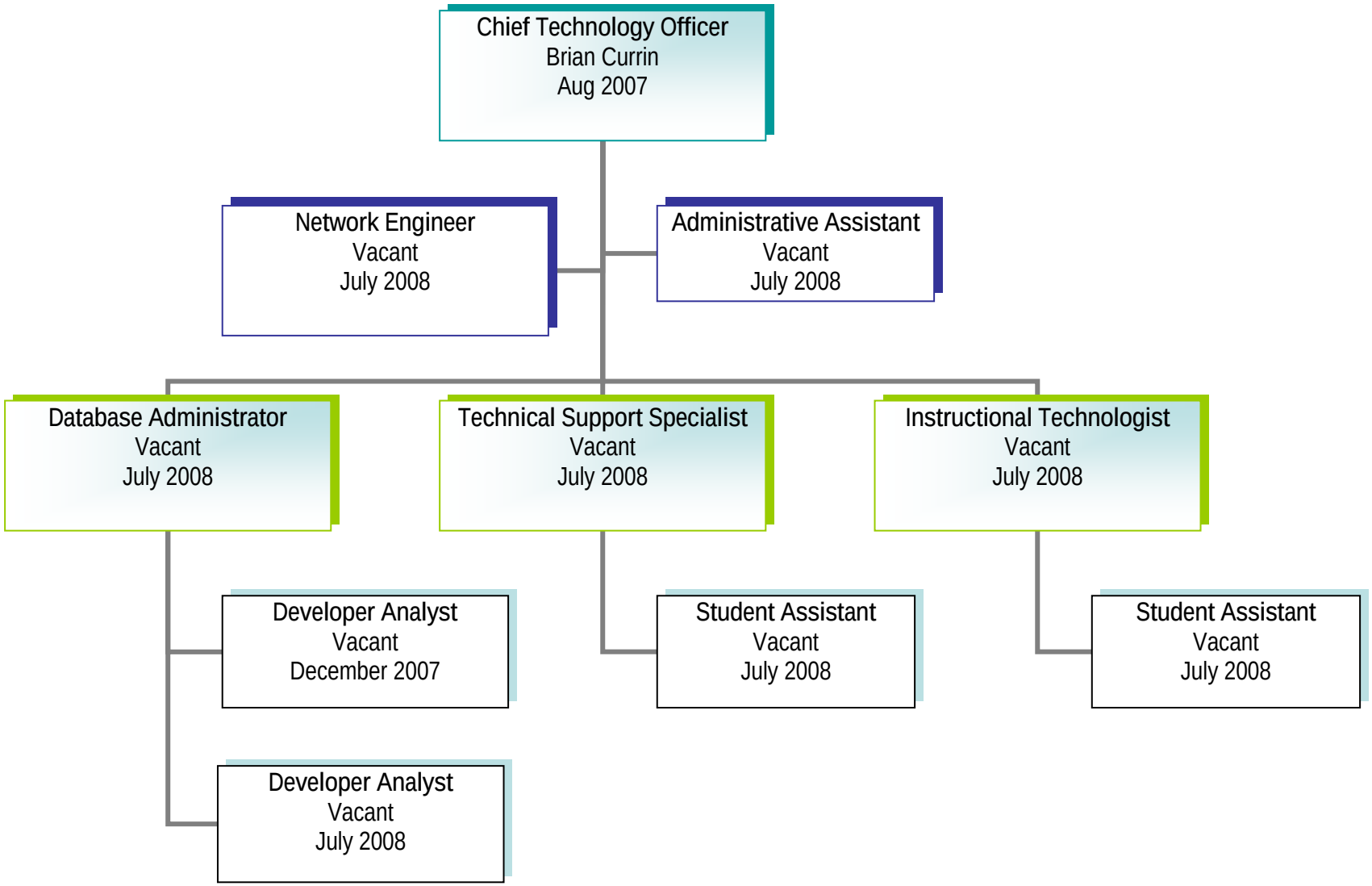
Executive Vice President, Instruction & Student Services
Organizational Chart FY09



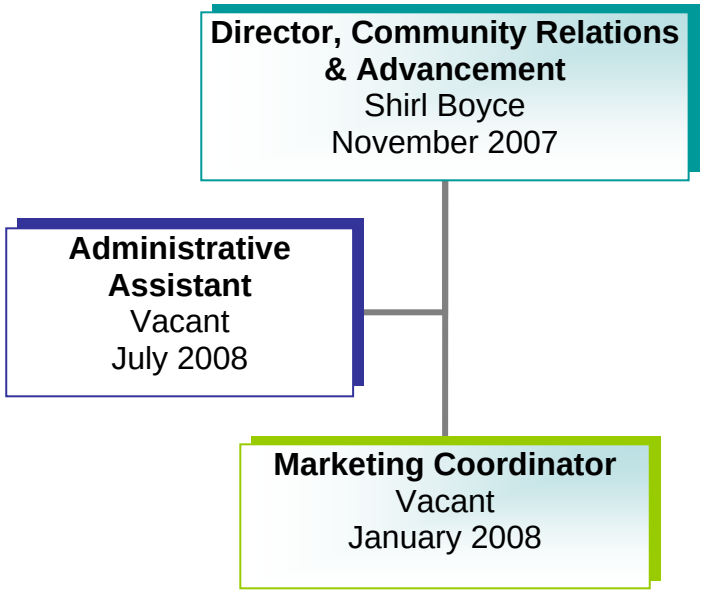
Finance & Administration Organizational Chart
FY09



Information Technologies Organizational Chart
FY09



Community Relations & Advancement Organizational Chart
FY09



APPENDIX 3

COLLEGE OF WESTERN IDAHO
General Fund Budget Narrative
July 1, 2007 – June 30 2008

The format of the budget information is presented in a similar format as North Idaho College and College of Southern Idaho. The College of Western Idaho (CWI) Trustees will decide on the format and the presentation of the information in summary versus detail information and vote whether or not to approve the content of the budgets. The first year of the budgeting process for CWI differs from the established community colleges, due to the fact that both the current fiscal year's budget (July 1, 2007 through June 30, 2008) and the second fiscal year's budget (July 1, 2008 through June 30, 2009) are past due for the State Board of Education's (SBOE) normal budgeting schedule. SBOE extended the deadlines for both years' budgets to the end of October, 2007. Each year, there will be a comparison to the previous year's budget by function and by category. Because fiscal year 2008 is the initial budget year for the new community college in Ada and Canyon counties, both fiscal year budgets are presented on the same spreadsheets. There is a separate narrative for fiscal year 2009.

REVENUES

1. State Appropriations - Academic
The base academic appropriation for the College of Western Idaho is $5,000,000.

2. Interest Revenue
The State Board of Education approved an initial allocation of $300,000 as start-up funds. The $300,000 was deposited in CWI's checking account on September 26th. The balance of $4,700,000 will be disbursed after the State Board of Education approves the Fiscal Year 2008 budget. SBOE has indicated that they are willing to call a special meeting for the purpose of approving the FY 2008 and FY 2009 budgets. After CWI receives the balance of the appropriation and after the Trustees decide the type(s) of investments, the amount invested will be determined by quarterly cash flow analyses.

EXPENDITURES

The budgets for expenditures are organized by the following functions: Instruction, Academic Support, Student Services, Physical Plant Operations, and Institutional Support. In future years, Research and Public Service will be added when needed.

1. Technology

a. The Chief Technology Officer currently works half time (.5 FTE) for the College of Western Idaho. We plan to bring him up to full time in January, 2008.

b. The FY 2008 budget includes a projection of the cost for an Enterprise Resource Planning system, plus the related training and set up fees. We plan to have the finance system online for the beginning of the next fiscal year, (July 1, 2008); the Human Resource/Payroll system ready for Jan 1, 2008 and the student tracking/financial aid system ready for July 1, 2009.

2. Student Services

a. Student Services needs to be functioning by April, 2008 in order to register students for Fall 2008 classes. The budget reflects this time line.
b. The budget for Student Services operating expense reflects estimates of costs for student services associated with the partnership of our host institution, plus some occupancy cost projections.

3. Physical Plant

a. In preparation of offering credit classes fall 2008, plus preparing to get the ERP systems on line, we will need to rent some office space off campus. The off campus rent for three months and the occupancy costs for the suite of offices on the third floor are budgeted at $25,000.
b. The occupancy costs for the current space used as executive offices are calculated at $6 SF, per an email from Stacy Pearson, Boise State University Vice President for Finance and Administration.
c. As of October 13, 2007, there have been no discussions to clarify charges for offering non-credit classes Jan 2008; therefore no budget was added for occupancy for The Center for Workforce Training or Adult Basic Education.
d. The off campus rent was calculated at $16 SF per Chairman Hess.

4. Institutional Support

a. The budget for Institutional Support is based on current operations plus what is necessary for the timelines mentioned above.
b. There is budget set aside for consultants in the President's Office budget and in the Trustee budget. The need for consultants has been discussed at the September 18 and the October 1 Trustee meetings.
c. Services under the VPFA budget include audit, legal services, general insurance, and institutional memberships. The projection of costs for legal services was based on the assumption that the services of an attorney will be higher the first year due to the agreements needed for the accreditation partnership.
d. An Accounting Supervisor will be needed soon to assist with developing the chart of accounts and other preparation necessary to implement the finance system by July 1, 2008. An HR/PR assistant manager will be needed in January.
e. The projection of costs associated with the BSU partnership is based on the signed agreement to process the first eight (8) employees for $18,000, plus 5% of salary and fringe for any future employees and 5% for processing all non-salary payments. Other than the $18,000, the other

projections are based on conversations and email correspondence with Stacy Pearson, BSU VPFA. There will be several other contracts developed in the next few months to address the costs associated with the partnership agreement with BSU.

f. $165,000 has been budgeted for marketing under the Public Information Officer's section, plus a .5 FTE to assist with marketing.
g. Budget has also been targeted for the design and production of a catalog, a student handbook, and marketing.

COLLEGE OF WESTERN IDAHO
Proposed FY08 Budget

	BUDGET FY08
REVENUE	
GENERAL EDUCATION TUITION & FEES	0
PTE TUITION & FEES	0
COUNTY TUITION PAYMENTS	0
STATE APPROPRIATIONS-ACADEMIC	5,000,000
STATE APPROPRIATIONS-ONE TIME FUN	0
LIQUOR REVENUE	0
COUNTY PROPERTY TAXES	0
INTEREST ON INVESTMENTS	20,000
GRANT MANAGEMENT FEES	0
OTHER REVENUES	0
TOTALS	5,020,000

Does not include Selland College funding
or expenses because we do not have
MOUs in place from BSU or from SDPTE

EXPENSES

ACADEMIC SUPPORT	
Chief Technology Officer Administration	
PERSONNEL	99,744
FRINGE BENEFITS	32,054
OPERATING EXPENSE	470,107
CAPITAL OUTLAY	1,701,635
Sub-Total	2,303,540
TOTAL ACADEMIC SUPPORT	2,303,540
STUDENT SERVICES	
Student Services	
PERSONNEL	80,000
FRINGE BENEFITS	27,944
OPERATING EXPENSE	223,000
CAPITAL OUTLAY	-
Sub-Total	330,944
Student Financial Services	
PERSONNEL	22,500
FRINGE BENEFITS	8,416
OPERATING EXPENSE	8,500
CAPITAL OUTLAY	-
Sub-Total	39,416
Total Student Services	370,359

COLLEGE OF WESTERN IDAHO
Proposed FY08 Budget

EXPENSES

PHYSICAL PLANT OPERATIONS	
PERSONNEL (Security)	32,500
FRINGE BENEFITS	27,641
OPERATING EXPENSE	4,400
Office Rent off campus	16,000
Rent/Occupancy - BSU West	9,000
Grounds BSU West	35,000
CAPITAL OUTLAY	30,000
Total Physical Plant Operations	154,541
INSTITUTIONAL SUPPORT	
President's Office	
PERSONNEL	179,751
FRINGE BENEFITS	55,224
OPERATING EXPENSE	175,000
CAPITAL OUTLAY	25,000
Sub-Total	434,975
Exec VP of Instruction/Student Services	
PERSONNEL	105,000
FRINGE BENEFITS	35,414
OPERATING EXPENSE	24,000
CAPITAL OUTLAY	12,000
Sub-Total	176,414
VP Finance & Adminsitration	
PERSONNEL	123,714
FRINGE BENEFITS	43,052
OPERATING EXPENSE	41,000
SERVICES	200,000
PARTNERSHIP WITH BSU COSTS	289,434
CAPITAL OUTLAY	35,326
Sub-Total	732,526
Accounting	
PERSONNEL	45,000
FRINGE BENEFITS	14,983
OPERATING EXPENSE	6,500
CAPITAL OUTLAY	5,000
Sub-Total	71,483
Human Resource Services	
PERSONNEL	40,500
FRINGE BENEFITS	16,052
OPERATING EXPENSE	5,000
CAPITAL OUTLAY	14,500
Sub-Total	76,052

COLLEGE OF WESTERN IDAHO
Proposed FY08 Budget

EXPENSES	
RESERVES	
OPERATING EXPENSE	128,000
Sub-Total	128,000
Public Information Officer	
PERSONNEL	75,000
FRINGE BENEFITS	23,303
OPERATING EXPENSE	177,000
CAPITAL OUTLAY	7,500
Sub-Total	282,803
Marketing	
PERSONNEL	24,056
FRINGE BENEFITS	8,752
OPERATING EXPENSE	6,500
CAPITAL OUTLAY	-
Sub-Total	39,308
Catalog & Student Handbook	
PERSONNEL	-
FRINGE BENEFITS	-
OPERATING EXPENSE	180,000
CAPITAL OUTLAY	-
Sub-Total	180,000
Trustees	
OPERATING EXPENSE	70,000
Sub-Total	70,000
Total Institutional Support	2,191,560
GRAND TOTAL	**5,020,000**

APPENDIX 4

COLLEGE OF WESTERN IDAHO
General Fund Budget Narrative
July 1, 2008 – June 30 2009

REVENUES

1. General Education Tuition and Fees

The budget for the general tuition and fees is based on the Fall 2008 freshman and sophomore student count at BSU West:

a. 1,200 full time students paying $1,180 per semester
b. 560 part time students each taking six credit hours per semester paying $118 per credit hour.

2. Professional Technical Education Fees (PTE)

The budget for the PTE tuition and fees is based on:

a. 1,200 full time are currently registered for Selland College PTE classes
b. 780 full time students (65% of the current Selland PTE students) paying $1,180 per semester
c. 420 part time (35% of the current Selland PTE students) each taking 5.5 credit hours per semester paying $118 per credit hour

3. County Tuition Payments

a. The revenue estimate is based on 300 students attending CWI from outside Ada and Canyon counties.
b. The counties outside the taxing district will be charged $500 per student per semester.

4. State Appropriations - Academic

The base academic appropriation for the College of Western Idaho is $5,000,000.

5. State Appropriations – One Time Funds Request

CWI will be offering classes one semester before it is eligible to receive local property tax revenues. The college is in effect $2,000,000 short, due to the statute that does not allow the tax levy to take affect the same year that the community college referendum was passed by the voters. The budget proposes that a one time request for state appropriated funds be made to assist with some of the physical plant costs detailed in the budget.

6. Liquor Revenue

The state has set aside $300,000 of the liquor tax revenue for the state's community colleges. CWI will receive one-third of these revenues.

7. County Property Taxes

CWI will start receiving local property tax revenues in January, 2009. The budget reflects one-half year of local property tax revenues.

8. Interest Revenue

9. Other Revenues
In future years, the following will be classified as "Other Revenue," tuition loan agreements, late fees, and other miscellaneous or irregular items.

EXPENDITURES

The expenditures are organized by the following functions: Instruction, Academic Support, Student Services, Physical Plant Operations, and Institutional Support. In future years, Research and Public Service will be added when needed.

The changes from the fiscal year 2008 budget are listed below.

1. Instruction

Budget for instruction include the following:

a. 1 dean and 2 area coordinators
b. 20 full time faculty
c. 45 adjunct faculty
d. 2.5 FTE staff for Adult Basic Education
e. Associated operating and capital expense

2. Academic Support

a. Associate Vice President for Instruction added as of July1, 2008
b. Technology
    i. Annual maintenance and licensing agreements
    ii. Capital set side for servers and computers necessary for ERP
    iii. Enterprise Application Services include one data base manager and two developer/analysts
    iv. Desktop/Helpdesk adds 1 FTE for technical support
    v. E-Learning adds 1 FTE and $300,000 in capital outlay to support new technology delivery systems. This is a starting point to support Chairman Hess' vision presented in the Sept 18 regular meeting.

c. Expenditure projections for Library, Tutoring and Teaching Support were provided by BSU. MOUs will be developed for these areas of support
d. Other
    i. $75,000 was set aside to cover printing and graphic costs associated with development of logo(s), and associated printing costs and services.
    ii. Academic Computing cost estimate of $740,595 was based on a recommendation from BSU.

3. Student Services

a. Student Services will have 4 FTE
b. Enrollment Services will have 3 FTE
c. Student Financial Services will have 1 FTE
d. $200,000 is budgeted for recruitment expenses
e. $200,000 is estimated for partnership related expenditures.

4. Physical Plant

The estimates listed below will be refined during the development of the MOUs with BSU.

a. Off campus rent, furniture and equipment budgeted at $119,000
b. The occupancy costs for BSU West academic building, Canyon County Center and the space occupied by Selland College on the Boise State University main campus is budgeted for $6.30 SF. The square foot amount from FY 2008 plus 5%. The total for FY 2009 is $1,996,520
c. Selland College currently leases space on Vista Avenue in Boise for $130,504. The fund source used to pay for the lease of this space is no longer available. The space is essential to the Adult Basic Education programs and is also used for some Center for Workforce Training offices. It could potentially be used for general education classes as well.
d. BSU has been paying for a lease near the Idaho Botanical Gardens, known as "The Old Guard Tower," for the Horticulture Program offered through Selland College. CWI will assume that lease of $26,553.
e. A classroom in the BSU West academic building will have to be converted to offices for the adjunct faculty. The current suite of offices in room 312 will be used for the Associate Vice President of Instruction, Department Chairs, and full time faculty. Budget of $110,000 has been targeted for this conversion.

5. Institutional Support

a. President's Office
    i. .5 FTE will pay for the Director of Canyon County Center. The other .5 FTE is covered under Instruction.
    ii. $50.000 set aside for a consultant
b. Foundation & Resources Director added.
c. Executive Vice President for Instruction & Student Services
    i. $15,000 budgeted for commencement
    ii. $60,000 budgeted for enrollment/student success consultants
d. Institutional Effectiveness Director added per the recommendation of the Executive Vice President of Instruction peer at Cascadia Community College. The position provides general oversight for the departments and the college to ensure that the vision, mission, goals and performance objectives are being met. The functions of this position are instrumental in the accreditation process and in the on going self-study requirements.

e. Vice President for Finance and Administration
    i. A systems analyst was added to assist with the finance and human resources implementation and support.
    ii. Services under the VPFA budget include audit, legal services, general insurance, and institutional memberships.
    iii. Partnership costs estimate based on the total Selland fiscal year 2007 personnel costs plus the personnel cost projections in the fiscal year 2009 proposed budget times 5% times .75. Stacy Pearson indicated that BSU plans to charge CWI a 5% fee of personnel costs for HR/PR services. CWI plans to have the payroll system functioning by January 2009. The budget covers the expense through March 2009, which factors in some leeway in case the timing of implementation is delayed.
    iv. A finance technician and two technical records specialist will be needed in FY 2009.
    v. Some reserves were built into the budget for employee recruitment costs, accrued leave expenses and a small amount for general reserves.
    vi. $75,000 was added under Public Safety/Risk Assessment to pay for Canyon County Security. This is another area that will be clarified by MOUs with BSU.
f. Public Information Officer
    i. An administrative assistant position was added to help support the PIO director and the marketing coordinator
    ii. The projected design costs for the student handbook and catalogue were reduced from the fiscal year 2008 $95,000 to $75,000.
g. Mail Service and Telephone Service
    i. The budgets are based on an estimate and will be determined in MOUs with BSU.
h. Trustee
    i. The trustee budget was reduced from the fiscal year 2008 budget. The 2008 budget included funds for a consultant.
    ii. The trustee budget was based on the budgets for North Idaho College's and College of Southern Idaho's trustees.

COLLEGE OF WESTERN IDAHO
Proposed FY09 Budget

APP 4

REVENUE	Budget FY 2008	Proposed Budget FY 2009	% Increase
GENERAL EDUCATION TUITION & FEES	0	3,624,960	N/A
PTE TUITION & FEES	0	2,385,960	N/A
COUNTY TUITION PAYMENTS	0	150,000	N/A
STATE APPROPRIATIONS-ACADEMIC	5,000,000	5,000,000	0.00%
STATE APPROPRIATIONS-ONE TIME FUNI	0	269,397	N/A
LIQUOR REVENUE	0	100,000	N/A
COUNTY PROPERTY TAXES	0	2,000,000	N/A
INTEREST ON INVESTMENTS	20,000	100,000	80.00%
GRANT MANAGEMENT FEES	0	0	N/A
OTHER REVENUES	0	0	N/A
TOTALS	5,020,000	13,630,317	63.17%

Does not include Selland College funding or expenses because we do not have MOUs in place from BSU or from SDPTE

EXPENSES

	Budget FY 2008	Proposed Budget FY 2009	% Increase
Instruction			
General Education Programs			
PERSONNEL	-	1,894,264	N/A
FRINGE BENEFITS	-	601,185	N/A
OPERATING EXPENSE	-	325,000	N/A
CAPITAL OUTLAY	-	90,000	N/A
Sub-Total	-	2,910,448	N/A
Adult Basic Education			
PERSONNEL	-	129,354	N/A
FRINGE BENEFITS	-	43,577	N/A
OPERATING EXPENSE	-	29,000	N/A
CAPITAL OUTLAY	-	-	N/A
Sub-Total	-	201,931	N/A
Total Instruction	-	3,112,380	N/A
ACADEMIC SUPPORT			
AVP of Instruction			
PERSONNEL	-	61,500	N/A
FRINGE BENEFITS	-	19,980	N/A
OPERATING EXPENSE	-	7,000	N/A
CAPITAL OUTLAY	-	3,000	N/A
Sub-Total	-	91,480	N/A

COLLEGE OF WESTERN IDAHO
Proposed FY09 Budget

	Budget FY 2008	Proposed Budget FY 2009	% Increase
Chief Technology Officer Administration			
PERSONNEL	99,744	157,244	57.65%
FRINGE BENEFITS	32,054	55,058	71.77%
OPERATING EXPENSE	470,107	487,000	3.59%
CAPITAL OUTLAY	1,701,635	330,000	-80.61%
Sub-Total	2,303,540	1,029,302	-55.32%
Enterprise Application Services			
PERSONNEL	-	180,000	N/A
FRINGE BENEFITS	-	59,931	N/A
OPERATING EXPENSE	-	8,000	N/A
CAPITAL OUTLAY	-	20,000	N/A
Sub-Total	-	267,931	N/A
Desktop/Helpdesk Support			
PERSONNEL	-	53,500	N/A
FRINGE BENEFITS	-	18,314	N/A
OPERATING EXPENSE	-	6,000	N/A
CAPITAL OUTLAY	-	15,000	N/A
Sub-Total	-	92,814	N/A
E-Learning Instructional Technology Support			
PERSONNEL	-	54,692	N/A
FRINGE BENEFITS	-	18,570	N/A
OPERATING EXPENSE	-	2,500	N/A
CAPITAL OUTLAY	-	301,500	N/A
Sub-Total	-	377,262	N/A
Other Academic Support			
Library			
PERSONNEL	-	148,888	N/A
FRINGE BENEFITS	-	52,112	N/A
OPERATING EXPENSE	-	459,000	N/A
CAPITAL OUTLAY	-	-	N/A
Sub-Total	-	660,000	N/A
Tutoring & Teaching Support			
PERSONNEL	-	238,394	N/A
FRINGE BENEFITS	-	81,934	N/A
OPERATING EXPENSE	-	811,095	N/A
CAPITAL OUTLAY	-	-	N/A
Sub-Total	-	1,131,423	N/A
Other (Printing & Graphics etc)			
PERSONNEL	-	-	N/A
FRINGE BENEFITS	-	-	N/A
OPERATING EXPENSE	-	75,000	N/A
CAPITAL OUTLAY	-	-	N/A
Sub-Total	-	75,000	N/A
Total Academic Support	2,303,540	3,725,212	61.72%

COLLEGE OF WESTERN IDAHO
Proposed FY09 Budget

	Budget FY 2008	Proposed Budget FY 2009	% Increase
STUDENT SERVICES			
Student Services			
PERSONNEL	80,000	205,000	156.25%
FRINGE BENEFITS	27,944	78,924	182.44%
OPERATING EXPENSE	223,000	242,500	8.74%
CAPITAL OUTLAY	-	-	N/A
Sub-Total	330,944	526,424	59.07%
Enrollment Services			
PERSONNEL	-	90,000	N/A
FRINGE BENEFITS	-	39,600	N/A
OPERATING EXPENSE	-	200,000	N/A
CAPITAL OUTLAY	-	-	N/A
Sub-Total	-	329,600	N/A
Student Financial Services			
PERSONNEL	22,500	50,000	N/A
FRINGE BENEFITS	8,416	17,910	112.82%
OPERATING EXPENSE	8,500	1,800	-78.82%
CAPITAL OUTLAY	-	2,500	N/A
Sub-Total	39,416	72,210	83.20%
Total Student Services	370,359	928,234	150.63%
PHYSICAL PLANT OPERATIONS			
PERSONNEL (Security)	32,500	65,000	100.00%
FRINGE BENEFITS	27,641	35,396	28.06%
OPERATING EXPENSE	4,400	55,000	1150.00%
Office Rent off campus	16,000	64,000	N/A
Off Campus Furniture & Equip		55,000	
Rent/Occupancy - BSU West	9,000	411,730	4474.78%
Grounds BSU West	35,000		N/A
Rent - CCC	-	513,790	N/A
Rent Selland BSU Main Campus	-	1,071,000	N/A
Convert classroom to Offices	-	110,000	N/A
Rent - Oak Park		130,504	N/A
Lease - Horitculture		26,553	N/A
CAPITAL OUTLAY	30,000	50,000	66.67%
Total Physical Plant Operations	154,541	2,587,973	1574.62%
INSTITUTIONAL SUPPORT			
President's Office			
PERSONNEL	179,751	253,179	40.85%
FRINGE BENEFITS	55,224	67,637	22.48%
OPERATING EXPENSE	175,000	153,971	-12.02%
CAPITAL OUTLAY	25,000	5,000	-80.00%
Sub-Total	434,975	479,787	10.30%
Foundation & Resources			
PERSONNEL	-	100,000	N/A
FRINGE BENEFITS	-	35,976	N/A
OPERATING EXPENSE	-	27,000	N/A
CAPITAL OUTLAY	-	1,200	N/A
Sub-Total	-	164,176	N/A

COLLEGE OF WESTERN IDAHO
Proposed FY09 Budget

	Budget FY 2008	Proposed Budget FY 2009	% Increase
Exec VP of Instruction/Student Services			
PERSONNEL	105,000	120,000	14.29%
FRINGE BENEFITS	35,414	40,290	13.77%
OPERATING EXPENSE	24,000	89,000	270.83%
CAPITAL OUTLAY	12,000	2,000	100.00%
Sub-Total	176,414	251,290	42.44%
Institutional Effectiveness			
PERSONNEL	-	55,000	N/A
FRINGE BENEFITS	-	23,100	N/A
OPERATING EXPENSE	-	6,000	N/A
CAPITAL OUTLAY	-	3,700	N/A
Sub-Total	-	87,800	N/A
VP Finance & Adminsitration			
PERSONNEL	123,714	168,714	36.37%
FRINGE BENEFITS	43,052	58,095	34.94%
OPERATING EXPENSE	41,000	37,306	-9.01%
SERVICES	200,000	195,000	-2.50%
PARTNERSHIP WITH BSU COSTS	289,434	739,726	155.58%
CAPITAL OUTLAY	35,326	11,000	100.00%
Sub-Total	732,526	1,209,841	65.16%
Accounting			
PERSONNEL	45,000	111,000	146.67%
FRINGE BENEFITS	14,983	45,469	203.47%
OPERATING EXPENSE	6,500	4,500	-30.77%
CAPITAL OUTLAY	5,000	8,700	74.00%
Sub-Total	71,483	169,669	137.36%
Human Resource Services			
PERSONNEL	40,500	56,500	N/A
FRINGE BENEFITS	16,052	26,704	N/A
OPERATING EXPENSE	5,000	4,500	N/A
CAPITAL OUTLAY	14,500	12,500	N/A
Sub-Total	76,052	100,204	N/A
RESERVES			
PERSONNEL	-	-	N/A
FRINGE BENEFITS	-	-	N/A
OPERATING EXPENSE	128,000	57,600	-55.00%
CAPITAL OUTLAY	-	-	N/A
Sub-Total	128,000	57,600	-55.00%
Public Safety/ Risk Assesment			
PERSONNEL		-	N/A
FRINGE BENEFITS		-	N/A
OPERATING EXPENSE		75,000	100.00%
CAPITAL OUTLAY		-	N/A
Sub-Total	-	75,000	100.00%

COLLEGE OF WESTERN IDAHO
Proposed FY09 Budget

	Budget FY 2008	Proposed Budget FY 2009	% Increase
Public Information Officer			
PERSONNEL	75,000	105,000	40.00%
FRINGE BENEFITS	23,303	37,040	58.95%
OPERATING EXPENSE	177,000	173,000	-2.26%
CAPITAL OUTLAY	7,500	6,200	100.00%
Sub-Total	282,803	321,240	13.59%
Marketing			
PERSONNEL	24,056	24,056	N/A
FRINGE BENEFITS	8,752	8,752	N/A
OPERATING EXPENSE	6,500	2,000	100.00%
CAPITAL OUTLAY	-	-	N/A
Sub-Total	39,308	34,808	-11.45%
Catalog & Student Handbook			
PERSONNEL	-	-	N/A
FRINGE BENEFITS	-	-	N/A
OPERATING EXPENSE	180,000	160,000	-11.11%
CAPITAL OUTLAY	-	-	N/A
Sub-Total	180,000	160,000	-11.11%
Other Instutional Support (Telephone, Mail Servies ect)			
PERSONNEL	-	83,000	N/A
FRINGE BENEFITS	-	32,104	N/A
OPERATING EXPENSE	-	10,000	N/A
CAPITAL OUTLAY	-	10,000	N/A
Sub-Total	-	135,104	N/A
Trustees			
PERSONNEL	-	-	N/A
FRINGE BENEFITS	-	-	N/A
OPERATING EXPENSE	70,000	30,000	-57.14%
CAPITAL OUTLAY	-	-	N/A
Sub-Total	70,000	30,000	-57.14%
Total Institutional Support	2,191,560	3,276,519	49.51%
GRAND TOTAL	**5,020,000**	**13,630,317**	**171.52%**

COLLEGE OF WESTERN IDAHO
2008 - 2009 Proposed Schedule of Tuition Fees
Effective Summer 2008, Fall 2008 and Spring 2009

APPENDIX 5

Fee Description	Part Time Per Credit Hour	Full Time 10 - 18 Credits	Overload Per Credit Hour over 18 credits
Tuition	$ 62.50	$ 625.00	$ 62.50
Registration Services	$ 23.00	$ 230.00	$ 23.00
Library Fee	$ 5.00	$ 50.00	$ 5.00
Technology Fee	$ 15.00	$ 150.00	$ 15.00
Computer Lab Fee	$ 7.50	$ 75.00	$ 7.50
Student Activity Fee	$ 5.00	$ 50.00	$ 5.00
Total	$ 118.00	$ 1,180.00	$ 118.00
Out of State/Foreign	$ 300.00	$ 3,000.00	
Dual Credit	$ 65.00		
One time Student ID System	$ 5.00		
One Time application fee	$ 25.00		
One Time graduation fee	$ 30.00		

*Notes

Current Idaho Code 33-2110 limits the amount that community colleges can charge for tuition to $1250 per year (625 per semester). CSI & NIC have requested the maximum tuition be reaised to $2,500 per year. Need clarification on whether or not we can request more than $625 as tuition.

Tuition can not be raised more than 10% per year

Out of county students cost their counties $500 per semester with a maximum lifetime per student of $3,000

1

COLLEGE OF WESTERN IDAHO
2008 - 2009 Proposed Schedule of Tuition Fees
Effective Summer 2008 if Legislative Action is Passed, Fall 2008 and Spring 2009
With new legislation

APPENDIX 6

Fee Description	Part Time Per Credit Hour	Full Time 12 - 18 Credits	Overload Per Credit Hour over 18 credits
Tuition	$ 100.00	$ 1,200.00	$ 100.00
Technology Fee	$ 8.00	$ 96.00	$ 8.00
Student Activity Fee	$ 5.00	$ 60.00	$ 5.00
Computer Lab Fee	$ 5.00	$ 60.00	$ 5.00
Total	$ 118.00	$ 1,416.00	$ 118.00
Out of State/Foreign	$ 300.00	$ 3,600.00	
One time Student ID System	$ 5.00		
One Time application fee	$ 25.00		
One Time graduation fee	$ 30.00		

*Notes

Current Idaho Code 33-2110 limits the amount that community colleges can charge for tuition to $1250 per year (625 per semester). SBOE approved legislative action to request to increase the maximum tuition to $2,500 per year.

Tuition can not be raised more than 10% per year

Out of county students cost their counties $500 per semester with a maximum lifetime per student of $3,000

2000
$ 2,300,000.00
$ 236.00
2800000

REFERENCE – APPLICABLE STATUTE, RULE OR POLICY

HOUSE BILL NO. 283

]]]] LEGISLATURE OF THE STATE OF IDAHO]]]]
Fifty-ninth Legislature First Regular Session - 2007

IN THE HOUSE OF REPRESENTATIVES

HOUSE BILL NO. 283

BY APPROPRIATIONS COMMITTEE

AN ACT

APPROPRIATING MONEYS FOR THE OFFICE OF THE STATE BOARD OF EDUCATION FOR FISCAL YEAR 2008; LIMITING THE NUMBER OF FULL-TIME EQUIVALENT POSITIONS; EXPRESSING LEGISLATIVE INTENT REGARDING RESOURCE SHARING; DIRECTING THE DISTRIBUTION OF THE FUNDING FOR EMPLOYEE COMPENSATION; DIRECTING THE ALLOCATION OF SALARY SAVINGS; AND EXPRESSING LEGISLATIVE INTENT REGARDING FUNDING FOR NEW COMMUNITY COLLEGES.

Be It Enacted by the Legislature of the State of Idaho:

SECTION 1. There is hereby appropriated to the State Board of Education for the Office of the State Board of Education the following amounts to be expended according to the designated expense classes from the listed funds for the period July 1, 2007, through June 30, 2008:

	FOR PERSONNEL COSTS	FOR OPERATING EXPENDITURES	FOR CAPITAL OUTLAY	FOR TRUSTEE AND BENEFIT PAYMENTS	TOTAL
OFFICE OF THE STATE BOARD OF EDUCATION:					
FROM:					
General Fund	$1,545,900	$ 4,110,300	$2,000	$5,087,500	$10,745,700
Indirect Cost Recovery Fund	35,000	50,000			85,000
Federal Grant Fund	503,800	6,168,400		1,864,400	8,536,600
Miscellaneous Revenue Fund	**7,000**	**123,200**		**10,200**	**140,400**
TOTAL	$2,091,700	$10,451,900	$2,000	$6,962,100	$19,507,700

SECTION 2. In accordance with Section 67-3519, Idaho Code, the Office of the State Board of Education is authorized no more than twenty-seven (27) full-time equivalent positions at any point during the period July 1, 2007, through June 30, 2008, for the program specified in Section 1 of this act, unless specifically authorized by the Governor. The Joint Finance-Appropriations Committee will be notified promptly of any increased positions so authorized.

SECTION 3. The Legislature reaffirms that the Division of Professional-Technical Education and the Office of the State Board of Education each play

unique and vital roles in the state's educational system. The Legislature authorizes these agencies to share administrative resources only to the extent

necessary to achieve readily obtainable administrative efficiencies. The shared resources authorized in this section shall be narrowly defined as reception services. Each division administrator shall retain management decision-making autonomy over their respective divisions. The employees of the Division of Professional-Technical Education shall not be considered or used as adjunct staff by the Office of the State Board of Education. Under no circumstances shall this arrangement impair the individual ability of these agencies to fulfill their individual missions. This authorization is automatically withdrawn to the extent it is found to be inconsistent with laws or regulations pertaining to the use of federal or dedicated funds. The Legislature shall review this authorization each year and reserve its prerogative to withdraw it at any time.

SECTION 4. Agencies and institutions shall distribute the funding for employee compensation based on merit as follows:

(a) Agencies and institutions are directed to, based on merit, target funding first toward high turnover classifications and individuals below midpoint within their agency.

(b) Agencies and institutions are directed to, based on merit, target funding second toward positions within their agency that are below ninety percent (90%) of the Compa-Ratio.

(c) Agencies and institutions are directed to target any remaining funding based on merit using the merit matrix required by Idaho Code.

Agencies and institutions shall create compensation and distribution plans to ensure that they are consistent with the policies contained herein. Agency directors and institutional presidents shall approve all compensation and distribution plans and ensure that implementation of the plans is consistent with policies contained herein. Each agency and institution shall forward, for informational purposes, approved copies of the compensation and distribution plans to the Legislative Services Office and the Division of Financial Management by June 1, 2007. The effective date of implementation of ongoing salary adjustments shall be June 17, 2007.

SECTION 5. The Office of the State Board of Education is hereby directed to allocate salary savings, based on performance, to provide for employee salary needs before other operational budget priorities are considered. Where applicable, employees whose salaries are below the midpoint of their pay grade or occupational groups with significant turnover rates shall be considered first in the order of salary savings distributions.

SECTION 6. The Legislature seeks to encourage local communities to establish new community college districts under existing law. As such, it is legislative intent that a newly formed community college district shall be eligible for up to $5,000,000 in ongoing General Fund moneys. The State Board of Education shall evaluate the business and operating plans of any newly created community college in determining the amount of General Fund moneys the college is eligible to receive. Any portion of the $5,000,000 which is not allocated to a new college shall be reverted to the General Fund. In the event that more than one (1) district is formed, and the Board determines that additional funding is necessary, the Board may request additional funding as a part of the annual budget process.

SUBJECT

Medical Education Study Final Report

APPLICABLE STATUTE, RULE, OR POLICY

Senate Bill 1210

BACKGROUND

Senate Bill 1210 from the 2007 legislative session appropriated $300,000 to the Office of the State Board of Education for a medical education study to determine the need and feasibility of increased medical education opportunities in Idaho.

A subcommittee of the Board, the Medical Education Study Committee, was tasked with developing an RFP, selecting a vendor, and facilitating the process. The resulting RFP included a deadline of November 1, 2007 for a project end date. MGT of America, Inc. (MGT) was selected as the vendor and started work in August. MGT and the subcommittee met several times during the year.

DISCUSSION

The final Medical Education Study Final Report was published on the Board website on Friday, November 16, 2007. The report outlines four potentially successful alternatives for providing increased medical education opportunities in Idaho:

1. Establishment of a new, university-operated medical school based on the distributive model of medical education
2. Expansion of the package of contracted programs with medical schools in other states
3. Development of a new joint medical school from current medical education resources at the three state universities
4. Expansion of graduate medical education programs based in the state

IMPACT

The report weighed each alternative against the following seven criteria:

1. Impact on opportunity for Idaho students
2. Impact on state physician workforce
3. Challenges to gaining accreditation
4. Time required for full implementation
5. Start-up investment required
6. Annual operating support required
7. Economic impact on state

The report lists the advantages and disadvantages starting on page 7-4 (agenda page 110), and a table summarizing each alternative against the criteria is on page 7-6 (agenda page 112).

ATTACHMENTS

STAFF COMMENTS AND RECOMMENDATIONS

Staff from MGT of America, Inc. will make a brief presentation and be available for questions.

BOARD ACTION

This item is for informational purposes only. Any action will be at the Board's discretion.

MEDICAL EDUCATION STUDY FINAL REPORT

Submitted by

MGT OF AMERICA, INC.

November 1, 2007

MEDICAL EDUCATION STUDY

FINAL REPORT

Submitted to:

Medical Education Study Committee
Idaho State Board of Education
P.O. Box 83720
Boise, Idaho 83720-0037

Submitted by:

MGT OF AMERICA, INC.

2123 Centre Pointe Boulevard
Tallahassee, Florida 32308

November 1, 2007

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PREFACE

PREFACE

The following report is issued in compliance with Senate Bill 1210, which calls for "a comprehensive study of the feasibility and viability of offering a medical degree" to be conducted and submitted to the State Board of Education by November 1, 2007. The report was developed by a team of independent consultants from MGT of America, Inc., a firm with expertise in college and university planning, medical education program development, and medical education accreditation.[1] The report was prepared over a ten-week period between August 23 and November 1, 2007.

The requested scope of work represented a significant undertaking in an extremely limited amount of time. Consequently, the Study Team relied heavily on existing documents, input from numerous stakeholders, and its members' own expertise in developing a summary overview of the need for access to medical education in Idaho, the potential alternatives for responding to identified needs, and the relative advantages and disadvantages of those alternatives. While the time and budget available for the study necessitated a high-level overview, we believe the report provides sufficient information to enlighten the public debate on the future of medical education in Idaho.

The Study Team appreciates the assistance it received from many individuals and organizations during the course of the study. Those individuals included members of the State Board of Education's Project Advisory Committee, the staff of the Office of the State Board of Education, members of the Idaho Legislature and its staff, the presidents and staff of the three state universities and four state colleges, the leaders of the medical schools at the University of Washington and the University of Utah, and leaders in the Idaho healthcare industry. Organizations that provided information in support of the analyses included the American Medical Association, the Association of American Medical Colleges, the Accreditation Council for Graduate Medical Education, and the Western Interstate Commission for Higher Education.

The interpretations of the information and data provided by these individuals and organizations were the responsibility of the Study Team. Due to the complexity of the issues and our limited prior experience in Idaho, others will surely want to share different points of view with the State Board, Governor, and Legislature. We believe most stakeholders, however, will advise the state's leaders that access to medical education is a critical problem that will become even more pressing if appropriate steps are not taken in the near future.

Members of the Study Team appreciate the opportunity to assist the citizens of Idaho in this important endeavor and trust that our efforts will help guide state leaders in improving access to medical education in the state of Idaho.

[1] Information about key members of the Study Team may be found in the Appendix.

1.0 BACKGROUND AND PURPOSE OF STUDY

1.0 BACKGROUND AND PURPOSE OF STUDY

In August 2007, MGT of America, Inc., was engaged by the Idaho Board of Education to analyze potential models of medical education for the state. This chapter of the report provides background information that is needed to assess the models and includes an overview of:

- American medical education.
- National trends in medical education and the physician workforce.
- Idaho's interest in medical education and the physician workforce.

1.1 Overview of American Medical Education

The Association of American Medical Colleges (AAMC) defines academic medicine as "the combination of medical schools, teaching hospitals, and their faculty members and staff."[1] Three major components of academic medicine are:

- Medical education.
- Research.
- Patient care.

1.1.1 Types of Medical Schools

Two types of schools graduate physicians: allopathic and osteopathic. Allopathic medical schools grant the Doctor of Medicine degree (M.D.), and osteopathic schools grant the Doctor of Osteopathic Medicine degree (D.O.). Together, these schools number 151 and enroll approximately 81,000 students each year.

***Allopathic Schools*.** Allopathic schools are accredited by the Liaison Committee on Medical Education (LCME). The AAMC and the American Medical Association (AMA) sponsor LCME. Currently, there are 126 allopathic medical schools in the United States (U.S.). Six states do not have an allopathic medical school: Alaska, Delaware, Idaho, Maine, Montana, and Wyoming. In addition to those in the 44 remaining states, there are LCME-accredited allopathic medical schools in the District of Columbia and Puerto Rico. According to the AAMC, the total enrollment in allopathic colleges in Fall 2006 was 69,167.[2] The 2007 medical school entering class is the largest in U.S. history; 17,759 new students are enrolled in the 126 allopathic medical schools, representing a one year increase of 2.3 percent.[3]

***Osteopathic Schools*.** Osteopathic schools are accredited by the American Osteopathic Association (AOA) Commission on Osteopathic College Accreditation (COCA). There are currently 25 accredited colleges of osteopathic medicine in 28 locations in the U.S. According to the American Association of Colleges of Osteopathic Medicine (AACOM), 13,406 students were enrolled in D.O. programs in 2005-2006, which represented a 7

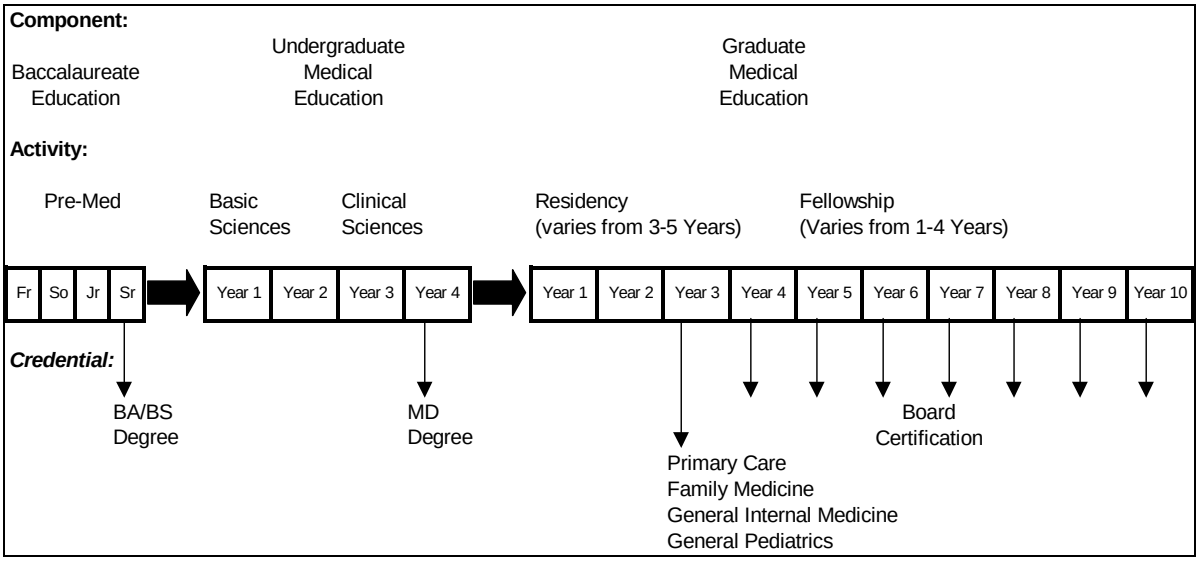
[1] AAMC. *Handbook of Academic Medicine: How Medical Schools and Teaching Hospitals Work.* 2004.
[2] AAMC. *FACTS – Applicants, Matriculants, and Graduates*. Table 18: Total Enrollment by Sex and School, 2002-2006.
[3] AAMC. October 16, 2007. *2007 U.S. Medical School Entering Class Is Largest Ever*. Press release.

percent increase from the previous academic year.[4] (In direct comparison, 68,008 students were enrolled in allopathic medical schools in Fall 2005, which represented an increase of 1.2 percent from Fall 2004).[5]

1.1.2 Stages in the Medical Education Pipeline

The medical education journey is long; it begins in college, continues in medical school (allopathic or osteopathic), and weaves through graduate medical education (i.e., residencies and fellowships) before physicians can practice independently. **Exhibit 1-1** provides an overview of the medical education sequence. At a minimum, 11 years of formal, post high school training are required before an individual may begin medical practice as an allopathic physician.

EXHIBIT 1-1
OVERVIEW OF TYPICAL SEQUENCE OF ALLOPATHIC MEDICAL EDUCATION



Source: MGT of America, Inc., 1999.

Baccalaureate Education. Prospective medical students, regardless of their baccalaureate majors, must complete the minimum required science courses in order to gain admission to medical school. Many colleges and universities still offer a pre-medicine major, but frequently campuses offer pre-med programs that allow students to complete the medical school admission requirements while majoring in specific disciplines. Students who apply to medical school often major in the natural sciences (biology, chemistry, physiology, etc.), but doing so is not a requirement for medical school admission, and a wide range of majors are represented among applicants. In fact, many schools of medicine encourage students to be firmly grounded in the liberal arts. Individuals interested in attending medical school usually take the Medical College Admission Test (MCAT) and apply for admission at one or more institutions.

[4] AACOM. *Annual Statistical Report on Osteopathic Medical Education*. 2006.
[5] AAMC. *FACTS – Applicants, Matriculants, and Graduates*. Table 18: Total Enrollment by Sex and School, 2002-2006.

***Undergraduate Medical Education*.** Undergraduate medical education (medical school) is a four year program (not to be confused with undergraduate education leading to the baccalaureate degree). Traditionally, the first two years of medical education have focused on additional mastery of the basic sciences, and the remaining two years on clinical training. In recent years, most medical schools have redesigned their curricula to integrate basic science and clinical education across the entire four year period. In the third year of medical school, students complete six required clinical rotations (clerkships): family medicine, general surgery, internal medicine, obstetrics and gynecology, pediatrics, and psychiatry. In the fourth year, students may explore their interests in elective clinical rotations. They also seek admission to residency training programs. Upon successful completion of undergraduate medical education, the student is awarded the M.D. A similar sequence is followed by those in pursuit of the D.O.

***Graduate Medical Education*.** Medical school graduates (allopathic and osteopathic) must complete graduate medical education training before they can practice medicine without supervision. This type of training is usually offered through major hospitals, medical centers, health clinics, and other ambulatory settings. The years of graduate medical education for M.D.s are known as *residency*. During their residencies, physicians prepare to practice in specialty areas (e.g., family medicine, pediatrics, psychiatry). **Exhibit 1-2** provides a general overview of the length of time required for the residency portion of graduate medical education. In some fields and sub-specialties, further training is required (fellowships).

EXHIBIT 1-2
YEARS OF TRAINING REQUIRED FOR SPECIALTY CERTIFICATION

1	2	3	4	5	6-7
FAMILY PRACTICE					
EMERGENCY MEDICINE					
PEDIATRICS			SUBSPECIALTIES		
INTERNAL MEDICINE			SUBSPECIALTIES		
OBSTETRICS/GYNECOLOGY					
OTOLARYNGOLOGY					
PATHOLOGY					
GENERAL SURGERY				SUBSPECIALTIES	
	NEUROLOGICAL SURGERY				
	ORTHOPAEDIC SURGERY				
	UROLOGY				
TRANSITIONAL or PRELIM MEDICINE or PRELIM SURGERY	ANESTHESIOLOGY				
	DERMATOLOGY				
	NEUROLOGY				
	NUCLEAR MEDICINE				
	OPHTHALMOLOGY				
	PHYSICAL MEDICINE				
	PSYCHIATRY				
	RADIOLOGY – DIAGNOSTIC				
	RADIATION ONCOLOGY				

Source: National Resident Matching Program (http://www.nrmp.org/res_match/about_res/index.html)
Note: These are unofficial assignments and are offered for informational purposes only.

1.1.3 Medical Research

Medical research may be characterized by type, funding sources and amounts, and resulting "spin-off" economic development.

***Types of Medical Research*.** Research is a key component of most levels of the higher education enterprise, including undergraduate and graduate medical education. According to the AAMC,[6] the growth of the biomedical research field is traced to the World War II era. The federal government developed partnerships with institutions during the war, and, after the war ended, created a national policy that called for considerable investment in basic science:

[6] AAMC. *Handbook of Academic Medicine: How Medical Schools and Teaching Hospitals Work.* 2004.

> *Vannevar Bush's landmark report,* Science—The Endless Frontier*, promulgated a "social contract" between the federal government, which would invest in the development of scientific knowledge and training of scientific investigators, and universities, which would be the principal loci of this research and educational activity. The National Institutes of Health (NIH) became the primary federal agency responsible for implementing this social contract for health-related research*.[7]

Medical schools, college and university campuses, and teaching hospitals conduct a significant portion of the basic science research, clinical research, and translational research in this country. Since World War II, the federal government has invested in basic science and health-related research through the National Institutes of Health (NIH), which supports "basic investigations of the structure and function of living systems at cellular, molecular, and organismal levels of inquiry, as well as clinical and behavioral research."[8] The AAMC[9] defines *clinical research* as:

> *a component of medical and health research intended to produce knowledge valuable for understanding disease, preventing and treating illness, and promoting health. Clinical research embraces a continuum of studies involving interaction with patients, diagnostic clinical materials or data, or populations…Clinical research refers to: Hypothesis-driven, patient-oriented studies that are generally peer-reviewed and are commonly, but not exclusively, conducted in medical schools and teaching hospitals. Physician-scientists play a key role in the conception, design, and performance of such research, which often occurs in physicians' offices and clinics.*

Whereas, the mission of translational research is to: [10]

> *translate the basic science discoveries into clinical applications, and to use the clinical observations to generate research foci for basic sciences. Translational research needs to focus on the integration of activities from bench to bedside. The three elements necessary for translational medicine are:*
>
> - *disease-based programs*
> - *access to animal models and proximity to relevant groups of patients*
> - *ease of communications among basic scientists and clinicians*
>
> *Translational research relies upon intermediaries, such as physician-scientists and graduate students, to distribute the information across the disciplines.*

***Funding for Medical Research*.** Grants and contracts for sponsored research provide a major part of the funding for U.S. medical schools. The AAMC reported that in 2004-2005, medical schools received $21.1 billion in research grants and contracts.[11] The

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[7] AAMC. *Handbook of Academic Medicine: How Medical Schools and Teaching Hospitals Work.* 2004, p. 29.
[8] AAMC. *The Handbook of Academic Medicine: How Medical Schools and Teaching Hospitals Work.* 2004.
[9] AAMC. *Promoting Translational and Clinical Science: The Critical Role of Medical Schools and Teaching Hospitals.* 2006, p. 12.
[10] Mount Sinai School of Medicine. *Report of the Translational Facility Workgroup.* n.d. http://www.mssm.edu/forfaculty/publications/translational/report.shtml
[11] AAMC. *AAMC Data Book: Medical Schools and Teaching Hospitals by the Numbers.* April 2007. p. 50.

primary source of support is NIH; the Department of Veterans Affairs (VA) and industry are also significant contributors.

***Economic Development*.** A report commissioned by the AAMC cited the 2005 total economic impact of AAMC members (allopathic medical schools and teaching hospitals) as more than $451 billion.[12] *Total economic impact* is defined as:

> *Both the direct economic impact and the indirect economic impact, generated in the economy as a result of the direct impact. Direct impact includes items such as institutional spending, employee spending, and spending by visitors to the institution. Indirect economic impact, also known as the multiplier effect, includes the re-spending of dollars within the local community.*

Presumably, if non-AAMC members were added to the equation (including osteopathic medical schools), the economic impact would increase. In addition, AAMC members provide more than 3 million full-time jobs and create significant tax revenue for their states and local communities.

1.1.4 Clinical Training and Patient Care

Medical schools and graduate medical education programs use a variety of sites for clinical training, including hospitals and medical centers, clinics, and physicians' offices. The AAMC uses the term *teaching hospital* to refer to "both individual hospitals and to health networks that contain hospitals and other components of the healthcare delivery system committed to educational activities in the health professions."[13] The AAMC Division of Health Care Affairs houses the Council of Teaching Hospitals and Health Systems (COTH) and provides policy analysis on graduate medical education financing and other hospital and physician issues. To be considered a teaching hospital, an institution must meet at least one of the following criteria:

- Reports a medical school affiliation to the AMA.
- Supports a residency program accredited by the Accreditation Council of Graduate Medical Education (ACGME).
- Supports an internship or residency program approved by the AOA.[14]

[12] Tripp Umbach. *The Economic Impact of AAMC-Member Medical Schools and Teaching Hospitals 2005.* AAMC.
[13] AAMC. *Handbook of Academic Medicine: How Medical Schools and Teaching Hospitals Work.* 2004.
[14] AAMC. *AAMC Data Book: Medical Schools and Teaching Hospitals by the Numbers.* April 2007. p. 85.

Three categories of academic medical center hospitals exist:

***Integrated or University-Owned Teaching Hospitals*.** More than 40 COTH member hospitals are owned by comprehensive or health sciences universities; 19 were formerly owned by universities; and 56 maintain strong ties to universities. Together, these COTH members are considered integrated academic medical center hospitals.[15]

The organizational relationships within academic medicine are complex, as explained by AAMC:[16]

> *At some institutions, these components are arranged in a "single ownership" model, where the parent university has legal and financial control over the medical school, primary teaching hospital, and faculty practice plan. At the other end of the continuum, the medical schools may be a "limited partner" in the clinical delivery system, having no ownership or control over the clinical enterprise. Many variations exist between these two extremes.*

Additional organizational complexities of the academic medicine enterprise are faculty practice plans or "organized arrangements for billing, collecting, and distributing professional fee income generated from the patient care services provided by faculty physicians."[17] These plans vary in terms of legal arrangements; 43 percent are housed within medical schools or universities, and 40 percent are separate not-for-profit organizations.

***Independent or Community-Based Teaching Hospitals*.** Accredited medical schools rely not only on university-owned or -affiliated hospitals for training medical students, but also on more than 1,000 community hospitals. Many patients are served at these community hospitals, often receiving initial diagnostic workup and post-treatment care in ambulatory settings. Medical students may receive clerkship training in community-based hospitals that are separate from the medical school campuses, sometimes at "clinical campuses" that are geographically distant from the main sites. Medical students also may receive clinical training in ambulatory clinics, physicians' offices, nursing homes, community clinics, and/or prison clinics.

***Veterans Administration Hospitals*.** Of the 113 VA hospitals in the nation, 56 are COTH members and another 37 are "other teaching VA" hospitals.[18] Approximately 70 percent of VA physicians have joint faculty appointments at affiliated medical schools. In 2003, the AAMC reported that 85 percent of the nation's medical schools were affiliated with VA hospitals. VA hospitals fund 9 percent of all residents (approximately 8,800 full-time residency positions) and are the nation's largest provider of graduate medical education. Twenty-five percent of all medical students and 30 percent of all residents receive some of their training in VA facilities.[19]

Of the 1,100 hospitals involved in medical education, COTH represents approximately 400 teaching hospitals and health systems. COTH member organizations must be

[15] AAMC. *Handbook of Academic Medicine: How Medical Schools and Teaching Hospitals Work.* 2004.
[16] AAMC. *Handbook of Academic Medicine: How Medical Schools and Teaching Hospitals Work.* 2004. p.9.
[17] AAMC. *Handbook of Academic Medicine: How Medical Schools and Teaching Hospitals Work.* 2004.
[18] AAMC. *AAMC Data Book: Medical Schools and Teaching Hospitals by the Numbers.* 2007. p. 99.
[19] AAMC. *Handbook of Academic Medicine: How Medical Schools and Teaching Hospitals Work.* 2004. p. 8.

affiliated with LCME-accredited medical schools. They are heavily involved in research and in the training of medical students. In addition, COTH teaching hospitals provide 75 percent of all residency training; the largest COTH providers of graduate medical education are the more than 60 Veterans Affairs member hospitals and medical centers. Furthermore, teaching hospitals fulfill a vital role in our communities by providing approximately 45 percent of the charity care in the U.S.[20]

1.1.5 Link Between Medical Education and Practice Location

In light of the physician shortage in the U.S., there is great interest in identifying factors that will help predict where physicians will decide to practice after they complete medical school and residency. Insight into the relationship between training sites and practice locations can help state officials appreciate how investment in medical education can affect the physician workforce.

***Link Between Medical School and Practice*.** The AAMC reports on the retention of medical students in states where they attended medical schools. On average, 39 percent of those who graduate from M.D./D.O. programs in a given state remain in the state. California leads the states with more than 60 percent retention, and New Hampshire is at the low end of the range at less than 10 percent retention. Utah, South Dakota, and Nevada exceed the average slightly, while North Dakota is approximately five percentage points below the average. Washington ranks twelfth in retention among the states with medical schools.

***Link Between Graduate Medical Education and Practice*.** The AAMC reports that, on average, 47.6 percent of physicians (M.D.s and D.O.s) who completed ACGME (allopathic) training programs in a state are practicing in that state. On the high end of the range, more than 70 percent of active physicians were retained in Alaska following completion of ACGME training; on the low end, approximately 25 percent of active physicians were retained in New Hampshire following ACGME training. Nevada, Arkansas, and Idaho rank near the top of the range, whereas South Dakota, Nebraska, North Dakota, and Utah fall within five percentage points below the average.[21]

Link Between Medical School, Graduate Medical Education, and Practice.
Retention of physicians is strongest when they receive both their medical school training and their residency training in the same state. "If students stay in one state for medical school and their residencies, there is an 80 percent chance that they will stay there."[22]

1.2 National Trends in Medical Education and Physician Workforce

Understanding the national trends in medical education and the physician workforce requires consideration of the projections of physician shortages and new models of medical education.

[20] Santana, S. *Teaching Hospitals and the Maze of Medicaid*. 2002. AAMC.
[21] AAMC. *Key Physician Data by State.* 2006. Figure 7.
[22] Edward Salsberg, Director, AAMC Center for Workforce Studies, quoted in *The Arizona Republic*, June 3, 2005, "Missouri University Plans a Mesa Medical School."

1.2.1 Projections of Physician Shortages

Over the past several years, there has been a growing recognition of an impending national physician shortage in the U.S. despite a steady slate of medical school graduates in recent decades. In the 1990s the prevailing concern was that the nation faced a potential overall physician surplus, with only minor shortages in some specialties and in some isolated geographic areas (i.e., a problem of distribution rather than shortage). Yet numerous reports from federal agencies and national associations now project physician shortages. These shortages are attributed to a number of factors — primarily the increased numbers of elders, with their relatively greater need for medical care, and the lack of growth in the production of new physicians over the past two decades, resulting in a quickly aging physician population.

The AAMC has called for a 30 percent increase in the production of new physicians by 2015, with some of the increase coming from internal growth of existing programs and some from new programs. In 2001, Florida opened the first new medical school in the nation in approximately two decades at Florida State University. More recently, the state authorized two additional medical schools, one at the University of Central Florida and the other at Florida International University. Plans for new schools are under way in several other states, including Texas, California, Pennsylvania, Virginia, and Michigan. According to the AAMC, more than half of the existing medical schools have reported plans for enrollment expansion, with several planning geographically separate campuses.

1.2.2 New Models of Medical Education

The national calls for growth in the numbers of medical students come at a time when curricular approaches to medical education are undergoing significant change. At the risk of oversimplification, the traditional medical school curriculum in the U.S. has been characterized by two years of basic science instruction in classrooms and labs, followed by two years of clinical training in major teaching hospitals. In recent years, there has been a movement toward providing earlier clinical exposure for medical students during the first two years of medical school, and more clinical exposure in community settings (rather than teaching hospitals) during the last two years. Additionally, student-centered learning and technology are playing increasingly important roles in the curriculum.

***Distributive Model*.** The past two decades have seen the emergence of a new model of medical education that is loosely termed the *distributive model*. This model involves providing either didactic and/or clinical training in locations separate from the main campus and more in ambulatory sites. Indeed, 16 of the 22 most recently accredited medical schools follow the community-based distributive model, and several new schools still being developed also have adopted this strategy for clinical training. The most visible difference under this approach is that clinical training takes place in a variety of community-based and ambulatory settings, including rural hospitals, doctors' offices, and public health clinics, as well as in large hospitals and medical centers. Between 50 and 70 percent of clerkship experiences may occur outside the hospital setting.

The advantages of this approach are twofold: medical students are exposed to practice settings more similar to those where the majority will eventually practice, and instructional cost per student can be isolated more easily, often resulting in a reduced

need for state appropriations. The distributive model also allows existing medical schools to expand their programs in terms of enrollment, outreach, and geographic distribution. Furthermore, distributive models that use local community facilities have the following benefits:

- Provide education in practice locations.
- Allow for better utilization of local resources.
- Increase local community support.
- Address local shortages of physicians.
- Address maldistribution of physicians.
- Increase retention of graduates in areas of training.
- Increase and distribute the economic engines of research.
- Increase the stability of resources.
- Promote cost efficiency.

The emphasis on early clinical exposure in the curriculum as well as community-based and ambulatory educational experiences requires increased numbers of physician faculty. Although technology can partially offset the demand for faculty in ambulatory settings, the need for physician faculty is significant. Since current and potential faculty members face pressures for increased clinical revenues, some medical schools are experiencing challenges in attracting and retaining qualified instructional personnel. Medical schools have had success in overcoming these challenges by offering innovative incentives (e.g., use of library resources).

***Telemedicine*.** Health care has benefited from advancements in technology and the evolution of telemedicine, which utilizes different technologies to support the medical community despite distance. Telemedicine is a key component in the growth of medical education as it allows individuals greater access to classroom and clinical experiences as well as mentoring, networking, and community building. It has proved particularly useful in rural settings but is also valuable in more populated areas for maximizing efficiency and outreach.

1.3 Idaho's Interest in Medical Education and Physician Workforce

Idaho has been one of the fastest growing states in the nation in recent years; the U.S. Census Bureau has projected that it will rank among the middle tier of states (37th) in terms of population by the year 2030, with nearly 2 million residents. As the state's population continues to escalate, higher levels of education and healthcare services are expected and can be provided. Yet this growth, combined with an increasing national physician shortage, has made it difficult for Idaho to improve its ratio of physicians per capita, a key indicator of physician access. In 2006, the AAMC reported that, of the 50 states, Idaho ranked 49th on this measure.[23] In addition to facing a significant shortage of physicians, Idaho is also experiencing a distribution problem, with most geographic regions designated as medically underserved.

[23] AAMC. *Key Physician Data by State.* 2006.

1.3.1 Previous Medical Education Initiatives

Idahoans have been proactive in their attempts to address the challenges presented by an aging physician workforce and a rapidly growing population. Several initiatives have been proposed since the mid-1990s.

Idaho Medical Education Program Proposal (1994). Idaho State University partnered with the University of Utah School of Medicine to propose establishment of a four year medical education program that would result in the M.D. jointly awarded by the two institutions. The first year of the program would be delivered by Idaho State faculty on the Pocatello campus; the remaining three years would be delivered by University of Utah School of Medicine faculty in Salt Lake City. The program would be limited to Idaho residents, and enrollment would start with 6 students per class and grow by 3 students per year for three years, reaching a maximum class size of 15. This proposal was not adopted.

Idaho Academic Medical Center Concept (early 2000s). The former University of Washington School of Medicine Clinical Coordinator in Idaho and the former president of Idaho State University conceived a model for a cooperative academic medical center. The design called for Boise State University, Idaho State University, and the University of Idaho to partner with the University of Utah and University of Washington schools of medicine to provide an "umbrella" for all medical education initiatives in Idaho, including undergraduate and graduate medical education (i.e., residencies and fellowships) and other healthcare programs. The model expanded medical education resources and offerings in Idaho during a transitional stage, leading to a fully Idaho-based and Idaho-involved program. Eventually, the administration of the program could be transitioned to Idaho in full, creating a free-standing program separate from the University of Washington and University of Utah. This model was never formally proposed.

Expansion of Contracted Medical School Seats (2007). The Idaho Legislature funded two additional WWAMI (a five state consortium based at the University of Washington) seats for the 2007 entering class, increasing Idaho's participation in the program to 20 students per year. In addition, the University of Utah School of Medicine received permission through the accreditation process to increase its class size by two in order to accommodate two additional Idaho students in fall 2007. However, the Idaho Legislature did not approve funding for the additional Utah seats, and Idaho's investment remains the same with eight seats.

1.3.2 Idaho Medical Association Resolution

In July 2005, the Idaho Medical Association (IMA) House of Delegates passed a resolution to ask the Idaho State Board of Education "to undertake a comprehensive study of the feasibility of establishing a medical school in Idaho including costs, benefits, and alternative approaches to establishing a traditional medical school, and that the Board seek extensive physician input throughout the study process". The IMA made a formal request of the State Board of Education in December 2005, and the State Board of Education received funding from the Idaho Legislature to conduct the study in 2007.

1.3.3 Legislation

In 2007, the Idaho Legislature appropriated funds to the State Board of Education for a medical education study to determine the need for and feasibility of increased medical education opportunities in Idaho. Specifically, Senate Bill 1210 directed the State Board of Education to:

> *engage the services of an external, independent consultant to undertake a comprehensive study of the feasibility and viability of offering a medical degree through: (i) a distributive model in partnership with Idaho's public universities and medical community; and (ii) other delivery models the board deems worthy of consideration. Neither the consultant nor the oversight of this study shall be affiliated with any of Idaho's public universities.*
>
> *The consultant shall report its findings to the State Board of Education not later than November 1, 2007. The State Board of Education shall report the findings of the study and make recommendations to the Second Regular Session of the Fifty-ninth Idaho Legislature.*

1.3.4 Idaho State Board of Education Request for Proposal for the Medical Education Study

In its July 5, 2007 Request for Proposal (RFP), the Idaho State Board of Education stated it was seeking qualified consultants:

> *To conduct a study of the feasibility of offering a four year medical degree program through a distributive model in partnership with Idaho's public universities and other medical resources or through other delivery models.*
>
> *The primary goals of the study, to be addressed in the report, include:*
>
> - *An analysis of the feasibility of offering a four year medical degree through a distributive model in partnership with Idaho's public universities and medical centers,*
> - *The development of alternative delivery models for providing medical education within the State of Idaho and their associated feasibility,*
> - *An analysis of the differences between the current facilities and faculty used to provide medical education and the requirements of each of the proposed models,*
> - *A cost/benefit analysis of each model, and*
> - *An analysis of the future needs for medical doctors within Idaho and how each model might address those needs. Specifically, an analysis of the current ratio of medical doctors to Idaho residents and any improvements that may be made to move toward parity with national or regional averages.*

The scope of the study included analysis of the strengths and weaknesses of alternative models, but did not include a request for the consultant to develop a specific recommendation on which model Idaho should employ.

2.0 IDAHO'S MEDICAL EDUCATION RESOURCES

2.0 IDAHO'S MEDICAL EDUCATION RESOURCES

This chapter highlights Idaho's current investment in medical education and presents potential avenues for exploration of additional resources. It provides overviews of the resources related to the three state universities, the University of Washington (UW) School of Medicine WWAMI program, the University of Utah (UU) School of Medicine, graduate medical education programs, and Idaho hospitals. Other potential resources for Idaho include a newly founded osteopathic school in Washington and a regional professional student exchange program.

2.1 Current State Investment in Medical Education

Although it is not currently home to a separately accredited medical school, the state of Idaho has already made a considerable investment in resources that might enable the cost-effective development of a new or expanded medical education program. These resources are found in the science and health-related programs of the three state universities, the contracted programs for medical education between the state of Idaho and universities in Washington and Utah, and graduate medical education programs that receive state support.

2.1.1 Health Professions Education and Research in Idaho Universities

The viability of many of the options to expand access to medical education in Idaho depends on the capacity of one or more of the state's universities in the biological sciences or other health professions programs. In this section, we provide a brief summary of the resources that each university might contribute to the development of a new medical education program.

2.1.2 The University of Idaho

The University of Idaho (UI) was established in 1889 and is the state's oldest public university. The main campus of UI is in Moscow, with satellite facilities in Boise, Coeur d'Alene, and Idaho Falls. The UI Research Park is located in Post Falls, and the UI Research and Extension Center in Twin Falls.

Role and Mission. UI is the state's land-grant university and, as such, has significant programs in agriculture and engineering. It also offers programs at the professional level in law and business. UI's role in the state higher education system is defined by the Board of Education:

> *The University of Idaho is a high research activity, land-grant institution committed to undergraduate and graduate-research education with extension services responsive to Idaho and the region's business and community needs. The university is also responsible for regional medical and veterinary medical education programs in which the state of Idaho participates.*
>
> *The University of Idaho will formulate its academic plan and generate programs with primary emphasis on agriculture, natural resources, and metallurgy,*

engineering, architecture, law, foreign languages, teacher preparation and international programs related to the foregoing. The University of Idaho will give continuing emphasis in the areas of business, education, liberal arts and physical, life, and social sciences, which also provide the core curriculum or general education portion of the curriculum.

In the early 1970s, UI's role was expanded to include responsibility for the state's involvement in medical education as host for the Idaho path of the University of Washington's WWAMI program.

Health-Related Programs and Degree Production. UI offers degrees in several natural science programs that are basic to the study of medicine. For academic year 2005-2006, the following degrees were awarded:[1]

- College of Science
  - Department of Biological Sciences: 27 baccalaureate degrees, 2 master's degrees, and 1 doctoral degree
  - Department of Chemistry: 17 baccalaureate degrees, 1 master's degree, and 6 doctoral degrees
- College of Agriculture and Life Sciences
  - Department of Microbiology, Molecular Biology, and Biochemistry: 30 baccalaureate degrees, 2 master's degrees, and 4 doctoral degrees

Faculty in Health Programs and NIH Research Productivity. UI has approximately 50 full-time faculty in the Departments of Biological Sciences; Chemistry; and Microbiology, Molecular Biology, and Biochemistry. The total amount of sponsored research at UI in 2004 was $80.7 million.[2] Of this amount, nearly $9.9 million was received from the National Institutes of Health (NIH); the total allocation was in the form of research grants.[3]

Strategic Partnerships. UI partners with nearby Washington State University (WSU) to operate a first-year training site for the UW School of Medicine through its WWAMI program. Additionally, UI is the lead institution for the IDeA Network of Biomedical Research Excellence (INBRE) grant from NIH (shared with Idaho State University [ISU] and Boise State University [BSU]) and for the Inland Northwest Research Alliance (INRA), a research consortium with ISU, BSU, WSU, Utah State University, Montana State University, University of Montana, and University of Alaska Fairbanks.

[1] IPEDS 2005-2006 completion data. This is not an exhaustive list of degrees awarded in the College of Science and College of Agriculture and Life Sciences.
[2] 2004 Progress Report on Plan of Action for Scholarly Activity (p.3), http://www.uro.uidaho.edu/documents/ProgressReport-PlanofAction-rev9-30-04.pdf&pid=72775&doc=1.
[3] NIH Awards to Domestic Institutions of Higher Education, By Rank FY 2004, http://grants.nih.gov/grants/award/trends/dheallinst04.htm.

2.1.3 Idaho State University

ISU was founded in 1901 as the Academy of Idaho. The school became Idaho Technical Institute in 1915; University of Idaho-Southern Branch in 1927; Idaho State College in 1947, when it also achieved four-year status; and Idaho State University in 1963. The main ISU campus is in Pocatello, and the university operates centers in Boise, Coeur d'Alene, Idaho Falls, and Twin Falls. In addition, ISU operates outreach centers in American Falls, Blackfoot, Preston, and Soda Springs.

Role and Mission. ISU's role in the state higher education system is defined by the Board of Education:

> *Idaho State University is a doctoral university serving a diverse population through research, state and regional public service, undergraduate and graduate programs. The university also has specific responsibilities in delivering programs in the health professions.*
>
> *Idaho State University will formulate its academic plan and generate programs with primary emphasis on health professions, the related biological and physical sciences, and teacher preparation. Idaho State University will give continuing emphasis in the areas of business, education, engineering, technical training and will maintain basic strengths in the liberal arts and sciences, which provide the core curriculum or general education portion of the curriculum.*

Health-Related Programs and Degree Production. The ISU College of Arts and Sciences offers degrees in several natural science programs that are basic to the study of medicine. In addition, ISU offers more than 30 health-specific degree programs in the Kasiska College of Heath Professions and the College of Pharmacy. For academic year 2005-2006, the following degrees were awarded:[4]

- College of Arts and Sciences
  - Biological Sciences: 45 baccalaureate degrees, 10 master's degrees, and 4 doctoral degrees
  - Chemistry: 12 baccalaureate degrees and 4 master's degrees
  - Biochemistry: 4 baccalaureate degrees
- College of Heath Professions
  - Nursing: 88 baccalaureate degrees and 22 master's degrees
  - Physician Assistant Studies: 29 master's degrees
  - Physical Therapy: 15 doctoral degrees
- College of Pharmacy: 1 master's degree and 66 doctoral degrees (3 Ph.D.s and 63 Pharm.D.s)

[4] IPEDS 2005-2006 completion data. This is not an exhaustive list of degrees awarded in the Colleges of Arts and Sciences, Health Professions, and Pharmacy.

Faculty in Health Programs and NIH Research Productivity. ISU has approximately 80 full-time faculty in the Department of Biological Sciences, Department of Chemistry, and College of Pharmacy. The total amount of sponsored research at ISU in 2005 was $28.5 million.[5] Of this amount, $583,830 was received from NIH.[6] The total NIH allocation was in the form of research grants—$231,586 was given to the College of Pharmacy and the remaining funds were given to other research units.

Strategic Partnerships. ISU has long-standing arrangements with approximately 150 hospitals, more than 110 pharmacy-affiliated sites, over 170 physicians (M.D.s and D.O.s), and more than 250 pharmacists across Idaho in support of its programs in the health professions. It operates 15 clinics—12 in Pocatello and 3 in Boise. The ISU Family Medicine Residency Program is affiliated with the UW and UU Family Medicine Residency Programs and the Portneuf Medical Center in Pocatello. ISU manages the residency certification process for students applying for the Idaho-sponsored slots at the UU School of Medicine. In addition, ISU partners with the Creighton University School of Dentistry in the Idaho Dental Education Program (IDEP). The first year of dental education is offered at ISU, and the remaining years are offered on the Creighton campus in Omaha, Nebraska. The program is open to eight Idaho students per year. ISU is also a member of INRA, as mentioned above.

2.1.4 Boise State University

BSU has been in existence as an institution of higher education since 1932, when it was established as Boise Junior College (BJC). In 1939 BJC became a public college, and in 1965 it achieved four-year status and was renamed Boise College. In 1969 the school became part of the state university system and was renamed Boise State College, and in 1974 it achieved university status and was named Boise State University. It has evolved as the state's largest university and currently enrolls approximately 19,000 students.

Role and Mission. BSU's role in the state higher education system is defined by the Board of Education:

> *Boise State University is a comprehensive, urban university serving a diverse population through undergraduate and graduate programs, research, and state and regional public service.*
>
> *Boise State University will formulate its academic plan and generate programs with primary emphasis on business and economics, engineering, the social sciences, public affairs, the performing arts, and teacher preparation. Boise State University will give continuing emphasis in the areas of the health professions, the physical and biological sciences, and education and will maintain basic strengths in the liberal arts and sciences, which provide the core curriculum or general education portion of the curriculum.*

[5] 2005 External Research Funding, Performance Measurement Report, p. 3, http://dfm.idaho.gov/Publications/BB/PerfReport/PR2008/perfrpt_isu.pdf.
[6] NIH Award Data for Individual Institutions, 2005, http://grants.nih.gov/grants/award/trends/FindOrg_Detail.cfm?OrgID=3541601&Year=2005.

Health-Related Programs and Degree Production. BSU offers degrees in several natural science programs that are basic to the study of medicine through its College of Arts and Sciences. In addition, it offers several degree programs through its College of Health Sciences. For academic year 2005-2006, the following degrees were awarded:[7]

- College of Arts and Sciences
  - Biology: 63 baccalaureate degrees and 10 master's degrees
  - Chemistry: 15 baccalaureate degrees
- College of Health Sciences
  - Nursing: 43 baccalaureate degrees

Faculty in Health Programs and NIH Research Productivity. BSU has approximately 30 full-time faculty in the Department of Biology and Department of Chemistry and Biochemistry. The total amount of sponsored research at BSU in 2006 was $23.8 million.[8] NIH supplied $79,822 all of which was given to the Department of Biology.[9]

Strategic Partnerships. As mentioned above, BSU is a member of INRA. The university also maintains several research centers, some of which support the study of science and health. For example, the Mechanical Engineering and Kinesiology Departments collaborate with local clinicians to support the Center for Orthopaedic and Biomechanics Research.

2.1.5 Summary of State University Presence in Medical Education

As noted above in the brief descriptions of each state university, the state of Idaho already has significant resources in place to expand capacity for medical education. Key information is summarized in **Exhibit 2-1**.

[7] IPEDS 2005-2006 completion data. This is not an exhaustive list of degrees awarded in the College of Arts and Sciences and College of Health Sciences.
[8] 2006 Fiscal Year, August Office Sponsored Programs, External Support (p. 7), http://osp.boisestate.edu/Forms/August%202006.pdf.
[9] NIH Award Data for Individual Institutions, 2006, http://grants.nih.gov/grants/award/trends/FindOrg_Detail.cfm?OrgID=478201&Year=2006.

EXHIBIT 2-1
IDAHO HIGHER EDUCATION RESOURCES FOR MEDICAL EDUCATION

Program/Institution	Undergraduate Enrollment			Graduate Enrollment			NIH~	Total Sponsored Research
	Total	Biological Sciences	Physical Sciences	Total	Biological Sciences	Physical Sciences		
Boise State University	17,040	515	217	1,789	42	42	$79,822	$23.8 million^
Idaho State University	10,640	603	209	1,795	107	97	$590,122	$28.5 million^^
University of Idaho	9,127	391	182*	2,281	103	89*	$10,384,645	$80.7 million^^^
Total	**36,807**	**1,509**	**608**	**5,865**	**252**	**228**	**$11,054,589**	**$133 million**

*Sources: IPEDS 2006 Enrollment Early Release file *IPEDS 2004 Enrollment file.*

~National Institutes of Health http://grants1.nih.gov/grants/award/trends/FindOrg_Detail.cfm?OrgID=3541601
http://grants1.nih.gov/grants/award/trends/FindOrg_Detail.cfm?OrgID=478201
http://grants1.nih.gov/grants/award/trends/FindOrg_Detail.cfm?OrgID=3543501

^2006 Fiscal Year, Office of Sponsored Programs, External Support (p. 7) http://osp.boisestate.edu/Forms/August%202006.pdf

^^2005 External Research Funding, Performance Measurement Report (p. 3)
http://dfm.idaho.gov/Publications/BB/PerfReport/PR2008/perfrpt_isu.pdf

^^^2004 Progress Report on Plan of Action for Scholarly Activity (p. 3)
http://www.uro.uidaho.edu/documents/ProgressReport-PlanofAction-rev9-30-04.pdf&pid=72775&doc=1

SELECT DEGREES AWARDED

Program	Boise State University			Idaho State University			University of Idaho		
	BA	Masters	PhD	BA	Masters	PhD	BA	Masters	PhD
Biology/Biological Sciences	63	10	-	45	10	4	27	2	1
Biochemistry	-	-	-	4	-	-	-	-	-
Chemistry, General	15	-	-	12	4	-	17	1	6
Microbiology, General	-	-	-	12	3	-	23	-	-
Molecular Biology	-	-	-	-	-	-	7	2	4
Nursing/Registered Nurse	43	0	0	88	22	0	0	0	0
Pharmacy	-	-	-	-	1	66	-	-	-
Physician Assistant	-	-	-	-	29	-	-	-	-
Physical Therapy	-	-	-	-	-	15	-	-	-
Total	**121**	**10**	**0**	**161**	**69**	**85**	**74**	**5**	**11**

Source: IPEDS Completion Data 2005-2006

2.1.6 Idaho Rural Physician Incentive Program

In an attempt to attract physicians to rural Idaho, the Legislature established the Rural Physician Incentive Program in 2003:

> *All state supported Idaho medical education students entering in the Fall 2003 semester or thereafter, will be assessed a fee equal to 4percent of the annual average medical support fee paid by the state. The incentive fee collected by the State Board of Education will be deposited into the Rural Physician Incentive Fund to repay the educational debts of rural physicians who practice primary care medicine in medically underserved areas of the state that demonstrate a need for assistance in physician recruitment. The maximum amount of educational debt payment that a rural physician may receive is $50,000 over a five-year period. Debt repayment is scheduled to begin in 2010.*[10]

Idaho-sponsored medical students have paid this fee for four years and the repayment portion of the program will not start for more than two years. The program's level of success will become apparent several years in the future, when physician retention is determined.

2.2 WWAMI

WWAMI is a regional medical education program sponsored by the UW School of Medicine. The states of Washington, Wyoming, Alaska, Montana, and Idaho (hence the initials WWAMI) partner with UW to provide their residents with access to publicly supported medical education. WWAMI traces its origins to 1972, when Washington, Alaska, Montana, and Idaho agreed to fund seats in the program. In 1996, Wyoming became the fifth state to join WWAMI. The program has enjoyed long and steady support from across the region since its founding.

2.2.1 Impact on Workforce in Idaho

Of the 436 WWAMI Idaho graduates, 217 (50 percent) are practicing or have practiced in Idaho. In addition, 37 percent of family physicians and 35 percent of primary care physicians in Idaho were WWAMI-trained. Finally, Idaho realizes a significant return on its WWAMI investment — there are 436 Idaho-sponsored WWAMI graduates, and 305 of *all* WWAMI graduates (from all five states) are practicing or have practiced in Idaho, resulting in a 70 percent (305/436) return on investment.

2.2.2 Organization of WWAMI

The four-year WWAMI program is designed to provide the first year of medical school in each of the five participating states. Current sites are in Pullman, Washington; Laramie, Wyoming; Anchorage, Alaska; Bozeman, Montana; and Moscow, Idaho — a site shared with WSU in Pullman. Information about each WWAMI site is summarized in **Exhibit 2-2**. A new WWAMI site is scheduled to open in Spokane, Washington in Fall 2008.

[10] University of Idaho Website: http://www.webs.uidaho.edu/wwami/idaho_rural_physician_incentive_program.htm

EXHIBIT 2-2
SUMMARY OF WWAMI TRAINING SITES

State	Host University	Location
Washington	Washington State University	Pullman*
Wyoming	University of Wyoming	Laramie
Alaska	University of Alaska	Anchorage
Montana	Montana State University	Bozeman
Idaho	University of Idaho	Moscow*

* The Pullman and Moscow sites function as a joint program.

WWAMI students from all sites join students from the UW School of Medicine's first-year class for the second year of medical school in Seattle. The third and fourth years of the program for the WWAMI cohort take place at clinical training sites in the outlying states and in Seattle, though students are not required to return to their home states for this training. Additionally, students from the UW class can swap training opportunities with WWAMI students upon approval. The "Idaho Track" provides an opportunity for students to complete their third and fourth years of training in Idaho. As a result, Idaho's medical education infrastructure includes numerous physicians, affiliated faculty, and clinical sites.

2.2.3 UW School of Medicine

The UW School of Medicine is recognized as one of the nation's leading medical education programs. In the 2008[11] release of the *U.S. News and World Report* medical school rankings, the UW school of medicine was ranked 1st overall in the Medical Schools–Primary Care category and 6th overall in the Medical Schools–Research category. In support of this prestigious standing, UW was ranked 1st in Family Medicine and 1st in Rural Medicine. The UW medical school ranks 2nd among the nation's medical schools in funding from NIH for biomedical research and related activities ($573.2 million in 2005).

2.2.4 Population Trends

When the WWAMI program was first established in 1972, the five-state region was very different from what it has become in the early twenty-first century. In 1970, the region had a total population of more than 5.4 million; its 2006 estimated population was nearly 10 million (see **Exhibit 2-3** for state-specific population figures).

[11] *US News and World Report* notes that the rankings are from 2007 although published in the 2008 edition.

EXHIBIT 2-3
POPULATION CHANGES IN WWAMI STATES

	2006 Est Pop	2000 Pop	Change 2000-2006	1970 Pop	Change 1970-2006
Washington	6,395,798	5,894,121	8.5%	3,409,169	87.6%
Wyoming	515,004	493,782	4.3%	332,416	54.9%
Alaska	670,053	626,932	6.9%	300,382	123.1%
Montana	944,632	902,195	4.7%	694,409	36.0%
Idaho	1,466,465	1,293,953	13.3%	712,567	105.8%
Total	**9,991,952**	**9,210,983**	**-**	**5,448,943**	**-**
Average	**-**	**-**	**7.5%**	**-**	**81.5%**

Source: U.S. Census Bureau

2.2.5 WWAMI Idaho Trends

In response to significant population growth, some WWAMI states have contracted with the UW School of Medicine to expand their slots. Idaho has realized a general increase in the number of applicants for WWAMI slots and in the number of qualified applicants (or the number of applicants interviewed). Yet the number of available WWAMI slots for Idaho students has increased minimally. As a result, growing numbers of qualified applicants are not offered admission to the UW School of Medicine through WWAMI (see **Exhibit 2-4**).

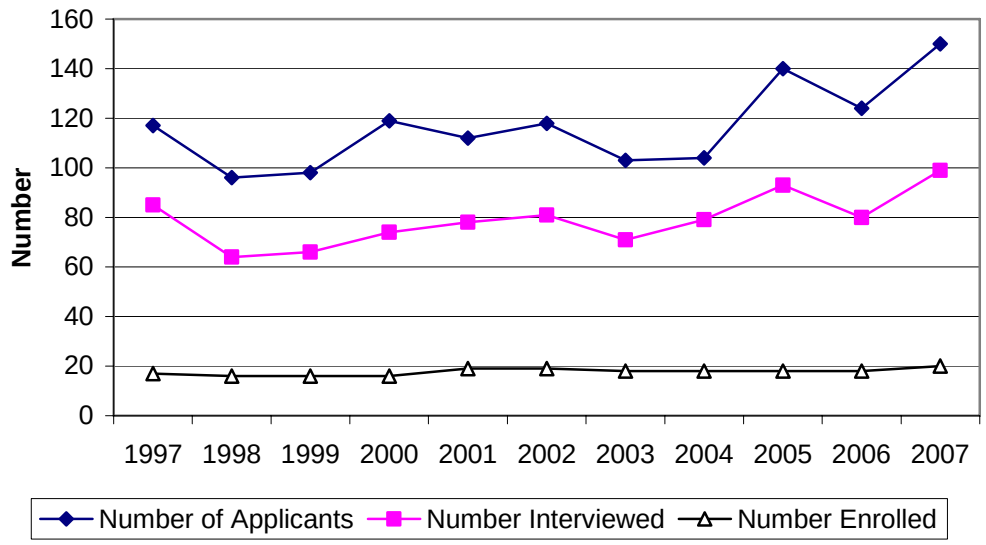
2.2.6 Financing WWAMI Slots

The WWAMI Idaho agreement allows Idaho-sponsored students to pay reduced tuition to the UW School of Medicine. In addition, the state of Idaho pays a support fee for each student. The state appropriation was $3,569,200[12] (~$49,572 per student; 72 students total); in FY 2006 and the state appropriation was $3,533,800[13] (~$47,754 per student; 74 students total) in FY 2007. The appropriation for FY 2008 is $3,664,000[14] (~$48,210 per student; 76 students total). In 2010, Idaho students will total 80 (20 in each class).

[12] *FY 2008 Idaho Legislative Budget Book*, p. 1-83. http://www.legislature.idaho.gov/Budget/publications/PDFs/LBB/FY2008/Education/HealthEdLBB.pdf
[13] *FY 2008 Idaho Legislative Budget Book*, p. 1-83. http://www.legislature.idaho.gov/Budget/publications/PDFs/LBB/FY2008/Education/HealthEdLBB.pdf
[14] Idaho Legislature, *Senate Bill 1201* http://www3.state.id.us/oasis/S1201.html

EXHIBIT 2-4
WWAMI IDAHO TRENDS: APPLICANTS AND SLOTS

Year	Number of Applicants	Number Interviewed	Number Enrolled	Applicants per Idaho Slot	Number Interviewed per Idaho Slot
1997	117	85	17	6.88	5.00
1998	96	64	16	6.00	4.00
1999	98	66	16	6.13	4.13
2000	119	74	16	7.44	4.63
2001	112	78	19	5.89	4.11
2002	118	81	19	6.21	4.26
2003	103	71	18	5.72	3.94
2004	104	79	18	5.78	4.39
2005	140	93	18	7.78	5.17
2006	124	80	18	6.89	4.44
2007	150	99	20	8	4.95

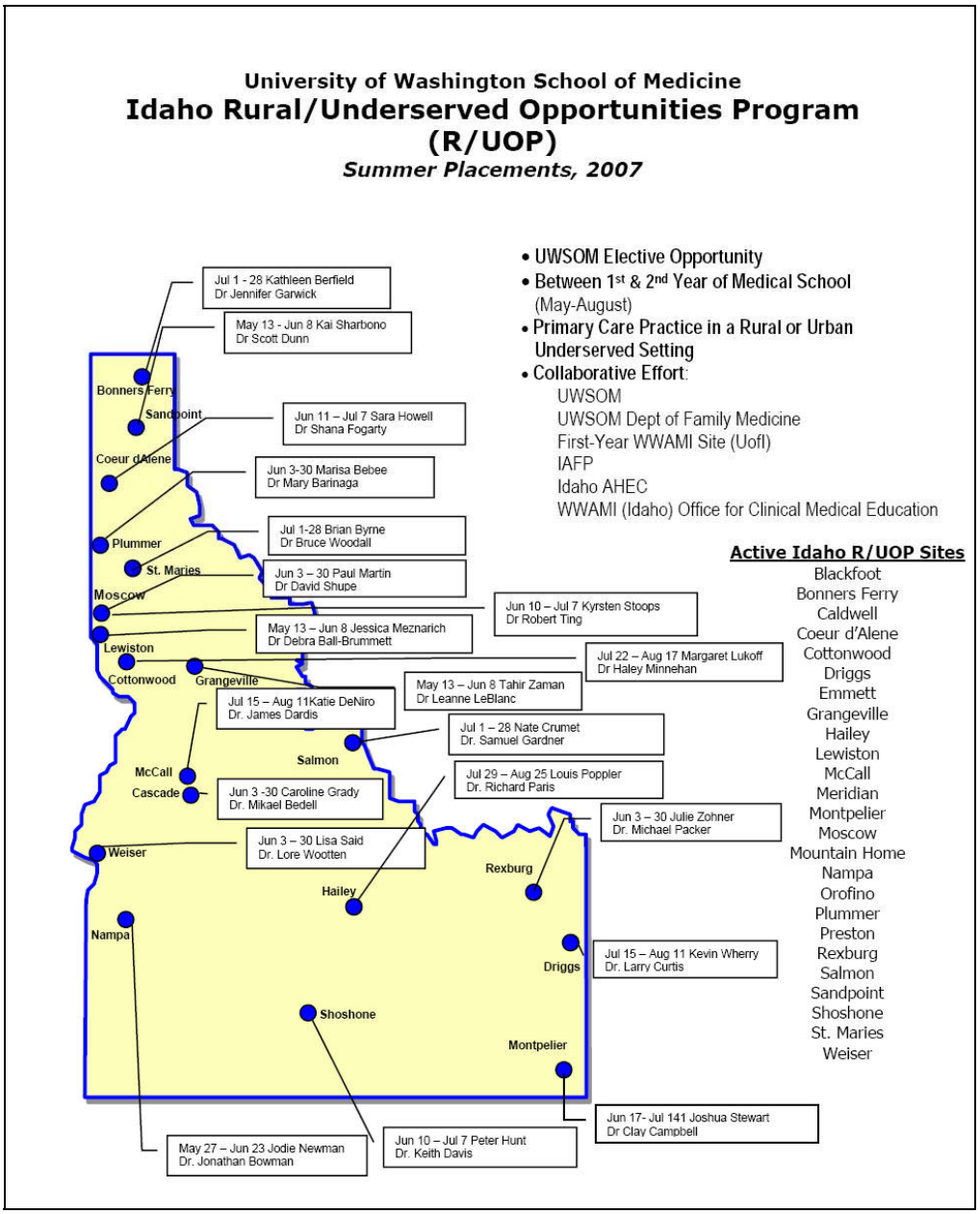


Source: University of Washington/WWAMI, 2007.

2.2.7 Rural/Underserved Opportunities Program

In 1989, the Rural/ underserved Opportunities Program (R/UOP) was developed to give UW School of Medicine students (including WWAMI students) clinical experiences in rural and underserved communities. R/UOP is an elective program; students are matched with physicians and are given stipends to support month-long summer experiences. In 2007, 20 WWAMI students participated in R/UOP in Idaho (see **Exhibit 2-5**).

EXHIBIT 2-5
2007 IDAHO R/UOP PLACEMENTS



Source: University of Washington School of Medicine, 2007.

2.3 University of Utah Contract

In addition to participating in WWAMI, the state of Idaho provides access to publicly supported medical education through a partnership with the University of Utah (UU) School of Medicine.

2.3.1 History of Contract

Idaho's relationship with the UU School of Medicine began through the Western Interstate Commission for Higher Education (WICHE). (See Section 2.6.2 for detailed information about WICHE.) Idaho students originally attended the UU School of Medicine through the WICHE Professional Student Exchange Program (PSEP). However, in the 1980s Idaho developed its own partnership with the UU School of Medicine.

2.3.2 Program Delivery Model

The first two years of medical school at UU take place on the UU campus in Salt Lake City and focus on the basic sciences. In the third and fourth years, students complete clinical rotations in a variety of disciplines; most rotations take place in the Salt Lake City area (e.g., UU Medical Center, LDS Hospital, Primary Children's Medical Center, UU Neuropsychiatric Institute, and the VA Medical Center), though students can request approval to complete clerkships elsewhere. Idaho-sponsored students are required to complete two rotations in Idaho.

2.3.3 Number of Slots and Trends

The state of Idaho originally contracted with the UU School of Medicine for five seats in the 1970s. In the early 1980s, Idaho reduced the seats to four due to financial difficulties. Idaho-sponsored seats increased to six in the late 1990s and to eight in 2004. The UU School of Medicine received accreditation approval to expand its entering medical school class size by two students in 2007 to accommodate a total of ten students from Idaho per year. However, the Idaho Legislature chose not to fund the additional seats. **Exhibit 2-6** highlights application trends for the last five years.

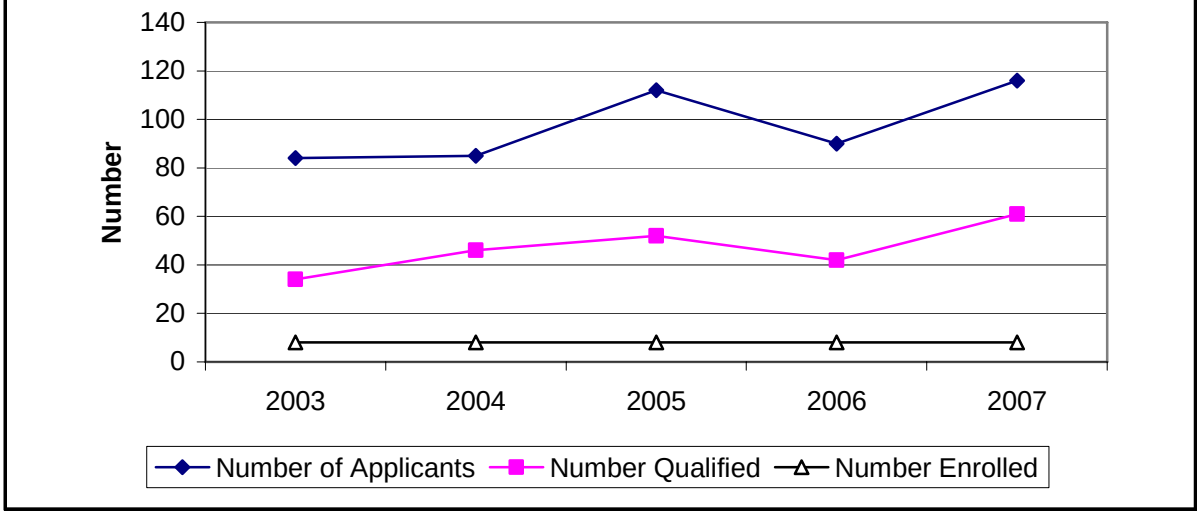
2.3.4 Financing the Slots

The Idaho-UU School of Medicine agreement allows Idaho-sponsored students to pay in-state tuition. In addition, the state of Idaho pays support fees for the 32 students enrolled (eight per year). The state appropriation was $979,600[15] (~$30,612 per student) in FY 2006 and $1,039,100[16] (~$32,471 per student) in FY 2007. The appropriation for FY 2008 is $1,088,800[17] (~$34,025 per student).

[15] *FY 2008 Idaho Legislative Budget Book*, p. 1-83. http://www.legislature.idaho.gov/Budget/publications/PDFs/LBB/FY2008/Education/HealthEdLBB.pdf
[16] *FY 2008 Idaho Legislative Budget Book*, p. 1-83. http://www.legislature.idaho.gov/Budget/publications/PDFs/LBB/FY2008/Education/HealthEdLBB.pdf
[17] Idaho Legislature, *Senate Bill 1201* http://www3.state.id.us/oasis/S1201.html

EXHIBIT 2-6
IDAHO-UU SCHOOL OF MEDICINE TRENDS: APPLICANTS AND SLOTS

Year	Number of Applicants	Number Qualified	Number Enrolled	Applicants per Slot	Number Qualified per Slot	Average GPA of Qualified Applicants	Average MCAT of Qualified Applicants
2003	84	34	8	10.5	4.3	3.8	28.0
2004	85	46	8	10.625	5.8	3.7	29.0
2005	112	52	8	14	6.5	3.7	29.0
2006	90	42	8	11.25	5.3	3.7	28.5
2007	116	61	8	14.5	7.6	3.7	29.0



Source: University of Utah.

2.4 Graduate Medical Education

Graduate medical education (GME) is the training medical school graduates receive before they can practice medicine without supervision.

2.4.1 GME Programs in Idaho

There are two GME programs based fully in Idaho:

- Family Medicine Residency of Idaho (Boise)
- Idaho State University Family Medicine Residency (Pocatello)

There are three UW residencies based in Seattle that provide some training in Idaho:

- Internal Medicine Residency Program (Seattle and Boise)
- Psychiatry Residency Program (Seattle and Boise)
- Pulmonary/Critical Care Fellowship Training Program (Seattle and Boise)

All of the programs are affiliated with the UW School of Medicine, and the ISU Family Medicine Residency is affiliated with the UU School of Medicine as well.

2.4.2 Numbers of Idaho GME Participants

Exhibit 2-7 highlights each GME program's length and number of participants.

EXHIBIT 2-7
GME PROGRAM PARTICIPANTS

GME Program	Total Training	Training in Idaho	Participants
Family Medicine (Boise)	3 years	3 years	10 per year
Family Medicine (Pocatello)	3 years	3 years	6 per year
Internal Medicine (Seattle and Boise)	3 years	1 year	~8 per year
Psychiatry (Seattle and Boise)	4 years	2 years	~6 per year
Pulmonary/Critical Care (Seattle and Boise)	3 years	1-2 years	1-2 per year

2.4.3 Financing GME Slots

Funding for GME programs comes from a wide variety of sources, including patient revenue, hospitals and medical centers, and grants. The programs' largest expenses are salaries and wages for the residents and fellows. This is in contrast to medical students, who pay tuition. Residents and fellows have completed their medical degrees and are providing services to patients as part of their graduate training.

2.4.4 Rural Tracks

The Family Medicine Residency of Idaho program in Boise offers a clinical training track in Caldwell. Residents spend the first year in Boise and the second and third years in Caldwell. Of the 10 residents who have completed the Caldwell track to date, 8 are practicing medicine in the Caldwell area. A second rural track based on the Caldwell model will open in Twin Falls for the 2008-2009 academic year.

2.5 Hospitals in Idaho

Hospitals and medical centers are the primary clinical training sites for medical school students and GME participants.

2.5.1 Statewide Summary Data

The Idaho Hospital Association recognizes 37 traditional community hospitals and 6 additional member facilities. There are 3,293 beds among the 43 facilities (**Exhibit 2-8**).

EXHIBIT 2-8
IDAHO HOSPITALS

Traditional Community Hospitals	Location	Acute Care Beds	Rehab Beds	Obstetric Beds	Psychiatric Care Beds	Intensive Care Beds	Pediatric Care Beds	Alcohol/Drug Rehab Beds	Other Care Beds	Long Term Care Beds	Total by Facility
Bear Lake Memorial Hospital	Montpelier	16	0	1	0	4	0	0	0		**21**
Benewah Community Hospital	St. Maries	18		1							**19**
Bingham Memorial Hospital	Blackfoot	21				4					**25**
Bonner General Hospital	Sandpoint	36		8		4					**48**
Boundary Community Hospital	Bonners Ferry	20									**20**
Caribou Memorial Hospital	Soda Springs	21		2		2				27	**52**
Cascade Medical Center	Cascade	10									**10**
Cassia Regional Medical Center	Burley	16		16		3					**35**
Clearwater Valley Hospital & Clinics	Orofino	23									**23**
Eastern Idaho Regional Medical Ctr	Idaho Falls	121		22	40	47	10	13			**253**
Elmore Medical Center	Mountain Home	25									**25**
Franklin County Medical Center	Preston	20								45	**65**
Gooding County Memorial Hospital	Gooding	14									**14**
Gritman Medical Center	Moscow	17		4		4					**25**
Harms Memorial Hospital	American Falls	10									**10**
Kootenai Medical Center	Coeur d'Alene	123	15	12	55	14	11	7	16		**253**
Lost Rivers District Hospital	Arco	14									**14**
Madison Memorial Hospital	Rexburg	34		9		4	2				**49**
McCall Memorial Hospital	McCall	11		2		2					**15**
Mercy Medical Center	Nampa	110		16		18	8				**152**
Minidoka Memorial Hospital	Rupert	24				1					**25**
Oneida County Hospital	Malad City	11									**11**
Portneuf Medical Center	Pocatello	161	14	7	15	36	17		23		**273**
Saint Alphonsus Reg Med Ctr	Boise	183	33	24	32	70	5				**347**
Shoshone Medical Center	Kellogg	25									**25**
St. Benedicts Family Medical Center	Jerome	19		4							**23**
St. Joseph Regional Medical Center	Lewiston	78		13	20	9	9		16		**145**
St. Luke's Boise/Meridian Reg Med Ctr	Boise/Meridian	226		88		118	49		56		**537**
St. Luke's Magic Valley Reg Med Ctr	Twin Falls	103		18	28	20	14		14		**197**
St. Luke's Wood River Medical Center	Ketchum	19				2					**21**
St. Mary's Hospital	Cottonwood	23									**23**
Steele Memorial Medical Center	Salmon	15		3							**18**
Syringa General Hospital	Grangeville	12				2					**14**
Teton Valley Hospital	Driggs	12		1							**13**
Walter Knox Memorial Hospital	Emmett	14		2							**16**
Weiser Memorial Hospital	Weiser	25									**25**
West Valley Medical Center	Caldwell	73		5	18	18	10				**124**
TOTAL		**1703**	**62**	**258**	**208**	**382**	**135**	**20**	**125**	**72**	**2965**
Other IHA Member Facilities	**Location**	**Acute Care Beds**	**Rehab Beds**	**Obstetric Beds**	**Psychiatric Care Beds**	**Intensive Care Beds**	**Pediatric Care Beds**	**Alcohol/Drug Rehab Beds**	**Other Care Beds**	**Long Term Care Beds**	**Total by Facility**
366th Medical Group (AFB)	Mountain Home										**10***
Idaho Elks Rehabilitation Hospital	Boise		56								**56**
Idaho State Hospital North	Orofino				60						**60**
Idaho State Hospital South	Blackfoot				106				29		**135**
Intermountain Hospital of Boise	Boise				53			24			**77**
Veterans Affairs Medical Center	Boise										**46****
TOTAL		**0**	**56**	**0**	**219**	**0**	**0**	**24**	**29**	**0**	**328**

Sources: Idaho Hospital Association, based on state reports as of November 2006. See * and ** for source exceptions.

* 366th Medical Group Web site, http://www.mountainhome.af.mil/library/factsheets/factsheet.asp?id=4368

** Boise VA Medical Center Web site, http://www1.va.gov/directory/guide/facility.asp?id=17

2.5.2 Communities With Capacity to Support Required Clerkships

While any of the hospitals included in **Exhibit 2-8** could conceivably handle a limited number of medical students, those with 200 or more beds hold the greatest potential to support an expanded program of medical education in the state. There are six hospitals in Idaho with approximately 200 or more beds (including St. Luke's Magic Valley Regional Medical Center with 197 beds). In order to fully determine which communities in Idaho can support required medical school clerkships, a detailed analysis must be conducted in light of the requirements of the Liaison Committee on Medical Education (LCME). Furthermore, it is important to note that only nine counties in Idaho have 60 physicians or more: Ada, Bannock, Blaine, Bonner, Bonneville, Canyon, Kootenai, Nez Perce, and Twin Falls. See Chapter 3.0 for more detailed information on physicians by county.

2.6 Other Potential Resources for Idaho

In addition to the partnerships Idaho maintains with the UW and UU medical schools, the newly created Pacific Northwest University of Health Sciences and WICHE are potential resources for the state.

2.6.1 Pacific Northwest University of Health Sciences

Founded in 2005, Pacific Northwest University of Health Sciences (PNWU) is a new institution in Yakima, Washington, that will enroll its first students in Fall 2008.

History of PNWU. The College of Osteopathic Medicine (COM) will be PNWU's first school and the first new medical school in the Pacific Northwest in 60 years. PNWU-COM plans to accept its first class of 70 students in September 2008. A 48,000 square-foot facility is under construction, with an estimated completion date of July 2008. PNWU-COM has received provisional accreditation from the Commission of Osteopathic College Accreditation (COCA) and is authorized by the Washington Higher Education Coordinating Board.

PNWU Mission. The PNWU-COM mission is as follows:

> *to provide men and women with a scholarly medical education and training of osteopathic principles, to encourage research, to promote lifelong scholarly activity, and to serve the Pacific Northwest through educational experiences within the five-state region, leading to an increase in the number of osteopathic physicians practicing in rural and underserved areas.*

Furthermore, "PNWU is devoted to training new generations of doctors who will serve the needs of those who live in the non-urban communities and rural areas of Alaska, Idaho, Montana, Oregon and Washington."

Program Delivery Model. The PNWU-COM curriculum will be structured around seven competencies: Patient Care, Medical Knowledge, Practice-Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, Systems-Based Practice, and Osteopathic Principles/Practice/Osteopathic Manipulative Treatment. The

first two years of the curriculum will consist of basic science courses and courses that focus on osteopathic principles and practices. The third and fourth years of the curriculum will be clinical-based. Students will be required to complete eight rotations: family medicine, emergency medicine, general internal medicine, pediatrics-neonate, general surgery, osteopathic principles and practice, women's health, and clinical medical/surgical subspecialty. The clinical sites will be established by the Assistant Dean of Clinical Sciences.[18]

Enrollment and Tuition. PNWU-COM will enroll 70 students per class for a full enrollment of 280 students. Tuition for the class entering in Fall 2008 will be $30,000, and yearly tuition increases will be implemented. In addition, students will pay a one-time acceptance fee of $1,000 and academic fees of $2,500 per year. The total cost for the class entering in Fall 2008 will be $33,675 for the first year, $34,000 for the second year, $35,575 for the third year, and $37,229 for the fourth year.

2.6.2 Western Interstate Commission for Higher Education (WICHE) Professional Exchange Program

WICHE is a coalition of 15 states that expands access to higher education and promotes resource sharing. Idaho became the eighth WICHE member in 1953. Robert Kustra, president of Boise State University, and Arthur Vailas, president of Idaho State University, are the current WICHE Idaho commissioners. The other WICHE states are Alaska, Arizona, California, Colorado, Hawai'i, Montana, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Utah, Washington, and Wyoming.

The key components of WICHE are as follows:

- Policy analysis and research
- Three student exchange programs
  - Western Undergraduate Exchange (WUE)
  - Western Regional Graduate Program (WRGP)
  - Professional Student Exchange Program (PSEP)
- Western Cooperative for Educational Telecommunications (WCET)
- Mental Health Program
- Other academic, organizational, and technological support programs

WICHE PSEP–Medicine. The PSEP–Medicine program provides students from participating states preferential admission and reduced cost for medical school. The home states pay administrative fees to the medical schools in support of their students.

Seventeen allopathic medical schools and four osteopathic medical schools participate in the WICHE PSEP. However, not all WICHE states sponsor students every year, and not all medical schools receive students every year. The 2006-2007 medical student distributions are listed in **Exhibit 2-9** (102 students total).

[18] Pacific Northwest University of Health Sciences College of Osteopathic Medicine. *Student Handbook.* 2007.

EXHIBIT 2-9
WICHE PSEP–MEDICINE STUDENT DISTRIBUTION 2006-2007

Allopathic												
Sending State	Receiving School											Total # Students
	Univ of Arizona	Loma Linda Univ	UC San Diego	UC San Fran	Univ of Colorado	Univ of Hawai'i	Univ of Nevada	Univ of New Mexico	Univ of North Dakota	Oregon Health & Science Univ	Univ of Utah	
Montana	3	1			11	1	1		3	7	1	28
Wyoming	1		1	1	9			1	1	1	3	18
Totals	**4**	**1**	**1**	**1**	**20**	**1**	**1**	**1**	**4**	**8**	**4**	**46**

Osteopathic						
Sending State	Receiving School					Total # Students
	Midwestern Univ - Arizona College of Osteopathic Medicine	Touro Univ College of Osteopathic Medicine	Touro Univ Nevada	Western Univ of Health Sciences College of Osteopathic Medicine of the Pacific	Out of Region	
Arizona	20	4		2	4	30
Montana	3	1	1	2		7
New Mexico	2	1				3
Washington	3	1		3		7
Wyoming	7			2		9
Totals	**35**	**7**	**1**	**9**	**4**	**56**

Source: WICHE Student Exchange Program Academic Year 2006-2007 Statistical Report, http://www.wiche.edu/SEP/PDF/StatReport0107FINAL_forWeb.pdf

2.7 Summary

The state of Idaho has invested significant resources in undergraduate and graduate medical education through:

- Its partnership with the UU School of Medicine.
- Its partnership with the UW School of Medicine/WWAMI.
- WWAMI Idaho Track.
- GME programs.
- Physicians, professionals, and medical centers participating in the training of students in healthcare programs (e.g., pharmacy).

The three state universities in Idaho offer additional resources on which to build new and/or expanded medical education programs. Numerous avenues for expanding medical education exist, yet the state will be best served if opportunities are examined in tandem with an analysis of current and projected medical education needs, as presented in Chapter 3.0.

3.0 ANALYSIS OF CURRENT AND PROJECTED NEEDS FOR MEDICAL EDUCATION IN IDAHO

3.0 ANALYSIS OF CURRENT AND PROJECTED NEEDS FOR MEDICAL EDUCATION IN IDAHO

Determining the need for medical education requires a multifaceted analysis of various factors related to a state's population, physician workforce, student access to programs, and the economy. In this chapter, we review and analyze available data to develop potential state goals for medical access in Idaho. The chapter includes the following sections:

- Framework for Analyzing Needs
- Perceptions of Medical Education Needs Within Idaho
- Recent and Projected Population Growth
- Student Access to Medical Education
- Residency Training
- Physician Access
- Economic Impact
- Summary of Demand Analysis
- Potential State Goals for Medical Access

3.1 Framework for Analyzing Needs

Our analysis of the need to expand access to medical education in Idaho is framed by three primary factors:

- Types of information to be solicited.
- Types of access to be reviewed.
- Timeframe to be considered.

Each of these three factors is summarized below.

3.1.1 Types of Information

We relied on two broad types of information to assess the possible need to expand access to medical education in Idaho. First, we considered the perceptions of numerous educational, healthcare, and elected leaders in the state. These individuals have first-hand exposure to the issues confronting the state's education and healthcare systems and an appreciation of the complexities surrounding any decision to expand medical education. Importantly, their views helped to define the types of factual data that would be needed to confirm whether their perceptions of conditions in the recent past would continue to apply in the near and long-term future.

The second broad type of information was a variety of statistical data drawn from recognized, authoritative sources. These data included information on such topics as medical workforce from the American Medical Association and similar bodies, medical school enrollments from the Association of American Medical Colleges and the Accreditation Council for Graduate Medical Education, overall college and university enrollments from the U.S. Department of Education, and population figures from the U.S. Census Bureau.

3.1.2 Types of Access

Although the stated purpose of the study was to assess the need to expand medical education, an important underlying factor was the need for adequate levels of healthcare services in the state. Accordingly, we considered access to have two major dimensions:

- Student access – measured by the number of seats in medical school available to potential students who were qualified to pursue medical education.
- Physician access – measured by the ability of residents of the state to gain access to the services of licensed physicians.

3.1.3 Timeframe

Although much of the analysis is based on current conditions in Idaho compared to the past and to current conditions in other states, another important element is projected needs. Projections of need are important for two reasons:

- The time required to establish medical education programs and to train physicians for the workforce is significant. A decision made now to expand medical education would not have significant impact on the workforce for a decade or more.
- The state's population has been growing rapidly, and that trend is expected to continue. We believe that state leaders appreciate the need to ensure that actions taken now to improve access to medical education are not already outdate by the time they are fully implemented.

We selected the year 2020 as the benchmark year for estimating future needs.

3.2 Perceptions of Medical Education Needs Within Idaho

During the course of the study, we interviewed approximately 200 higher education leaders, healthcare leaders, and elected officials. These interviews were conducted through a variety of means—face-to-face, by telephone, and in individual and small group settings. A common focus across these interviews was to determine the respondents' views on three central questions:

- Do Idaho students have adequate access to medical education?
- Do Idaho citizens have adequate access to physician services?
- What are the advantages and disadvantages of the various alternatives for expanding access to medical education?

Depending on the interviewee, other questions were addressed as well, such as the role his or her organization might play in medical education in the future.

The topic that met with the greatest consensus was the need to improve student access to medical education. Respondents across the various categories of stakeholders

generally agreed that Idaho students faced much greater difficulty in being admitted to medical school than their cohorts in other states and their predecessors from previous generations. Numerous respondents cited firsthand knowledge of well-qualified applicants who were unable to gain admission to medical school under either of the two state contracts with University of Washington and University of Utah.

The interviews also revealed general agreement, with some exceptions, concerning the need for more physicians in the state. Respondents typically observed that the problems with physician access were greater in rural Idaho than in the Treasure Valley, and that shortages were more pronounced in some medical specialties than in others. In noting the need for more physicians in the state, several respondents observed that providing more educational opportunities was not the only way to increase the physician base; other strategies could also be employed (e.g., increasing the medical reimbursement rates for procedures).

Unlike the first two questions, there was a significant diversity in opinions regarding the best way to expand access to medical education.

- Many observers expressed general satisfaction with the WWAMI program and noted the strong national reputation of the UW School of Medicine. These observers believed that the most efficient means to expand medical education would be to simply purchase more seats through the WWAMI program rather than invest in the infrastructure needed to build a new medical school. A subset of this group suggested that any significant increase in the number of WWAMI seats should come through the creation of an additional first year training site, either in Boise or in Pocatello. Another frequent suggestion for strengthening the WWAMI relationship was to expand the opportunity for second, third, and fourth year training in Idaho.

- Support was also expressed for expanding the number of contracted seats with the UU School of Medicine. There was some concern, however, that the program delivery model should be modified to enable Idaho residents to receive more of their training in the state rather than spending all but a few weeks of their four years in Utah as is currently required.

- Proponents of purchasing additional contracted seats often stated that they did not support the establishment of an Idaho medical school. Their reasons included the perception that Idaho does not have a large enough population to support the required clinical components of the medical school curriculum, the belief that a medical school in Idaho would not be of high quality, and concern that funding for a new medical school would reduce appropriations for the existing institutions of higher education in the state.

- Many respondents cited the potential advantages of establishing of a new medical school in Idaho. Proponents of this approach felt that the state had grown to a size where it should no longer rely on neighboring states to educate its students, especially in light of the impending national physician shortage. Further, they felt that an Idaho-based medical school would be more focused on meeting the needs of the state and have a greater positive economic

impact since state tax dollars would be invested within the state rather than elsewhere.

- Although residency training was not as well understood as M.D. training programs by most respondents, those with knowledge of medical education were nearly unanimous in their belief that the number of slots in the state's existing residency programs should be expanded and that programs in additional specialties should be established. The perceived advantage of investing in graduate medical education was the immediacy of its impact on the state's physician workforce and the stronger correlation between practice location and residency training location as compared to medical school location. A common suggestion was that graduate medical education in Idaho be expanded regardless of whether any action to expand M.D. training was pursued.

Many respondents further commended the Legislature and the Board of Education for commissioning the medical education study and expressed the desire that the study contribute to a more informed public debate on how (or even whether) to proceed in expanding access to medical education.

3.3 Recent and Projected Population Growth

As most long-term residents of Idaho know, the state's population has grown significantly over the past several decades. As shown in **Exhibit 3-1**, the state's population expanded by 120 percent between the 1950 and 2000 Census counts. This rate was significantly greater than that of the nation as a whole, making Idaho the 16th fastest-growing state (Idaho ranked 8th in growth rate between 1970 and 2000). Idaho was the 44th most populous state at the start of the period and the 39th by 2000.

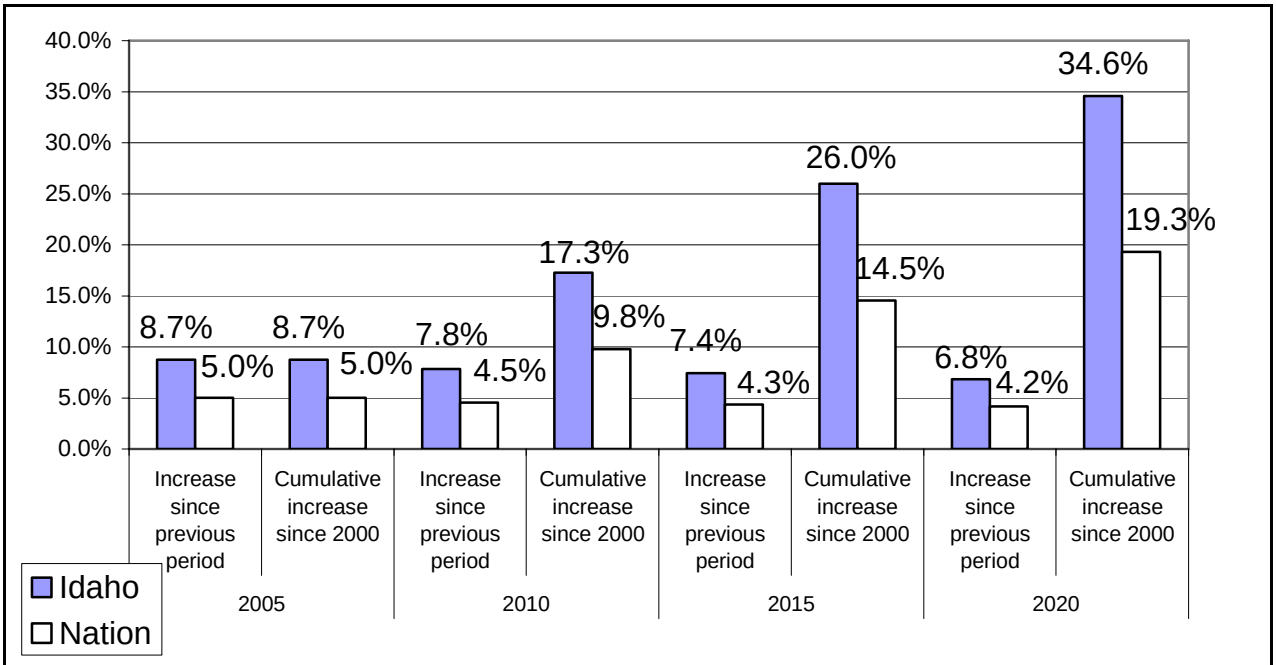
EXHIBIT 3-1
LONG-TERM HISTORICAL TRENDS IN POPULATION GROWTH
IDAHO AND THE NATION

Census Year	Idaho				50 State Summary		
	Population	% Increase	Cumulative % Increase	Rank	Population	% Increase	Cumulative % Increase
1950	588,637			44	150,697,361		
1960	667,191	13%	13%	43	179,323,175	19%	19%
1970	712,567	7%	21%	43	203,211,926	13%	35%
1980	943,935	32%	60%	41	226,545,805	11%	50%
1990	1,006,749	7%	71%	42	248,709,873	10%	65%
2000	1,293,953	29%	120%	39	281,421,906	13%	87%
50-Year Change	705,316	120%	120%	16	130,724,545	87%	87%

Source: U.S. Census Bureau.

During the early years of the twenty-first century, Idaho's population has continued to grow, and the state is expected to remain one of the fastest-growing states in the nation. The state's population grew by over 100,000 (nearly 9 percent) between 2000 and 2005, compared to a national growth rate of 5 percent for the same period. As shown in **Exhibit 3-2**, this growth is projected to continue at nearly twice the national rate, with the state's population reaching approximately 1.74 million by 2020. If this projection is realized, Idaho will become the 37th most populous state in the nation and no longer fall in the lowest quartile of states in terms of population size.

EXHIBIT 3-2
PROJECTED POPULATION GROWTH IN IDAHO
2000 THROUGH 2020



Entity	Year	2000	2005	2010	2015	2020
Idaho	Number	1,293,953	1,407,060	1,517,291	1,630,045	1,741,333
	Increase		113,107	110,231	112,754	111,288
	% Increase		8.7%	7.8%	7.4%	6.8%
	Cumulative Increase		113,107	223,338	336,092	447,380
	% Increase		8.7%	17.3%	26.0%	34.6%
Nation	Number	281,421,906	295,507,134	308,935,581	322,365,787	335,804,546
	Increase		14,085,228	13,428,447	13,430,206	13,438,759
	% Increase		5.0%	4.5%	4.3%	4.2%
	Cumulative Increae		14,085,228	27,513,675	40,943,881	54,382,640
	% Increase		5.0%	9.8%	14.5%	19.3%

Source: U.S. Census Bureau.

Several age cohorts within the overall population are especially important when analyzing the need to expand medical education. The oldest age cohort—those aged 65 and above—place a well above average demand on physician services. An above average growth rate among this cohort translates into a need for the expansion of the physician base to outpace the overall growth of the population. The population projections by age in **Exhibit 3-3** reveal that the 65 and over age cohort in Idaho is expected to grow by 85 percent between 2000 and 2020, compared to the overall growth rate of 35 percent.

EXHIBIT 3-3
IDAHO POPULATION PROJECTIONS FOR
SELECTED AGE COHORTS

Age Cohorts	Year	2000	2005	2010	2015	2020
Ages 22-30	Number	157,559	187,857	196,217	184,991	183,362
	Increase		30,298	8,360	(11,226)	(1,629)
	% Increase		19.2%	4.5%	-5.7%	-0.9%
	Cumulative Increase		30,298	38,658	27,432	25,803
	% Increase		19.2%	24.5%	17.4%	16.4%
Ages 65 & Above	Number	145,916	158,646	181,416	220,113	269,439
	Increase		12,730	22,770	38,697	49,326
	% Increase		8.7%	14.4%	21.3%	22.4%
	Cumulative Increase		12,730	35,500	74,197	123,523
	% Increase		8.7%	24.3%	50.8%	84.7%
All Ages	Number	1,293,953	1,407,060	1,517,291	1,630,045	1,741,333
	Increase		113,107	110,231	112,754	111,288
	% Increase		8.7%	7.8%	7.4%	6.8%
	Cumulative Increase		113,107	223,338	336,092	447,380
	% Increase		8.7%	17.3%	26.0%	34.6%

Source: U.S. Census Bureau.

A second age cohort of concern in the analysis of medical school access is the young adult population. Residents between the ages of 22 and 30 make up the vast majority of medical school applicants. Changes in the numbers in this cohort are likely to translate into fluctuating numbers of students seeking to enroll in medical school. **Exhibit 3-3** shows that this age cohort is expected to grow at a slower than average rate between 2000 and 2020.

In summary, Idaho's population is increasing rapidly, and the growth pattern is projected to continue. Idaho is no longer among the nation's smallest states and is quickly becoming one of the middle-tier states in terms of population. Importantly, the state's elderly population, a group with increased demands for medical care, is growing at an exceptionally high rate and will stretch physician resources more tightly.

3.4 Student Access to Medical Education

Student access to medical education can be assessed in various ways. Perhaps the most common approach has been to compare all 50 states per capita on the number of seats in medical school for entering students. More sophisticated analyses also consider the numbers of traditional college-age residents and/or the numbers of college graduates. Also, adjustments for interstate programs (such as WWAMI) are required for a more accurate reflection of the number of medical school seats that are available to a state's residents. Further, comparisons to selected groups of states are often more informative than consideration of only the national average.

A more difficult, but important, determination is the quality of the applicant pool. Since medical schools are highly selective by design, measurement of student access needs to consider the ability of *qualified* applicants to enter medical school.

The analyses in this section provide a variety of perspectives on whether Idaho students have adequate access to medical education.

3.4.1 National Benchmark Comparisons of Seats per Capita

The most basic measure of access to medical education is seats per capita. In **Exhibit 3-4**, various measures of entering seats per capita are listed for all 50 states:

- Seats per overall population.
- Seats per young adult population, ages 18-24.
- Seats per prior year college graduate at the baccalaureate level

In all cases, the numbers of entering seats per state have been adjusted to reflect known standing arrangements between states for students to attend medical school outside their home states.

As seen, Idaho (with 18 WWAMI seats and 8 Utah seats) had 1.82 seats per 100,000 total population in 2006. This rate was only 32 percent of the national average, resulting in Idaho ranking 48th on this measure among the states.

Similar results were also found when measuring access on the basis of the young adult population and recent college graduates. Idaho ranked 48th in entering seats per 10,000 population in the 18-24 age range (31 percent of the national average). Likewise, Idaho ranked 49th in entering seats per prior year baccalaureate graduates (31 percent of the national average).

States often seek other benchmarks in addition to the national average to assess their performance toward public goals. For the Idaho medical education study, we provide three additional benchmarks based on groupings of states that are similar in age, size, or geographic location:

- Mountain States
- Northwest States
- Small Population States

EXHIBIT 3-4
NATIONAL COMPARISONS AMONG STATES ON ACCESS TO MEDICAL EDUCATION, 2005

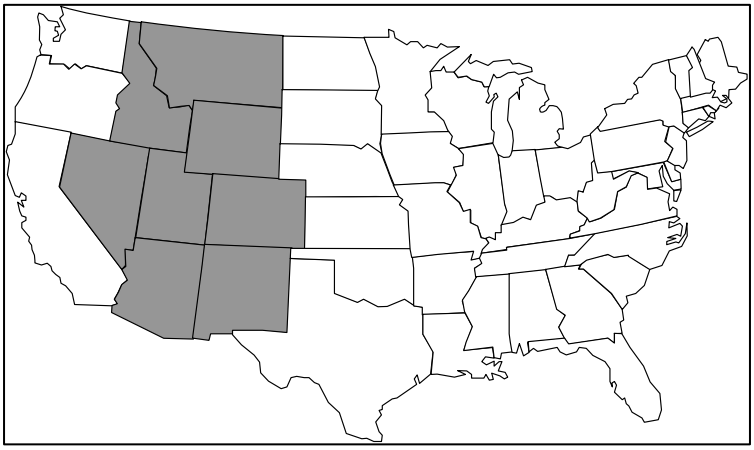
State	1st Year Medical School Seats per 100,000 Population		1st Year Medical School Seats per 10,000 Ages 18-24 Population		1st Year Medical School Seats in State per 100 Baccalaureate Graduates	
	Ratio	Rank	Ratio	Rank	Ratio	Rank
U.S.	5.65		5.75		1.17	
Alabama	4.94	30	5.28	27	1.04	28
Alaska	1.51	49	1.27	49	0.70	40
Arizona	1.88	47	1.93	47	0.38	48
Arkansas	5.21	27	5.46	24	1.29	16
California	3.02	40	2.90	42	0.74	39
Colorado	2.93	42	2.87	43	0.54	44
Connecticut	5.56	22	6.33	18	1.17	20
Delaware	0.00	50	0.00	50	0.00	50
District of Columbia	78.56	1	74.93	1	4.97	1
Florida	2.54	43	2.95	41	0.69	41
Georgia	4.43	33	4.46	33	1.14	23
Hawai'i	5.05	29	5.05	29	1.21	17
Idaho	**1.82**	**48**	**1.76**	**48**	**0.36**	**49**
Illinois	8.92	9	8.99	8	1.78	5
Indiana	4.60	32	4.72	32	0.79	38
Iowa	4.75	31	4.85	31	0.68	42
Kansas	6.36	18	6.17	21	1.08	25
Kentucky	5.90	19	6.17	20	1.38	13
Louisiana	9.51	5	8.85	9	1.99	4
Maine	0.00	50	0.00	50	0.00	50
Maryland	7.79	13	7.89	14	1.74	6
Massachusetts	9.59	4	10.09	4	1.35	14
Michigan	5.45	23	5.58	23	1.07	27
Minnesota	5.21	28	4.96	30	0.94	32
Mississippi	3.46	38	3.41	37	0.86	36
Missouri	7.85	12	7.95	12	1.32	15
Montana	2.14	46	2.20	45	0.39	47
Nebraska	13.65	3	13.48	3	2.00	3
Nevada	2.20	44	2.54	44	0.95	31
New Hampshire	5.80	20	6.30	19	0.93	34
New Jersey	3.78	37	4.41	34	1.03	29
New Mexico	3.89	35	3.79	36	1.02	30
New York	8.98	8	9.24	7	1.58	9
North Carolina	5.23	26	5.46	25	1.15	21
North Dakota	9.18	6	8.36	10	1.13	24
Ohio	7.70	14	8.03	11	1.55	10
Oklahoma	4.06	34	4.02	35	0.79	37
Oregon	3.01	41	3.10	39	0.65	43
Pennsylvania	9.07	7	9.69	6	1.45	11
Rhode Island	7.92	11	7.91	13	0.90	35
South Carolina	5.23	25	5.38	26	1.18	18
South Dakota	6.61	16	6.47	16	1.07	26
Tennessee	6.91	15	7.26	15	1.58	8
Texas	5.35	24	5.06	28	1.38	12
Utah	3.81	36	3.17	38	0.46	46
Vermont	16.63	2	16.35	2	2.12	2
Virginia	5.73	21	5.79	22	1.17	19
Washington	2.17	45	2.14	46	0.48	45
West Virginia	8.61	10	9.92	5	1.63	7
Wisconsin	6.45	17	6.41	17	1.14	22
Wyoming	3.14	39	3.00	40	0.94	33

Source: Population—U.S. Census Bureau; Medical School Seats—Association of American Medical Colleges and Idaho State Legislature Budget Book; Graduates—U.S. Department of Education.

3.4.2 Mountain State Benchmark Comparisons of Seats per Capita

The Mountain State grouping is comprised of eight states in the western U.S., excluding those on the Pacific coast. These states, illustrated in **Exhibit 3-5**, share a number of characteristics such as relative age, population size and density, and economic capacity to support public goods and services.

EXHIBIT 3-5
MOUNTAIN STATE GROUPING FOR ANALYSIS
OF ACCESS TO MEDICAL EDUCATION



As indicated in **Exhibit 3-6**, Idaho ranked last among the eight Mountain States in the number of seats per 100,000 population in 2005, and was at 68 percent of the average of the other states. On the basis of young adult population, Idaho also ranked last among the Mountain States (66 percent of average). When comparing seats on a per baccalaureate degree basis, Idaho ranked last again, and was at 68 percent of the group average. Even though Idaho ranked at the bottom of this group on all three measures, it fell much nearer the Mountain State group average than the much higher national average.

EXHIBIT 3-6
COMPARISONS AMONG MOUNTAIN STATES
ON ACCESS TO MEDICAL EDUCATION, 2005

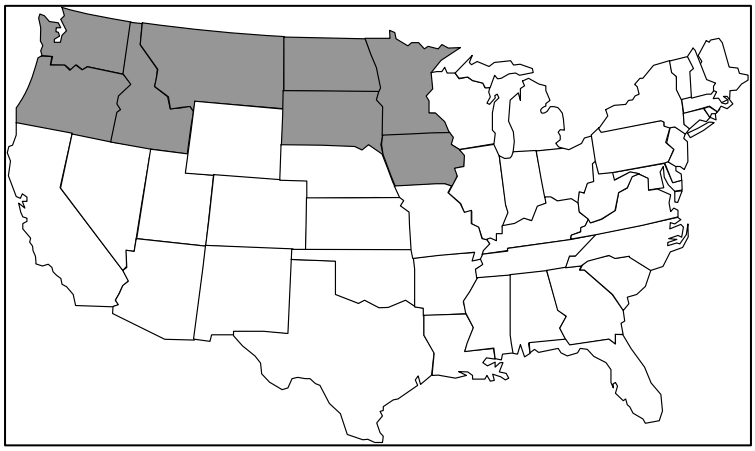
State	1st Year Medical School Seats per 100,000 Population		1st Year Medical School Seats per 10,000 Ages 18-24 Population		1st Year Medical School Seats in State per 100 Baccalaureate Graduates	
	Ratio	Rank	Ratio	Rank	Ratio	Rank
Group	2.69		2.66		0.53	
Arizona	1.88	7	1.93	7	0.38	7
Colorado	2.93	4	2.87	4	0.54	4
Idaho	**1.82**	**8**	**1.76**	**8**	**0.36**	**8**
Montana	2.14	6	2.20	6	0.39	6
Nevada	2.20	5	2.54	5	0.95	2
New Mexico	3.89	1	3.79	1	1.02	1
Utah	3.81	2	3.17	2	0.46	5
Wyoming	3.14	3	3.00	3	0.94	3

Source: Population—U.S. Census Bureau; Medical School Seats—Association of American Medical Colleges and Idaho State Legislature Budget Book; Graduates—U.S. Department of Education.

3.4.3 Northwest State Benchmark Comparisons of Seats per Capita

A second set of states selected for comparison are those that are considered to be in the Northwest. These eight states are illustrated in the map in **Exhibit 3-7**. Like the Mountain States, these states share a number of characteristics that may play an important role in their ability to support expanded access to medical education.

EXHIBIT 3-7
NORTHWEST STATE GROUPING FOR ANALYSIS
OF ACCESS TO MEDICAL EDUCATION



Idaho ranked last among the eight Northwest States in the number of seats per 100,000 population in 2005, and was at 47 percent of the average of the other states (see **Exhibit 3-8**). On the basis of population ages 18-24, Idaho ranked last among the Northwest States (46 percent of average). When comparing seats per recent college graduate, Idaho ranked last again, and was at 50 percent of the group average. Even

though Idaho also ranked last on all measures in this group of states, it was further below the Northwest State average than the Mountain State average.

EXHIBIT 3-8
COMPARISONS AMONG NORTHWEST STATES
ON ACCESS TO MEDICAL EDUCATION, 2005

State	1st Year Medical School Seats per 100,000 Population		1st Year Medical School Seats per 10,000 Ages 18-24 Population		1st Year Medical School Seats in State per 100 Baccalaureate Graduates	
	Ratio	Rank	Ratio	Rank	Ratio	Rank
Group	3.85		3.80		0.72	
Idaho	**1.82**	**8**	**1.76**	**8**	**0.36**	**8**
Iowa	4.75	4	4.85	4	0.68	4
Minnesota	5.21	3	4.96	3	0.94	3
Montana	2.14	7	2.20	6	0.39	7
North Dakota	9.18	1	8.36	1	1.13	1
Oregon	3.01	5	3.10	5	0.65	5
South Dakota	6.61	2	6.47	2	1.07	2
Washington	2.17	6	2.14	7	0.48	6

Source: Population—U.S. Census Bureau; Medical School Seats—Association of American Medical Colleges and Idaho State Legislature Budget Book; Graduates—U.S. Department of Education.

3.4.4 Small Population State Benchmark Comparisons of Seats per Capita

The final set of states selected for comparison is based solely on population size. A common perception revealed in the state leader interviews was that Idaho is too small to support expanded access to medical education. In 2005, the following seven states, like Idaho, had populations of more than 1 million, but less than 2 million:

- Hawai'i, population of 1.27 million
- Maine, population of 1.31 million
- Nebraska, population of 1.76 million
- New Hampshire, population of 1.31 million
- New Mexico, population of 1.93 million
- Rhode Island, population of 1.07 million
- West Virginia, population of 1.81 million

As shown in **Exhibit 3-9**, Idaho ranked seventh among the eight Small Population States in the number of seats per 100,000 population in 2005, and was at 27 percent of the average of the other states. On the basis of young adult population, Idaho again ranked 7th among the Small Population States (25 percent of average). When comparing seats on a per baccalaureate degree basis, Idaho ranked 7th again, and was at 30 percent of the group average. Maine, another state without an allopathic medical school, ranked below Idaho on all three measures. Even though Idaho did not rank last on any measure among this group of states, it was proportionately further below the group average for Small Population States than any of the other three benchmark averages.

EXHIBIT 3-9
COMPARISONS AMONG SMALL STATES
ON ACCESS TO MEDICAL EDUCATION, 2005

State	1st Year Medical School Seats per 100,000 Population		1st Year Medical School Seats per 10,000 Ages 18-24 Population		1st Year Medical School Seats in State per 100 Baccalaureate Graduates	
	Ratio	Rank	Ratio	Rank	Ratio	Rank
Group	6.65		6.91		1.19	
Hawai'i	5.05	5	5.05	5	1.21	3
Idaho	**1.82**	**7**	**1.76**	**7**	**0.36**	**7**
Maine	0.00	8	0.00	8	0.00	8
Nebraska	13.65	1	13.48	1	2.00	1
New Hampshire	5.80	4	6.30	4	0.93	5
New Mexico	3.89	6	3.79	6	1.02	4
Rhode Island	7.92	3	7.91	3	0.90	6
West Virginia	8.61	2	9.92	2	1.63	2

Source: Population—U.S. Census Bureau; Medical School Seats—Association of American Medical Colleges and Idaho State Legislature Budget Book; Graduates-—U.S. Department of Education.

Many interviewees expressed the view that Idaho was too small to operate its own medical school, especially one equal in quality to the schools with which the state currently contracts for entering medical student seats. While we are unable to provide meaningful information on the relative quality of medical schools across the nation (it should be noted that all U.S. medical schools are required to meet high standards of quality set forth in the accreditation criteria of the Liaison Committee on Medical Education [LCME]), we do provide details on the number of medical schools in states with populations of less than 2 million in **Exhibit 3-10**.

As seen, 10 of the other 14 states in this category have medical schools (3 of the other 4 without schools are also WWAMI states). It is important to note that in 2 of these 10 states (Rhode Island and New Hampshire), the schools are private rather than state universities. The public schools in small population states typically have entering classes of 60 to 100 students. Interestingly, West Virginia, with a population of 1.8 million, operates two state-supported allopathic medical schools as well as a state-supported osteopathic school. Idaho is the most populous state in the nation that does not operate its own medical school.

EXHIBIT 3-10
MEDICAL SCHOOLS IN SMALL STATES
WITH LESS THAN 2 MILLION POPULATION

State	Population 2005	Contract Programs	Medical Schools		
			Public	Private	Osteopathic
Wyoming	508,798	WWAMI			
Vermont	622,387		University of Vermont		
North Dakota	634,605		University of North Dakota		
Alaska	663,253	WWAMI			
South Dakota	774,883		University of South Dakota		
Delaware	841,741				
Montana	934,737	WWAMI			
Rhoda Island	1,073,579			Brown University	
Hawai'i	1,273,278		University of Hawaii		
New Hampshire	1,306,819			Dartmouth College	
Maine	1,318,220				University of New England^
Idaho	**1,429,367**	**WWAMI**			
Nebraska	1,758,163		University of Nebraska	Creighton University	
West Virginia	1,814,083		University of West Virginia & Marshall University		WV School of Osteopathic Medicine^^
New Mexico	1,925,985		University of New Mexico		

^The University of New England osteopathic school is private.
^^The West Virginia School of Osteopathic Medicine is public.
Source: Population—U.S. Census Bureau; Medical School Information—U.S. Department of Education.

3.4.5 Projected Medical School Access in 2020

As noted in the introduction to this chapter, expansion of medical education necessitates long-term planning due to the time required for universities to develop or expand programs and for students to advance through the medical education pipeline. In **Exhibit 3-11**, we summarize results of our analyses of projected student access to medical education in the year 2020. These projections were based on announced plans of medical schools in the various states to expand their enrollment capacities and U.S. Census Bureau population projections for each state.

EXHIBIT 3-11
PROJECTED ACCESS TO MEDICAL EDUCATION IN 2020
BASED ON PROJECTED POPULATION AND
MEDICAL SCHOOL EXPANSION PLANS

Comparison Group	Projected 1st Year Medical School Seats	Projected Total Population 2020	Projected Seats per 100,000 Population	Projected Ages 18-24 Population 2020	Projected Seats per 10,000 Ages 18-24 Population
National Summary	21,784	335,804,546	6.49	29,338,501	7.42
Mountain State Summary	793	23,815,716	3.33	2,138,628	3.71
Northwest State Summary	878	23,068,580	3.81	1,953,434	4.49
Small Population State Summary	751	11,188,150	6.71	877,125	8.56
Idaho	28	1,741,333	1.61	142,208	1.97

Source: Population—U.S. Census Bureau; Projected Medical School Seats—AAMC reports on medical school expansion and individual medical school Web sites.

Nationally, the projected number of first-year seats in medical schools is expected to increase by 30 percent, compared to projected population growth of 13 percent. Projected growth in the Mountain States is even more dramatic, with the number of

seats increasing by 56 percent (significant expansions have been announced in Arizona and Colorado). Growth at lesser rates is planned for the Northwest States and Small Population States. Overall, the seats per 100,000 population in 2020 are projected to total:

- 6.49 nationally
- 3.33 in the Mountain States
- 3.81 in the Northwest States
- 6.71 in the Small Population States
- 1.61 in Idaho

A similar pattern is projected for seats per population aged 18-24, with Idaho still well below any comparison average. The minimal increase in growth is based on the two additional WWAMI seats that were funded beginning in 2007.

3.4.6 Summary of Benchmark Comparisons

This section of the report provides data to assess Idaho students' relative level of access to medical school as compared to their peers across the nation. A variety of benchmarks based on different population cohorts and state groupings have been presented. **Exhibit 3-12** displays the results of these comparisons as well as the numbers of medical school seats that would be required to place Idaho students at parity with their various sets of peers.

Overall, Idaho ranks near the bottom of each comparison group for each population cohort. As compared to the 26 state-supported students from Idaho in 2006, a significantly larger number would be needed to achieve parity. Using the average of each measure across state groupings, the typical number of first-year medical school seats needed for parity in access ranges from 66 to 71 across the various comparisons for 2005, and from 86 to 89 seats for 2020.

EXHIBIT 3-12
SUMMARY OF BENCHMARK COMPARISONS
ON ACCESS TO MEDICAL EDUCATION

Comparison Basis and Year	Idaho	National Average	Mountain State Average	Northwest State Average	Small Population State Average	Average of Four Comparison Groups
Seats per 100,000 Population						
2005	1.82	5.65	2.69	3.85	6.65	4.71
2020	1.61	6.49	3.33	3.81	6.71	5.08
Total Idaho Seats to Achieve Parity						
2005		*81*	*38*	*55*	*95*	*67*
2020		*113*	*58*	*66*	*117*	*89*
Seats per 10,000 18-24 Population						
2005	1.76	5.75	2.66	3.80	6.91	4.78
2020	1.97	7.42	3.71	4.49	8.56	6.05
Total Idaho Seats to Achieve Parity						
2005		*85*	*39*	*56*	*102*	*71*
2020		*106*	*53*	*64*	*122*	*86*
Seats per 100 College Graduates						
2005	0.36	1.17	0.53	0.72	1.19	0.90
Total Idaho Seats to Achieve Parity						
2005		*85*	*39*	*52*	*87*	*66*

3.4.7 Analysis of Sufficiency of Current Pool of Applicants

Our analyses of student access suggest that a significantly greater number of medical school seats would need to be available to Idaho students in order for them to have the same level of opportunity for medical education as their peers in other states. An obvious question is whether there are enough qualified applicants to fill such an expanded number of seats.

As national medical education leaders have become more concerned about the need for expanded training capacity over the past several years, the AAMC has called for a 30 percent increase in medical school enrollments. As part of its analyses, the AAMC examined the depth of the national applicant pool for medical education to determine whether there were adequate numbers of qualified students. Specifically, it addressed the question: Can applicant growth sustain higher enrollment at current levels of quality? It concluded:

> *We believe future applicant pools should be large enough to sustain a national first-year medical school enrollment of 21,434 students, equal to a 30 percent increase over the matriculating class of 2002. If 2 percent of college graduates continue to apply to medical school, the projected growth in numbers of college graduates will likely swell applicant pools by 2010 to levels needed to meet the minimum applicant-to-matriculant ratios that have sustained medical school admissions in the past.*[1]

To examine the implications of this question for Idaho medical education, we compared the medical school applicant pools from each of the states. As seen in **Exhibit 3-13**,

[1] Association of American Medical Colleges. *Analysis in Brief* (Volume 7, Number 3). 2007.

Idaho residents who apply to medical school exceed the national averages for each of the three components of the Medical College Admissions Test (MCAT) and have higher grade point averages (GPAs) in science courses, non-science courses, and overall.

Medical school admissions officers widely accept the composite MCAT score of 24 (8 in each of the three sections) to be the threshold score predictive of passage of the United States Medical Licensure Exam (USMLE) Part I. Evidence has shown that 95 percent of applicants scoring 24 on the MCAT will pass the USMLE Part I. In practice, many medical schools recruit students with the strongest MCAT scores, and class averages of 30 or higher are typical in America's most selective medical schools. Our interpretation of the data is that Idaho's applicant pool is well above the national average, approaching the average for students admitted to America's most selective medical schools.

With a state average combined score of 28.2, Idaho apparently has a disproportionately large number of well-qualified potential students who are not even applying to medical school due to the intense competition for the limited number of state-funded medical school seats.

EXHIBIT 3-13
MCAT SCORES AND GPAs FOR APPLICANTS BY STATE OF LEGAL RESIDENCE, 2006

State of Legal Residence	MCAT Verbal		MCAT PhysSc		MCAT BioSc		GPA Science		GPA Other		GPA Total	
	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD	Mean	SD
Alabama	9.0	2.1	8.7	2.2	9.1	2.0	3.42	0.44	3.67	0.31	3.53	0.36
Alaska	9.6	1.7	9.1	1.9	9.6	1.9	3.37	0.41	3.63	0.32	3.48	0.34
Arizona	8.8	2.2	8.6	2.1	9.1	2.0	3.34	0.47	3.62	0.34	3.47	0.37
Arkansas	8.7	2.2	7.9	2.0	8.6	2.0	3.38	0.48	3.67	0.32	3.52	0.36
California	9.1	2.2	9.8	2.2	10.1	2.1	3.34	0.45	3.57	0.31	3.44	0.36
Colorado	9.4	2.0	9.3	2.0	9.8	1.9	3.43	0.42	3.61	0.34	3.51	0.35
Connecticut	9.5	2.0	9.4	2.0	10.0	1.8	3.38	0.38	3.60	0.27	3.48	0.30
Delaware	8.6	2.5	8.6	2.8	9.1	2.6	3.33	0.48	3.60	0.33	3.44	0.41
District of Columbia	8.4	2.7	8.3	2.4	8.8	2.3	3.18	0.59	3.42	0.44	3.30	0.50
Florida	8.6	2.3	8.5	2.1	9.0	2.1	3.34	0.47	3.63	0.33	3.47	0.38
Georgia	8.6	2.2	8.4	2.3	8.9	2.3	3.32	0.47	3.58	0.33	3.44	0.37
Hawaii	8.5	2.1	8.7	2.3	9.2	2.1	3.28	0.52	3.58	0.33	3.43	0.39
Idaho	**9.3**	**1.8**	**9.2**	**2.0**	**9.7**	**1.7**	**3.47**	**0.42**	**3.69**	**0.28**	**3.57**	**0.33**
Illinois	9.0	2.1	9.1	2.2	9.4	2.0	3.34	0.46	3.59	0.35	3.45	0.37
Indiana	9.2	1.9	9.1	2.0	9.5	1.9	3.46	0.43	3.70	0.27	3.57	0.33
Iowa	9.5	1.9	9.3	2.1	9.9	1.8	3.50	0.39	3.73	0.25	3.60	0.31
Kansas	8.8	2.1	8.5	2.0	9.0	1.9	3.46	0.43	3.69	0.30	3.57	0.34
Kentucky	8.8	2.0	8.4	2.2	8.9	2.2	3.39	0.45	3.66	0.33	3.51	0.36
Louisiana	8.5	2.0	8.3	2.0	8.8	2.0	3.41	0.44	3.66	0.32	3.52	0.36
Maine	9.4	1.8	9.1	2.4	9.6	2.0	3.45	0.40	3.63	0.27	3.53	0.31
Maryland	8.9	2.4	9.1	2.5	9.6	2.3	3.34	0.46	3.60	0.31	3.45	0.36
Massachusetts	9.5	2.1	9.6	2.3	10.1	2.0	3.36	0.44	3.55	0.33	3.44	0.36
Michigan	8.9	2.1	9.3	2.3	9.7	2.1	3.37	0.47	3.61	0.32	3.48	0.38
Minnesota	9.3	2.0	9.4	2.0	9.7	1.9	3.42	0.42	3.64	0.30	3.52	0.33
Mississippi	8.6	2.2	7.8	2.1	8.4	2.2	3.42	0.49	3.69	0.32	3.54	0.38
Missouri	9.2	2.1	9.0	2.2	9.5	2.0	3.49	0.41	3.67	0.33	3.57	0.35
Montana	9.4	1.8	9.0	1.7	9.8	1.6	3.51	0.41	3.71	0.26	3.60	0.32
Nebraska	8.8	2.0	8.5	1.9	9.0	1.9	3.47	0.42	3.69	0.30	3.57	0.33
Nevada	8.4	2.2	8.3	2.2	9.0	2.4	3.26	0.53	3.57	0.37	3.40	0.41
New Hampshire	9.7	2.2	9.0	2.2	9.8	2.0	3.47	0.41	3.60	0.35	3.53	0.36
New Jersey	9.0	2.1	9.4	2.2	9.8	2.0	3.39	0.45	3.58	0.31	3.48	0.35
New Mexico	9.1	2.1	8.4	2.1	9.2	2.0	3.36	0.45	3.62	0.35	3.48	0.36
New York	9.0	2.2	9.3	2.3	9.6	2.1	3.35	0.45	3.58	0.32	3.46	0.36
North Carolina	9.1	2.2	8.8	2.3	9.2	2.3	3.33	0.47	3.55	0.34	3.43	0.38
North Dakota	9.0	1.7	8.8	1.8	9.3	1.7	3.51	0.37	3.73	0.28	3.61	0.30
Ohio	9.0	2.0	9.0	2.1	9.4	1.9	3.41	0.44	3.66	0.31	3.52	0.35
Oklahoma	8.8	2.1	8.2	2.1	8.7	1.9	3.44	0.42	3.69	0.29	3.55	0.32
Oregon	9.5	2.1	9.6	2.2	10.1	1.9	3.44	0.43	3.63	0.30	3.53	0.34
Pennsylvania	9.2	2.0	9.3	2.2	9.7	1.9	3.40	0.42	3.63	0.31	3.50	0.34
Puerto Rico	5.9	2.2	6.3	1.7	6.7	2.2	3.21	0.55	3.61	0.35	3.39	0.43
Rhode Island	9.2	2.3	9.1	2.4	9.6	2.2	3.34	0.43	3.60	0.31	3.46	0.35
South Carolina	8.8	2.1	8.2	2.1	8.8	2.0	3.39	0.45	3.59	0.34	3.48	0.37
South Dakota	9.1	1.8	8.7	2.2	9.3	2.0	3.51	0.42	3.70	0.32	3.60	0.36
Tennessee	8.6	2.1	8.3	2.2	8.8	2.1	3.33	0.50	3.61	0.34	3.46	0.39
Texas	8.9	2.2	9.1	2.3	9.5	2.1	3.41	0.44	3.63	0.33	3.47	0.37
Utah	9.2	1.7	9.3	1.9	10.0	1.7	3.46	0.38	3.69	0.28	3.56	0.30
Vermont	9.8	1.8	9.5	2.1	10.0	1.8	3.41	0.41	3.56	0.28	3.47	0.31
Virginia	9.2	2.1	9.1	2.3	9.5	2.1	3.31	0.45	3.54	0.34	3.41	0.37
Washington	9.5	1.9	9.8	2.0	10.2	1.8	3.44	0.37	3.65	0.27	3.53	0.30
West Virginia	8.7	2.0	8.2	2.1	8.6	2.0	3.40	0.39	3.70	0.27	3.54	0.30
Wisconsin	9.4	1.9	9.4	2.1	9.9	1.8	3.49	0.40	3.68	0.28	3.57	0.32
Wyoming	9.1	2.0	8.5	2.0	9.3	1.9	3.47	0.36	3.66	0.25	3.55	0.28
U.S. Territories	7.2	1.7	6.6	1.7	7.8	2.1	3.22	0.48	3.64	0.25	3.41	0.36
Canada	8.2	2.0	9.6	1.9	10.0	1.9	3.38	0.51	3.57	0.36	3.47	0.41
Other	8.8	2.2	10.1	2.3	10.2	2.2	3.45	0.48	3.60	0.34	3.52	0.39
All	9.0	2.2	9.1	2.2	9.5	2.1	3.38	0.45	3.61	0.32	3.48	0.36

Source: Association of American Medical Colleges.

We also analyzed applicant information for the WWAMI program from each of the participating states over the past five years. As seen in **Exhibit 3-14**, the ratio of applicants per entrant in Idaho was the highest among the five states. Idaho entrants ranked second on MCAT scores among the five states and were above average on GPA performance. Since the WWAMI applicant base is much stronger than the overall national applicant pool, the performance of Idaho students is especially impressive. Importantly, these analyses provide confidence that a significant expansion of medical school enrollment among Idaho students could occur without adverse impact on the quality of students.

EXHIBIT 3-14
ANALYSIS OF WWAMI APPLICANT POOL
BY STATE, 2003-2007 ENTERING CLASSES

Year Entered	State of Residence	Total Applicants	Number of Entering Students	Average MCAT Score	Average Undergraduate GPA	Applicants per Entrant
2007	Washington	731	105	10.746	3.67	6.96
2007	Wyoming	46	11	8.848	3.75	4.18
2007	Alaska	83	20	9.106	3.44	4.15
2007	Montana	87	20	9.519	3.54	4.35
2007	Idaho	150	20	10.433	3.73	7.50
2007	**Total**	**1,097**	**176**	**10.266**	**3.64**	**6.23**
2006	Washington	648	104	10.580	3.61	6.23
2006	Wyoming	54	14	8.852	3.67	3.86
2006	Alaska	78	10	10.500	3.61	7.80
2006	Montana	97	20	9.783	3.74	4.85
2006	Idaho	124	18	9.543	3.58	6.89
2006	**Total**	**1,001**	**166**	**10.221**	**3.63**	**6.03**
2005	Washington	623	103	10.534	3.62	6.05
2005	Wyoming	62	12	9.889	3.71	5.17
2005	Alaska	67	11	9.909	3.61	6.09
2005	Montana	98	20	10.150	3.72	4.90
2005	Idaho	140	18	10.037	3.71	7.78
2005	**Total**	**990**	**164**	**10.344**	**3.65**	**6.04**
2004	Washington	628	109	10.517	3.64	5.76
2004	Wyoming	47	10	9.567	3.78	4.70
2004	Alaska	66	10	10.367	3.69	6.60
2004	Montana	103	20	10.150	3.75	5.15
2004	Idaho	104	18	10.407	3.74	5.78
2004	**Total**	**948**	**167**	**10.395**	**3.68**	**5.68**
2003	Washington	651	107	10.504	3.67	6.08
2003	Wyoming	55	10	9.433	3.77	5.50
2003	Alaska	59	10	9.866	3.64	5.90
2003	Montana	95	20	9.883	3.76	4.75
2003	Idaho	103	18	10.204	3.71	5.72
2003	**Total**	**963**	**165**	**10.292**	**3.69**	**5.84**
5-Yr Sum	Washington	3,281	528	10.576	3.64	6.21
5-Yr Sum	Wyoming	264	57	9.297	3.73	4.63
5-Yr Sum	Alaska	353	61	9.811	3.57	5.79
5-Yr Sum	Montana	480	100	9.897	3.70	4.80
5-Yr Sum	Idaho	621	92	10.132	3.69	6.75
5-Yr Sum	**Total**	**4,999**	**838**	**10.303**	**3.66**	**5.97**

Source: WWAMI Program Office – Idaho.

Idaho Medical Students in Other Than State-Funded Seats. Idaho students, like those all over the nation, pursue medical education beyond the borders of their home states (even after adjusting for contracted seats in nearby states). Their reasons for doing so are varied and include a desire to graduate from a nationally prestigious school, to carry on a family tradition of attending a certain school, or simply to go wherever they can gain admission. For the entering class of 2006, data from the AAMC show that 61 Idaho residents began attending medical school—all at out-of-state locations (see **Exhibit 3-15**). After adjusting for the 26 state-funded seats in 2006 with the Washington and Utah programs, we determined that more than half the students left Idaho without state support for their medical educations.

Perhaps more importantly, Idaho applicants have one of the lowest rates of entrance among students across the 50 states. Nearly 60 percent of all applicants to medical school from Idaho failed to matriculate in 2006, compared to a national average of 55.6 percent. Given the previously noted stronger than average academic qualifications of Idaho applicants, a likely interpretation is that Idaho students were pursuing too few seats in the region to have a high probability of admission.

EXHIBIT 3-15
MIX OF IN-STATE AND OUT-OF-STATE
MEDICAL SCHOOL ATTENDANCE, 2006

State of Legal Residence	Applicants	Matriculation Status					
		Matriculated In State		Matriculated Out of State		NOT Matriculated	
		N	%	N	%	N	%
Alabama	542	226	41.7	56	10.3	260	48.0
Alaska	85	-	-	29	34.1	56	65.9
Arizona	574	110	19.2	113	19.7	351	61.1
Arkansas	305	132	43.3	17	5.6	156	51.1
California	4,452	808	18.1	1,160	26.1	2,484	55.8
Colorado	646	117	18.1	140	21.7	389	60.2
Connecticut	414	77	18.6	118	28.5	219	52.9
Delaware	78	-	-	38	48.7	40	51.3
District of Columbia	87	15	17.2	17	19.5	55	63.2
Florida	1,748	477	27.3	247	14.1	1,024	58.6
Georgia	1,154	315	27.3	167	14.5	672	58.2
Hawaii	214	56	26.2	37	17.3	121	56.5
Idaho	**150**	**-**	**-**	**61**	**40.7**	**89**	**59.3**
Illinois	1,844	627	34.0	216	11.7	1,001	54.3
Indiana	702	240	34.2	90	12.8	372	53.0
Iowa	341	94	27.6	43	12.6	204	59.8
Kansas	434	150	34.6	65	15.0	219	50.5
Kentucky	412	190	46.1	26	6.3	196	47.6
Louisiana	886	341	38.5	58	6.5	487	55.0
Maine	84	-	-	39	46.4	45	53.6
Maryland	913	147	16.1	266	29.1	500	54.8
Massachusetts	897	217	24.2	216	24.1	464	51.7
Michigan	1,347	394	29.3	212	15.7	741	55.0
Minnesota	761	193	25.4	132	17.3	436	57.3
Mississippi	314	110	35.0	28	8.9	176	56.1
Missouri	568	199	35.0	83	14.6	286	50.4
Montana	101	-	-	50	49.5	51	50.5
Nebraska	291	111	38.1	18	6.2	162	55.7
Nevada	165	49	29.7	20	12.1	96	58.2
New Hampshire	97	6	6.2	38	39.2	53	54.6
New Jersey	1,358	302	22.2	363	26.7	693	51.0
New Mexico	238	70	29.4	39	16.4	129	54.2
New York	2,702	883	32.7	434	16.1	1,385	51.3
North Carolina	962	270	28.1	124	12.9	568	59.0
North Dakota	134	41	30.6	13	9.7	80	59.7
Ohio	1,485	565	38.0	147	9.9	773	52.1
Oklahoma	383	140	36.6	42	11.0	201	52.5
Oregon	380	84	22.1	101	26.6	195	51.3
Pennsylvania	1,423	438	30.8	237	16.7	748	52.6
Puerto Rico	374	188	50.3	10	2.7	176	47.1
Rhode Island	80	13	16.3	26	32.5	41	51.3
South Carolina	503	210	41.7	29	5.8	264	52.5
South Dakota	142	44	31.0	28	19.7	70	49.3
Tennessee	682	227	33.3	67	9.8	388	56.9
Texas	3,279	1,160	35.4	174	5.3	1,945	59.3
Utah	488	75	15.4	149	30.5	264	54.1
Vermont	87	36	41.4	10	11.5	41	47.1
Virginia	913	241	26.4	195	21.4	477	52.2
Washington	694	103	14.8	187	26.9	404	58.2
West Virginia	241	119	49.4	22	9.1	100	41.5
Wisconsin	680	213	31.3	104	15.3	363	53.4
Wyoming	56	-	-	24	42.9	32	57.1
Other	1,218	-	-	222	18.2	996	81.8
Total	39,108	10,823	27.7	6,547	16.7	21,738	55.6

Source: Association of American Medical Colleges, Applicant Matriculant File as of October 27,2006.

3.5 Residency Training

As introduced in Chapter 1.0, residency training (or graduate medical education—GME) is an essential step in the medical education process. Physicians are not allowed to practice without supervision until some residency training is completed.

Not only is the opportunity to pursue GME a key component of student access, it is very important for physician access as well. The location of a new physician's residency training is the best single predictor of where he or she will eventually practice.

For purposes of assessing adequacy of GME opportunity in a state, two major issues should be considered:

- The number of first-year residency seats offered in the state each year.
- The number and range of medical specialties in which residencies are offered.

Exhibit 3-16 provides a high-level summary of the opportunity for GME in Idaho compared to the same benchmarks used for considering medical school access.

EXHIBIT 3-16
GRADUATE MEDICAL EDUCATION OFFERINGS
IDAHO AND BENCHMARK STATES

Benchmark	Number of 1st Year GME Seats	Number of Accredited Programs	Programs in Core Clinical Specialties			
			Family Medicine	Internal Medicine	Obstetrics/ Gynecology	Pediatrics
Idaho	17	4	3	0	0	0
National Average	716	167	9	8	5	4
Mountain State Average	195	46	4	2	1	1
Northwest State Average	169	42	5	2	1	1
Small Population State Average	162	43	3	2	1	1

Source: *Graduate Medical Education Data Resource Book, 2005-2006*, Accreditation Council for Graduate Medical Education.

In terms of the number of seats available for medical school graduates to begin residency training, Idaho provided opportunities for 17 physicians in 4 accredited programs in 2005. By comparison, the national average of all 50 states was 716 first year seats, the Mountain State average was 195 seats, the Northwest State average was 169 seats, and the Small Population State average was 162 seats. The lack of opportunity for GME in Idaho is even more pronounced when considering the range of core program offerings. Idaho only offers three core programs (all in family medicine), while the other benchmark averages are significantly greater. Most other states provide coverage of all core clinical specialties.

To place the data above in greater perspective, **Exhibit 3-17** compares the number of residency seats to the population and the number of M.D. students for the various state benchmarks. On the basis of GME seats per 100,000 population, Idaho (with 1.16 only seats) ranks ahead of only Montana and trails all of the benchmarks by a considerable margin. When comparing first year residency seats per first year medical school seats, Idaho again ranks next to last.

At a minimum, a state needs to provide as many first-year residency seats as it has first-year medical school seats. Otherwise, some of the new M.D. graduates are forced to leave the state and the investment in the future medical workforce is devalued. Obviously, any state action to increase the number of medical school seats will need to be coupled with a decision to increase residency seats or slippage on this measure will occur.

EXHIBIT 3-17
COMPARISON OF FIRST-YEAR GRADUATE MEDICAL EDUCATION (GME) SEATS TO POPULATION AND FIRST-YEAR MEDICAL SCHOOL SEATS BY STATE

State	Medical School First-Year Seats	GME First-Year Seats	GME Seats per Medical School Seat	Population	GME Seats per 100,000 Population
Alaska	10	12	1.20	670,053	1.79
Alabama	232	442	1.90	4,599,030	9.61
Arkansas	150	216	1.44	2,810,872	7.68
Arizona	115	453	3.94	6,166,318	7.35
California	1,109	3,155	2.85	36,457,549	8.65
Colorado	143	408	2.85	4,753,377	8.58
Connecticut	197	695	3.53	3,504,809	19.83
District of Columbia	483	581	1.20	581,530	99.91
Delaware	-	84	n.a	853,476	9.84
Florida	480	1,054	2.19	18,089,888	5.83
Georgia	416	684	1.64	9,363,941	7.30
Hawai'i	64	152	2.38	1,285,498	11.82
Iowa	143	238	1.66	2,982,085	7.98
Idaho	**26**	**17**	**0.65**	**1,466,465**	**1.16**
Illinois	1,164	1,935	1.66	12,831,970	15.08
Indiana	290	457	1.58	6,313,520	7.24
Kansas	173	215	1.25	2,764,075	7.78
Kentucy	250	332	1.33	4,206,074	7.89
Louisiana	432	496	1.15	4,287,768	11.57
Massachusetts	635	1,723	2.72	6,437,193	26.77
Maryland	444	876	1.97	5,615,727	15.60
Maine	-	90	n.a	1,321,574	6.81
Michigan	559	1,511	2.71	10,095,643	14.97
Minnesota	253	731	2.90	5,167,101	14.15
Missouri	458	837	1.83	5,842,713	14.33
Mississippi	103	149	1.44	2,910,540	5.12
Montana	20	7	0.35	944,632	0.74
North Carolina	457	938	2.05	8,856,505	10.59
North Dakota	61	42	0.69	635,867	6.61
Nebraska	245	212	0.87	1,768,331	11.99
New Hampshire	79	124	1.56	1,314,895	9.43
New Jersey	334	906	2.71	8,724,560	10.38
New Mexico	76	170	2.24	1,954,599	8.70
Nevada	54	81	1.49	2,495,529	3.25
New York	1,749	5,495	3.14	19,306,183	28.46
Ohio	896	1,703	1.90	11,478,006	14.84
Oklahoma	152	229	1.51	3,579,212	6.40
Oregon	119	261	2.19	3,700,758	7.05
Pennsylvania	1,137	2,507	2.20	12,440,621	20.15
Rhode Island	89	253	2.84	1,067,610	23.70
South Carolina	224	354	1.58	4,321,249	8.19
South Dakota	51	37	0.72	781,919	4.73
Tennessee	414	677	1.64	6,038,803	11.21
Texas	1,264	2,338	1.85	23,507,783	9.95
Utah	94	233	2.49	2,550,063	9.14
Virginia	431	706	1.64	7,642,884	9.24
Vermont	106	89	0.84	623,908	14.26
Washington	134	578	4.33	6,395,798	9.04
Wisconsin	357	579	1.62	5,556,506	10.42
West Virginia	161	205	1.28	1,818,470	11.27
Wyoming	16	14	0.88	515,004	2.72
US	17,045	36,493	2.14	299,398,484	12.19

Source: *Graduate Medical Education Data Resource Book, 2005-2006*, Accreditation Council for Graduate Medical Education.

3.6 Physician Access

As noted in the introduction to this chapter, the need to provide access for Idahoans to physician services is one of the primary reasons for the need to provide reasonable student access to medical education. In this section of the needs analysis, we assess the need for physicians in Idaho.

3.6.1 National Comparisons of Physicians per Capita

Our interviews with state leaders indicated that the need for more physicians in Idaho is a common perception. Our statistical analyses of physicians per capita across the states confirm this perception.

We compared Idaho to other states using two different counts of physicians. The *Total Physicians* count is what its name implies – the number of licensed physicians living in the state. The *Physicians Engaged in Patient Care* count is a subset of the first, and excludes those physicians who are retired or who serve primarily in administrative or academic capacities. According to the American Medical Association Masterfile, Idaho had 2,825 total physicians in 2005, and 2,321 of those were engaged in patient care (82 percent).

Comparisons based on both physician-counting methods are shown in **Exhibit 3-18**. Idaho ranks 49th among the 50 states (50th if the District of Columbia is considered) on the total physician measure and last on the patient care physician measure. The rate of 198 total physicians per 100,000 population is 66 percent of the national average, and 162 patient care physicians per 100,000 population is 68 percent of the corresponding national rate. Compared to the median (i.e., the middle ranking state), Idaho is 70 percent of that national benchmark on the total physicians measure and 72 percent of the patient care physician measure. In any of these cases, Idaho would need an approximate 40-50 percent increase in the number of physicians to be at parity with the rest of the nation in physician access.

EXHIBIT 3-18
MEASURES OF PHYSICIAN ACCESS
BY STATE, 2005

State	Physicians in State per 100,000 Population		Patient Care Physicians per 100,000 Population	
	Ratio	Rank	Ratio	Rank
Alaksa	248	38	214	33
Alabama	238	42	198	41
Arkansas	228	45	189	45
Arizona	247	39	191	43
California	299	18	234	22
Colorado	296	19	236	19
Connecticut	407	6	319	7
District of Columbia	827	1	623	1
Delaware	282	25	225	25
Florida	294	20	224	26
Georgia	243	40	200	39
Hawai'i	356	8	283	8
Iowa	213	48	166	48
Idaho	**198**	**50**	**162**	**50**
Illinois	302	17	244	13
Indiana	239	41	199	40
Kansas	254	36	203	38
Kentucky	255	35	212	35
Louisiana	281	26	233	23
Massachusetts	496	2	382	2
Maryland	456	3	345	3
Maine	311	12	244	14
Michigan	270	28	216	29
Minnesota	319	11	257	11
Missouri	264	32	215	31
Mississippi	202	49	166	49
Montana	267	31	212	34
North Carolina	285	24	228	24
North Dakota	270	29	224	27
Nebraska	269	30	218	28
New Hampshire	306	15	241	16
New Jersey	342	9	277	9
New Mexico	275	27	216	30
Nevada	215	47	176	47
New York	426	4	338	4
Ohio	293	21	234	21
Oklahoma	196	51	158	51
Oregon	311	13	242	15
Pennsylvania	333	10	258	10
Rhode Island	397	7	321	6
South Carolina	259	33	214	32
South Dakota	250	37	206	37
Tennessee	291	22	241	17
Texas	234	44	193	42
Utah	235	43	190	44
Virginia	305	16	245	12
Vermont	422	5	321	5
Washington	308	14	239	18
Wisconsin	287	23	234	20
West Virginia	258	34	209	36
Wyoming	219	46	177	46
US Average	300		239	
US Median	281		224	

Source: American Medical Association

Similar analyses of physicians per capita were developed for each of the three groups of comparison states. Since Idaho ranks last nationally, the obvious finding is that the state also ranks at the bottom of each comparison group. Compared to the group averages, Idaho's ratio of patient care physicians per capita is:

- 83 percent of the Mountain State average,
- 76 percent of the Northwest State average,
- 69 percent of the Small Population State Average.

Details of the comparisons with the selected groups of states are listed in **Exhibit 3-19**.

EXHIBIT 3-19
PHYSICIAN ACCESS IN SELECTED
COMPARISON STATES, 2005

State	Physicians in State per 100,000 Population		Patient Care Physicians per 100,000 Population	
	Ratio	Rank	Ratio	Rank
Mountain States				
Arizona	247	4	191	4
Colorado	296	1	236	1
Idaho	**198**	**8**	**162**	**8**
Montana	267	3	212	3
Nevada	215	7	176	7
New Mexico	275	2	216	2
Utah	235	5	190	5
Wyoming	219	6	177	6
Average	244		195	
Northwest States				
Idaho	**198**	**8**	**162**	**8**
Iowa	213	7	166	7
Minnesota	319	1	257	1
Montana	267	5	212	5
North Dakota	270	4	224	4
Oregon	311	2	242	2
South Dakota	250	6	206	6
Washington	308	3	239	3
Average	267		214	
Small Population States				
Hawai'i	356	2	283	2
Idaho	**198**	**8**	**162**	**8**
Maine	311	3	244	3
Nebraska	269	6	218	5
New Hampshire	306	4	241	4
New Mexico	275	5	216	6
Rhode Island	397	1	321	1
West Virginia	258	7	209	7
Average	296		237	

Source: American Medical Association

3.6.2 Age Distribution of Physicians

Another perception across our interviews is that the physician shortage in the state is likely to become more acute in the near future due to the aging of the workforce. That is, many of the state's doctors are expected to retire in the near future. Although reliable data do not exist on physicians' plans for retirement, data are available that categorize physicians in each state into ten year age groupings.

Using data from the American Medical Association, we determined that 40 percent of the state's physicians are age 55 years or older, and that 21 percent are 65 years or older. As shown in **Exhibit 3-20**, Idaho has the 6th oldest physician workforce among the 50 states. To the extent that an aging physician workforce is a contributing factor to the nation's impending physician shortage, the impact is likely to be more pronounced in Idaho.

EXHIBIT 3-20
AGE DISTRIBUTION OF PHYSICIANS BY STATE, 2005

State	Total	Age Categories					Age 55 & Over	
		< 35	35-44	45-54	55-64	65	%	Rank
Total Physicians	902,053	140,093	212,050	222,469	157,596	169,845	36.3%	
Alabama	10,809	1,672	2,576	2,974	1,880	1,707	33.2%	40
Alaska	1,643	143	460	463	350	227	35.1%	29
Arizona	14,699	1,709	3,575	3,686	2,584	3,145	39.0%	12
Arkansas	6,315	931	1,503	1,715	1,071	1,095	34.3%	33
California	108,053	14,594	23,204	24,522	21,731	24,002	42.3%	4
Colorado	13,816	1,762	3,512	3,520	2,528	2,494	36.3%	23
Connecticut	14,234	2,224	3,230	3,616	2,429	2,735	36.3%	25
Delaware	2,372	366	573	567	383	483	36.5%	21
Dist of Columbia	4,815	1,131	973	908	867	936	37.4%	18
Florida	52,324	4,939	11,101	13,419	9,245	13,620	43.7%	2
Georgia	22,222	3,212	5,813	6,002	3,636	3,559	32.4%	46
Hawaii	4,528	547	1,013	1,183	881	904	39.4%	9
Idaho	**2,825**	**198**	**728**	**761**	**556**	**582**	**40.3%**	**6**
Illinois	38,513	7,883	8,941	8,852	6,596	6,241	33.3%	37
Indiana	14,977	2,172	3,706	4,122	2,537	2,440	33.2%	39
Iowa	6,319	1,009	1,483	1,661	1,061	1,105	34.3%	34
Kansas	6,978	1,005	1,642	1,743	1,230	1,358	37.1%	19
Kentucky	10,646	1,628	2,704	2,770	1,841	1,703	33.3%	38
Louisiana	12,650	2,236	2,975	3,041	2,212	2,186	34.8%	31
Maine	4,095	374	889	1,130	798	904	41.6%	5
Maryland	25,498	3,979	5,961	6,273	4,579	4,706	36.4%	22
Massachusetts	31,908	6,293	7,964	7,325	5,115	5,211	32.4%	47
Michigan	27,316	5,106	6,465	6,340	4,583	4,822	34.4%	32
Minnesota	16,373	2,773	4,184	4,256	2,583	2,577	31.5%	50
Mississippi	5,872	750	1,471	1,520	1,036	1,095	36.3%	24
Missouri	15,322	2,957	3,709	3,788	2,468	2,400	31.8%	48
Montana	2,496	109	540	732	545	570	44.7%	1
Nebraska	4,727	834	1,180	1,215	733	765	31.7%	49
Nevada	5,196	519	1,457	1,270	874	1,076	37.5%	16
New Hampshire	4,003	410	952	1,102	705	834	38.4%	14
New Jersey	29,786	4,013	6,889	7,724	5,558	5,602	37.5%	17
New Mexico	5,292	647	1,196	1,354	1,139	956	39.6%	8
New York	82,301	15,818	18,117	18,788	13,686	15,892	35.9%	26
North Carolina	24,698	4,055	6,437	6,515	3,705	3,986	31.1%	51
North Dakota	1,712	188	435	463	339	287	36.6%	20
Ohio	33,618	6,420	8,267	7,823	5,288	5,820	33.0%	41
Oklahoma	6,950	933	1,501	1,804	1,329	1,383	39.0%	11
Oregon	11,301	1,241	2,748	2,817	2,244	2,251	39.8%	7
Pennsylvania	41,358	7,199	8,919	10,495	7,008	7,737	35.7%	28
Rhode Island	4,259	851	1,042	974	615	777	32.7%	43
South Carolina	10,992	1,726	2,837	2,673	1,829	1,927	34.2%	35
South Dakota	1,936	191	484	582	366	313	35.1%	30
Tennessee	17,349	2,560	4,341	4,783	2,888	2,777	32.7%	44
Texas	53,571	8,950	14,030	12,994	8,974	8,623	32.8%	42
Utah	5,857	881	1,527	1,463	1,032	954	33.9%	36
Vermont	2,624	368	574	687	470	525	37.9%	15
Virginia	23,049	3,561	5,482	5,763	3,974	4,269	35.8%	27
Washington	19,349	2,223	4,489	5,075	3,798	3,764	39.1%	10
West Virginia	4,681	739	1,043	1,075	941	883	39.0%	13
Wisconsin	15,855	2,222	4,157	4,316	2,508	2,652	32.5%	45
Wyoming	1,113	71	261	307	230	244	42.6%	3
Possessions	11,379	1,538	2,366	3,356	1,836	2,283	36.2%	
APO's and FPO's	991	229	422	158	90	92	18.4%	
Address Unknown	488	4	2	4	112	366	98.0%	

Source: American Medical Association

3.6.3 Number of Physicians by Idaho County

The number of physicians per capita in each of the state's counties varies significantly. Ada County, the state's most populous, had 2.68 patient care physicians per 1,000 residents in 2005 – a rate that placed it above the national average. By contrast, the statewide average for this measure was only 1.62. The numbers of patient care physicians in each of the state's 44 counties, along with the rate per 1,000 population for odd-numbered years over the past decade, are listed in **Exhibit 3-21**.

Over one-half of the state's counties (23 counties) had fewer than 10 physicians, and 17 of those counties had 5 or fewer physicians. By contrast, six counties had 100 or more physicians in 2005. The ratio of physicians per 1,000 population was below 1.00 in 30 of the 44 counties.

EXHIBIT 3-21
PATIENT CARE PHYSICIANS BY COUNTY, 2005

Region Name	1997		1999		2001		2003		2005	
	Number	Per 1,000 Populatio	Number	Per 1,000 Populatio	Number	Per 1,000 Populatio	Number	Per 1,000 Populatio	Number	Per 1,000 Populatio
Idaho	1739	1.44	1802	1.44	1957	1.48	2198	1.61	2321	1.62
Ada	586	2.19	620	2.19	731	2.34	862	2.65	925	2.68
Adams	1	0.26	10	2.64	0	-	1	0.29	2	0.56
Bannock	146	1.97	139	1.86	132	1.74	150	1.94	153	1.97
Bear Lake	5	0.77	6	0.91	7	1.09	6	0.95	6	0.97
Benewah	7	0.78	7	0.77	8	0.89	10	1.11	7	0.76
Bingham	21	0.51	21	0.50	25	0.59	21	0.49	24	0.55
Blaine	60	3.49	67	3.87	70	3.54	69	3.33	65	3.07
Boise	NA	NA	NA	NA	1	0.14	2	0.28	1	0.13
Bonner	36	1.04	37	1.03	43	1.15	55	1.40	60	1.47
Bonneville	152	1.90	157	1.93	159	1.90	185	2.12	182	1.98
Boundary	6	0.61	8	0.80	7	0.71	7	0.69	8	0.76
Butte	2	0.65	2	0.66	1	0.35	1	0.35	3	1.08
Camas	NA	NA	NA	NA	NA	NA	0	-	0	-
Canyon	136	1.17	130	1.04	140	1.01	160	1.05	149	0.90
Caribou	3	0.41	3	0.41	3	0.41	3	0.42	5	0.70
Cassia	27	1.26	23	1.07	25	1.16	25	1.16	24	1.12
Clark	NA	NA	NA	NA	NA	NA	0	-	0	-
Clearwater	11	1.17	12	1.28	14	1.62	14	1.66	12	1.44
Custer	2	0.47	2	0.49	3	0.70	1	0.24	1	0.24
Elmore	9	0.36	17	0.66	22	0.76	22	0.77	25	0.88
Franklin	4	0.37	4	0.35	5	0.43	5	0.42	5	0.40
Fremont	2	0.17	3	0.25	3	0.25	2	0.16	2	0.16
Gem	7	0.48	6	0.40	7	0.45	8	0.51	9	0.55
Gooding	4	0.29	2	0.15	4	0.28	4	0.28	5	0.35
Idaho County	12	0.80	14	0.93	15	0.97	14	0.91	14	0.89
Jefferson	3	0.16	1	0.05	2	0.10	4	0.20	4	0.19
Jerome	10	0.57	9	0.50	8	0.43	12	0.63	12	0.61
Kootenai	157	1.59	163	1.56	186	1.66	211	1.79	263	2.06
Latah	38	1.15	41	1.26	35	1.00	39	1.12	47	1.34
Lemhi	4	0.50	2	0.25	2	0.26	7	0.90	6	0.76
Lewis	0	-	1	0.25	0	-	0	-	0	-
Lincoln	1	0.26	1	0.26	1	0.24	1	0.23	1	0.22
Madison	28	1.13	30	1.21	31	1.11	30	1.01	27	0.87
Minidoka	12	0.59	8	0.39	9	0.46	9	0.47	8	0.42
Nez Perce	78	2.12	83	2.25	73	1.97	79	2.10	79	2.08
Oneida	0	-	1	0.25	1	0.24	1	0.24	1	0.24
Owyhee	NA	NA	1	0.10	2	0.18	1	0.09	1	0.09
Payette	8	0.40	8	0.38	12	0.58	10	0.47	11	0.50
Power	4	0.49	2	0.24	3	0.40	2	0.27	2	0.26
Shoshone	12	0.86	11	0.81	10	0.74	9	0.69	12	0.92
Teton	4	0.76	5	0.88	6	0.93	5	0.71	8	1.07
Twin Falls	125	2.03	126	2.00	135	2.09	134	2.00	130	1.87
Valley	15	1.86	15	1.91	13	1.69	15	1.93	19	2.29
Washington	1	0.10	4	0.39	3	0.30	2	0.20	3	0.30

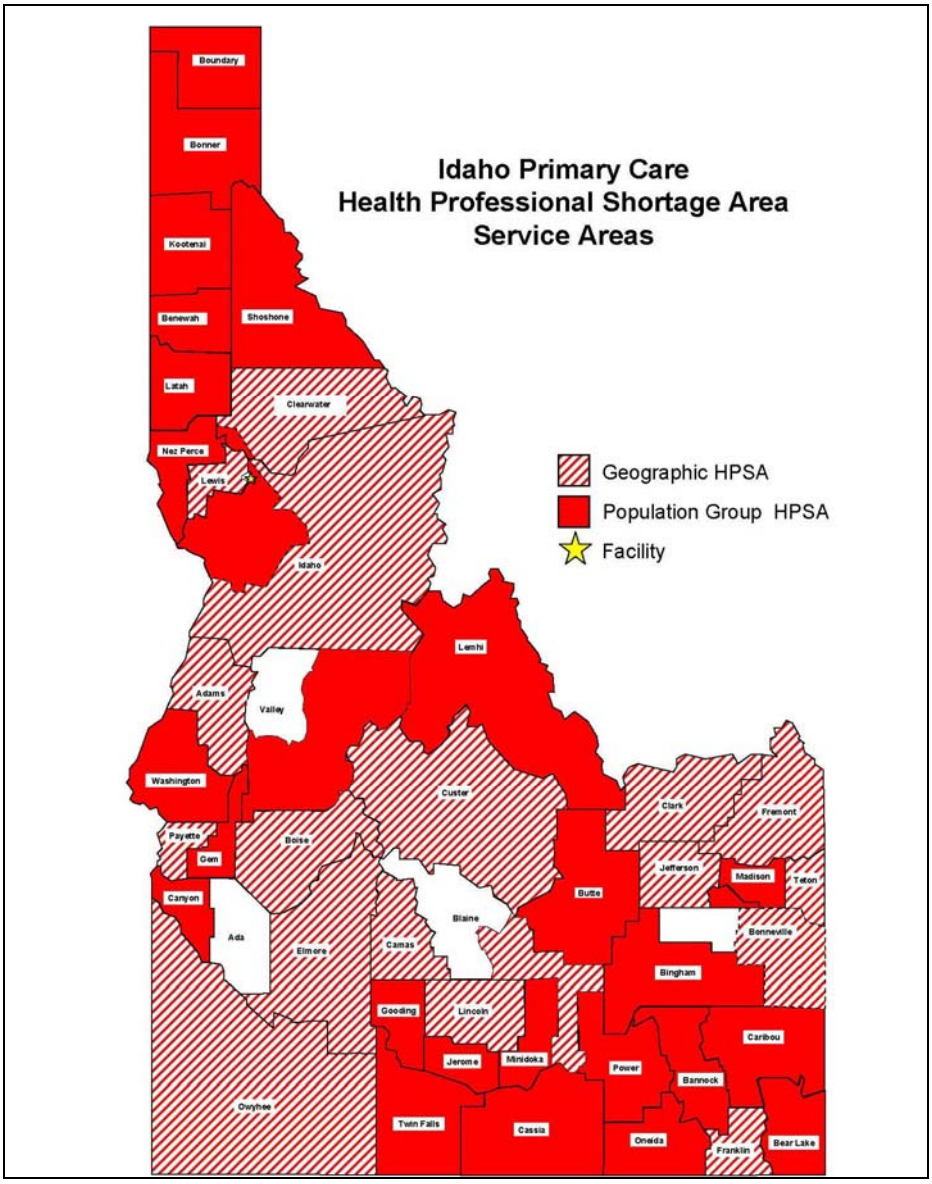
Source: American Medical Association

3.6.4 Health Professions Shortage Areas

The federal government reviews health workforce and population data for areas across the nation and, based on its analyses, designates certain areas as a "health professions shortage area" or HPSA. One use of the HPSA designation is to determine eligibility for federal funds

About 20 percent of the nation's population lives in HPSA areas for primary care physicians. A map of the HPSAs in Idaho is illustrated in **Exhibit 3-22**.

EXHIBIT 3-22
HEALTH PROFESSIONS SHORTAGE AREAS – IDAHO, 2006



Source: HPSA State Office of Rural Health and Primary Care, Division of Health, Department of Health and Welfare, 2007.

3.7 Economic Impact

Some of the state's leaders we interviewed felt that the lack of access to medical education and physician services in the state has an adverse economic impact. A report from the American Academy of Family Physicians found that the economic impact of each family physician in Idaho is $812,189 per year.[2] The adverse economic impact can be based on healthcare dollars leaving Idaho as its residents go to other states for needed care. Additionally, it can come from the inability to participate fully in the growing bio-tech industry.

3.7.1 Growth of Healthcare Industrial Sector

The healthcare sector is among the fastest growing components of the U.S. economy. Based on data in **Exhibit 3-23**, the healthcare component of the gross domestic product grew by more than 44 percent nationally between 2000 and 2005. By contrast, the overall gross domestic product in the United States increased by approximately 27 percent during the same period.

In 2005, the healthcare component comprised 6.9 percent of the economy, compared to only 6.1 percent in 2000. Healthcare ranked second among nineteen components in the rate of growth over the five year period.

[2] *Economic Impact of Family Physicians in Idaho*. American Academy of Family Physicians. 2007.

EXHIBIT 3-23
GROWTH OF THE HEALTHCARE INDUSTRY

Industry	Current Dollars				Change 2000-2005	
	2000	2003	2004	2005	% Change	Rank
Gross domestic product^	9,817	10,971	11,734	12,487	27%	-
Private industries	8,614	9,557	10,251	10,935	27%	-
Agriculture, forestry, and fishing	98	114	142	119	21%	17
Mining	121	142	172	214	77%	1
Utilities	189	223	235	239	26%	12
Construction	436	501	550	594	36%	5
Manufacturing	1,426	1,369	1,420	1,497	5%	19
Wholesale trade	592	633	695	733	24%	16
Retail trade	662	751	790	829	25%	15
Transportation and warehousing	302	322	333	362	20%	18
Information	458	492	539	578	26%	14
Finance and insurance	741	885	927	1,012	37%	4
Real estate and rental and leasing	1,191	1,375	1,486	1,563	31%	8
Professional, scientific, & technical services	675	727	784	862	28%	11
Management of companies & enterprises	183	192	221	231	26%	13
Administrative and waste management	282	317	347	376	33%	6
Educational services	79	100	106	113	43%	3
Health care and social assistance	599	751	803	864	44%	2
Arts, entertainment, and recreation	89	106	112	118	33%	7
Accommodation and food services	261	293	313	338	30%	9
Government	1,203	1,415	1,483	1,552	29%	10

^Includes industries not shown separately.
Source: U.S. Census Bureau, Statistical Abstract of the U.S., 2007.

3.7.2 Healthcare as Percent of State Domestic Product

Although healthcare is becoming an increasingly important component of the economy, it is relatively underrepresented in the Idaho gross state product. As seen in **Exhibit 3-24**, healthcare represents 6.7 percent of the gross product of Idaho compared to 6.9 percent nationally (Idaho ranks 35th). This suggests that a disproportionate share of spending on healthcare is leaving the state rather than being retained in Idaho to help build the economy.

EXHIBIT 3-24
HEALTHCARE AS PERCENT OF STATE GROSS PRODUCT, 2004

State	Total	Health Care and Social Assistance	Health Care and Social Share of State GDP	Rank
United States	11,655.3	802.7	6.9%	-
Alabama	141.4	9.8	6.9%	29
Alaska	36.0	2.0	5.6%	46
Arizona	194.2	13.4	6.9%	30
Arkansas	82.7	6.1	7.4%	19
California	1,519.2	89.4	5.9%	41
Colorado	201.4	11.7	5.8%	42
Connecticut	182.5	13.7	7.5%	17
Delaware	52.3	2.7	5.2%	48
District of Columbia	77.5	3.5	4.5%	50
Florida	609.4	44.8	7.4%	20
Georgia	339.7	19.5	5.7%	44
Hawaii	50.2	3.4	6.8%	32
Idaho	**43.5**	**2.9**	**6.7%**	**35**
Illinois	533.7	34.0	6.4%	38
Indiana	229.4	16.2	7.1%	26
Iowa	110.2	7.4	6.7%	34
Kansas	98.9	7.0	7.1%	25
Kentucky	133.0	10.6	8.0%	13
Louisiana	160.2	10.4	6.5%	36
Maine	43.3	4.5	10.4%	1
Maryland	230.7	16.7	7.2%	21
Massachusetts	312.7	26.4	8.4%	8
Michigan	366.6	26.3	7.2%	24
Minnesota	224.6	17.6	7.8%	14
Mississippi	77.1	5.4	7.0%	27
Missouri .	205.8	15.2	7.4%	18
Montana	27.6	2.5	9.1%	6
Nebraska	68.0	4.9	7.2%	23
Nevada	99.1	5.0	5.0%	49
New Hampshire	52.1	4.2	8.1%	12
New Jersey	410.3	28.5	6.9%	28
New Mexico	63.6	4.1	6.4%	37
New York	906.8	68.8	7.6%	16
North Carolina	324.0	20.3	6.3%	39
North Dakota	22.7	2.0	8.8%	7
Ohio	425.2	33.2	7.8%	15
Oklahoma	111.8	7.6	6.8%	31
Oregon	134.6	9.7	7.2%	22
Pennsylvania	463.8	42.3	9.1%	3
Rhode Island	41.8	3.8	9.1%	4
South Carolina	131.5	7.6	5.8%	43
South Dakota	29.7	2.5	8.4%	9
Tennessee	216.8	17.9	8.3%	10
Texas	903.2	53.7	5.9%	40
Utah	82.5	4.6	5.6%	45
Vermont	22.0	2.0	9.1%	5
Virginia	327.0	17.2	5.3%	47
Washington	253.1	17.1	6.8%	33
West Virginia	49.9	4.7	9.4%	2
Wisconsin	207.7	16.8	8.1%	11
Wyoming	24.1	1.0	4.1%	51

Source: U.S. Census Bureau, Statistical Abstract of the U.S., 2007.

3.7.3 Trends in Funding for Biomedical Research

Federal funding for biomedical research has increased significantly over the past two decades. In fact, as widely known in the academic community, funding more than doubled between 1999 and 2004 for the National Institutes of Health, which is the primary federal agency that sponsors biomedical research and development. The twenty year trend of federal funding for health research and development (R&D), by agency, is depicted in **Exhibit 3-25**.

Roughly three-quarters of federal funding for health-related research is awarded to colleges and universities. Two-thirds of the university amount (or one-half of all funds) go to the 126 allopathic medical schools in the United States. Thus, a state greatly increases its probability of attracting federal biomedical research funding if it has a medical school.

EXHIBIT 3-25
TRENDS IN FUNDING FOR BIOMEDICAL RESEARCH
(EXPRESSED IN MILLIONS OF DOLLARS)

Funding Sponsor	Fiscal Years					Percent Increase		
	1985	1990	1995	2000	2005^	85-95	95-05	85-05
Total, All Federal Agencies	6,790.8	9,790.6	13,430.1	19,516.3	31,733.3	98%	136%	367%
Department of Health & Human Services	5,411.4	8,341.2	11,417.9	17,562.9	28,798.9	111%	152%	432%
National Institutes of Health	4,827.7	7,136.5	10,681.8	16,918.3	27,665.3	121%	159%	473%
Other HHS Programs and Agencies	583.7	1,204.7	736.1	644.6	1,133.6	26%	54%	94%
Other Federal Agencies (total)	1,379.4	1,449.4	2,012.3	1,953.3	2,934.4	46%	46%	113%

^Preliminary Estimate
Source: National Institutes of Health

3.7.4 Sponsored Research at Distributive Medical Schools

The federal funding for biomedical research that goes to medical schools is by no means equally distributed across the schools. In fact, the top five schools received 17 percent of all funding in 2005. The top 20 schools received 49.3 percent of the funding, while the bottom 20 schools received only 1.1 percent.

A number of factors influence the success of a medical school in being able to attract federal R&D funding. Size of the institution (in terms of the numbers of faculty) and reputation are undoubtedly major considerations. Community-based medical schools (of which distributive schools are a subset) typically are not as competitive for federal research funds as major academic medical centers. As seen in **Exhibit 3-26**, the 17 medical schools that are considered by the AAMC to be community-based schools were awarded an average of $9.6 million per school while the other 106 schools received an average $107.9 million. Recent policy changes at NIH are expected to result in a more equitable distribution in the future.

EXHIBIT 3-26
NIH FUNDING FOR US MEDICAL SCHOOLS

Recipients of NIH Funding	Amounts
Total Funding for 123 Medical Schools	$ 11,604,771,157
Average Funding per School	$ 94,347,733
Percent of Total Granted to 5 Highest Funded Schools	17.0%
Average Funding for 5 Highest Funded Schools	$ 394,861,362
Percent of Total Granted to 20 Highest Funded Schools	49.3%
Average Funding for 20 Highest Funded Schools	$ 286,156,801
Percent of Total Granted to 20 Lowest Funded Schools	1.1%
Average Funding for 20 Lowest Funded Schools	$ 6,588,060
Percent of Total Granted to 17 Community-Based Schools	1.4%
Average Funding for 17 Community-Based Schools	$ 9,621,474

Source: National Institutes of Health

3.8 Summary of Demand Analysis

Qualitative as well as quantitative data related to demand for physicians and medical education in Idaho were analyzed in preparation for estimating potential state goals for medical access. The qualitative data, primarily perceptions from nearly 200 interviewees, are supported by quantitative data for a number of issues and not supported on other issues.

For example, perceptions of interviewees consistently held that shortages exist in the physician workforce outside the Treasure Valley, especially in rural areas, and in selected medical specialty areas. Quantitative data that support these perceptions include:

- Idaho ranks last or near last among the states in physicians per population measures, nationally and among Mountain States, Northwest States, and Small Population States.

- Further analysis reveals that 30 of Idaho's 44 counties are below a 1 physician per 1,000 population ratio, supporting the perception that access to physicians is uneven throughout the state.

- Idaho ranks high in the number of physicians age 55 and over—suggesting that retirements over the next 10 years will further reduce access to physicians at the same time that a national shortage of physicians occurs.

Another perception frequently expressed was that access to medical education is more restricted for Idahoans than for students residing in other states. Quantitative data that support this perception include:

- Nationally, Idaho ranks 48th in number of 1st year medical school seats per 100,000 population, 48th in 1st year medical school seats per 10,000 ages 18-24 population, and 49th in 1st year medical school seats in states per 100 baccalaureate graduates.

- Even when compared to similar groups of states, access to medical education ranks last or next to last (Mountain States, Northwest States, and Small Population States).

- Projections of medical education seats based on population estimates for 2020 and medical school expansion plans suggest a further decline in access.

Other perceptions held by some interviewees are not supported by quantitative data. For example, a number of interviewees stated their beliefs that Idaho's population base is not large enough to support the clinical components of a medical education program. Quantitative data analysis revealed:

- Idaho's population growth has been rapid, consistent, and projected to continue, especially for the 65 and older age cohort—an age cohort that places high demand on medical services.

- A number of states with populations less than that of Idaho have supported medical schools for many years, and Idaho is the largest state without its own medical school.

- Although healthcare is becoming an increasingly important component of the economy, it is relatively underrepresented in the Idaho gross state product. It appears that a disproportionate share of spending on healthcare is leaving the state rather than being retained in Idaho to help build the economy.

Qualitative data related to the quality of a potential Idaho medical education program varied. Some interviewees expressed their beliefs that Idaho could not develop a quality medical education program. On the other hand, during site visits to the three universities in Idaho, the consultant team learned that baccalaureate graduates applying to medical education programs have had high qualifications; a strong presence of quality related academic and health education programs and research activities exists across the state; and healthcare providers deliver quality services. Available quantitative data support the reports of high quality among applicants to medical school:

- Idaho residents who apply to medical school exceed the national averages for scores on each of the three components of the Medical College Admissions Test (MCAT) and have higher grade point averages (GPAs) in science courses, non-science courses, and overall.

- Idaho apparently has a disproportionately large number of well-qualified, potential students who are not even applying to medical school due to the intense competition for the limited number of state-funded medical school seats.

- In 2006, despite restricted access to medical education programs, 61 Idaho residents entered medical school (all at out-of-state locations), more than one-half without support from the state (WWAMI and UU contracts).

- Idaho applicants have one of the lowest rates of entrance among students across the 50 states. Given the previously noted stronger than average academic qualifications of Idaho applicants, a likely interpretation is that Idaho

students are pursuing too few seats in the region to have a high probability of admission.

- Idaho ranks ahead of only one state in number of residency seats per capita and in the residency seats per first year medical school seats. The lack of opportunity for GME in Idaho is even more pronounced when considering the limited range of core program offerings. Most other states provide coverage of all core clinical specialties.

In summary, evidence from qualitative and quantitative analyses reveals that:

- Access to physicians and medical education rank extremely low in Idaho compared to the nation and selected state groups.
- The Idaho population base is sufficient to support the clinical components of a medical education program.
- Highly qualified Idahoans are applying to medical schools in greater numbers than can be served by programs in other states.
- Idaho is ill-prepared to compete for its share of the rapidly expanding biomedical industry.

These analyses are used in the following section to estimate the potential state goals for medical education access.

3.9 Potential State Goals for Medical Access

A state investment to expand medical education, like any investment, should be made in light of the specific goals to be achieved. In the case of student access to medical school, some of the alternative strategies are likely to be impractical if the numbers of additional students to be served is relatively small, but may become much more attractive if there is believed to be significant unmet need. Thus, a goal for training the state's future physicians will be invaluable in determining the most appropriate course of action for medical education.

To assist in the goal-setting process, we suggest that the state consider an informal goal of meeting two-thirds of its annual requirement for new physicians through its own educational programs. The two-thirds rate is based on the current national proportion of medical school students who are in public institutions (or in schools that receive substantial state grants). That is, we offer that Idaho should be responsible for educating its own pool of physicians who are trained in state schools and expect to be able to compete with other states for its share of private school graduates.

To determine the number of physicians needed, we suggest that Idaho adopt a goal of reaching the national median rate of physicians per capita. The use of the national median (281), instead of the national average (300), removes the distorting effect of the major destination medical centers in several large urban areas and more closely approximates the averages of the three groupings of specially selected comparison

states (244, 267 and 296). Idaho would have needed 4,009 physicians in 2005 to have reached the national median.

Although it is not reasonable to quickly close the gap between Idaho's current 2,825 physicians and the 4,009 need to match the national median, it is feasible to set the 4,009 as a baseline for keeping pace with general turnover rates. Therefore, the annual new openings needed to keep pace with turnover is pegged to the national benchmark.

To determine the annual rate at which new physicians would need to be added to the workforce to maintain the goal of 4009 doctors, we assume a 3 percent annual turnover. This is based on the assumption that the typical new physician enters the workforce at the age of 30-35 and works for 30-35 years until he or she is approximately 65 years of age. Applying the 3 percent rate to the 4009 physician goal, approximately 120 new doctors would be needed per year just to handle turnover. If the state's policy is to accommodate two-thirds of its new doctors per year through state-funded programs, provisions should be made to support the training of roughly 80 medical students per year.

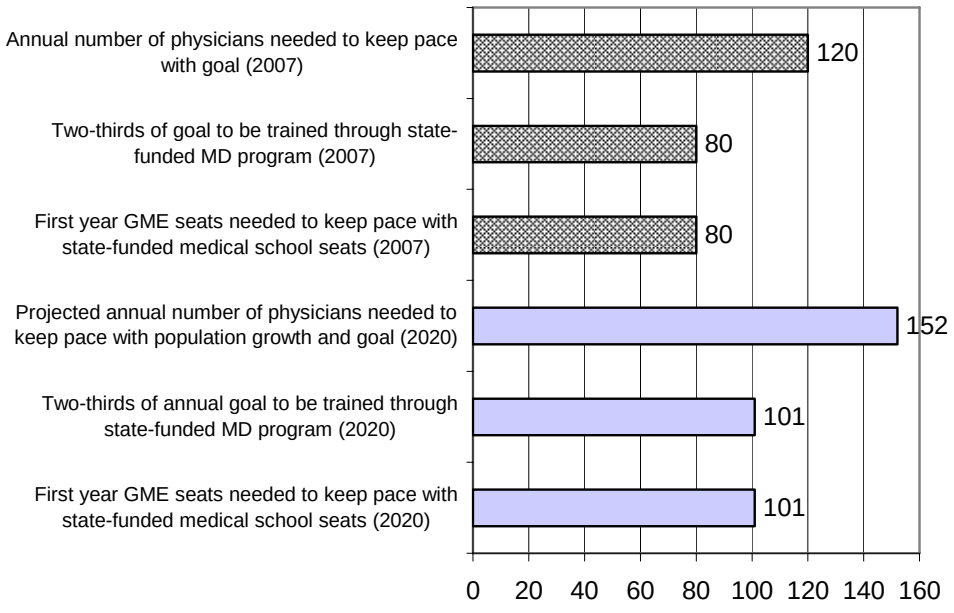
The 4,009 total physicians and 80 medical graduates per year are based on the state's population in 2005. Data shown earlier in **Exhibit 3-2** indicate that a 26 percent growth in population is projected in Idaho between 2005 and 2020. Just over 100 state-funded medical graduates per year would be needed to apply the goal to the projected population. Details of how the goal might be calculated and its impact are illustrated in **Exhibit 3-27**.

As previously discussed, residency training (or graduate medical education) is an essential step in the overall medical education pipeline. Further, the location of residency training is the best predictor of a physician's practice location. At a minimum, we suggest that Idaho set a goal of having an equal number of residency seats available in the state as it has seats for first year medical students.

EXHIBIT 3-27
POTENTIAL STATE GOALS FOR MEDICAL ACCESS

Current Status	
Total Current Active Physicians in Idaho (2005)	2,825
Idaho Physicians per 100,000 Population	198
US Median Physicians per 100,000 Population	281
Percentage Increase Required to Reach Median	42%
Percentage Population Increase from 2005 to 2020	26%

Goals	Potential Policy	Potential Current Goal	Potential Goal for 2020
Physician Access Goal		4,009	5,052
Assumed Annual Turnover Rate	3%		
New Physicians per Year to Fill Turnover		120	152
Student Access to Medical School Goal			
Percentage Share per State-Funded Programs	67%		
New Physicians to be Trained per Year		80	101
Graduate Medical Education Access Goal			
First-Year Seats		80	101



Source: Population—U.S. Census Bureau; Physicians—American Medical Association; MGT calculations.

4.0 APPROACH TO ASSESSING ALTERNATIVES

4.0 APPROACH TO ASSESSING ALTERNATIVES

Each of the alternatives under consideration has the potential to expand access to medical education for Idaho residents. Each also has its relative disadvantages. To gain a better understanding of how the alternatives compare to one another, we assessed them using a set of seven criteria.

4.1 Criteria Employed

The first two criteria relate directly to the ability of the alternative to effect state goals related to medical education.

- Impact on Opportunity for Idaho Students
- Impact of State Physician Workforce

The second two criteria address implementation challenges and, to some degree, consider the likelihood of success.

- Challenges to Gaining Accreditation
- Time Required for Full Implementation

The final three criteria relate to financial concerns—both the cash outlays that would be required to fund the alternative and the economic benefits that would derive from its implementation.

- Start-Up Investment Required
- Annual Operating Support Required
- Economic Impact on State

Each of the criteria is described in greater detail in the sections that follow.

4.2 Criterion A – Impact on Opportunity for Idaho Students

Description and Rationale. This criterion relates to the number of students that could be optimally served under the alternative. Some approaches for expanding access to medical education that are available to Idaho leaders have limited potential to handle large numbers of students, while others would be excessively expensive if only a limited number of students were to be served. The rationale for this criterion is self-evident given that the goal of the study is to address ways to expand access to medical education.

Information Sources. To gather the information necessary to apply this criterion, we conducted interviews with experienced medical educators at several out-of-state medical schools and with officials involved in interstate contracts for medical education. We also reviewed information on the size and finances of medical schools in other states.

Measures to Be Considered. For each of the alternatives for expanding access to medical school, we developed a range of numbers of first-year students that could be served.

4.3 Criterion B – Impact on State Physician Workforce

Description and Rationale. A major part of Idaho's interest in expanding student access to medical education is the need to ensure the adequacy of the state's future physician workforce. The "impact on workforce" criterion relates to the likelihood with which each alternative will supply future physicians for the state. This criterion concerns not only the absolute number of potential future physicians, but also their potential for practicing in Idaho in needed medical specialties or in communities with physician shortages.

Information Sources. Key information for applying this criterion comes from Association of American Medical Colleges' (AAMC) analyses of data from the American Medical Association Physician Masterfile. Of special focus in these analyses was the pattern of graduates' practice locations for medical schools in similar states or under similar program delivery models. Additional information comes from the University of Washington and University of Utah reports on the practice locations of Idaho-sponsored graduates of their medical education programs.

Measures to Be Considered. The key metric to be applied for the physician workforce criterion is the predicted number of physicians practicing in Idaho who were products of the state-funded program for access to medical education.

4.4 Criterion C – Challenges to Gaining Accreditation

Description and Rationale. Medical education programs, at both the undergraduate (i.e., medical school) and the graduate (i.e., residency) levels, must be accredited in order for their graduates to seek licensure and board certification. While we assume that any of the alternatives under consideration would become appropriately accredited, our concern in the accreditation criterion is whether implementation of the program would be unduly delayed or whether the alternative, as currently defined, would need to be modified.

Information Sources. The various accrediting bodies for medical education have well-documented standards for accreditation. Members of the project team are experienced in the accreditation process and are aware of trends in the expectations of visitation teams regarding what constitutes compliance with the standards.

Measures to Be Considered. Unlike the measures for the first two criteria, those for the accreditation criterion will not be quantitative. Instead, they will be observations on likely issues to be faced if the alternative is to be pursued.

4.5 Criterion D – Time Required for Full Implementation

Description and Rationale. Different alternatives for expanding access to medical education take different amounts of time to plan, implement, and reach full capacity. As Idaho leaders feel a sense of urgency in producing additional physicians for the state's medical workforce, the time required before new physicians are entering practice is a concern.

Information Sources. To develop a better understanding of the time required to fully implement the various alternatives, we conducted interviews with experienced medical education leaders who were familiar with each access strategy. Additionally, we reviewed recent efforts to expand access in other states to determine how long it took to implement programs.

Measures to Be Considered. The key metric to be applied is the number of years that will likely be required before the full planned complement of new physicians are in practice.

4.6 Criterion E – Start-Up Investment Required

Description and Rationale. Idaho's public officials take pride in their abilities to make efficient use of taxpayer dollars and are likely to demand that any program to expand access to medical education be cost-effective. The various alternatives for expanding access to medical education require significantly different amounts of funding for initial program planning and development and for capital investment.

Information Sources. Since no specific proposals based on detailed business plans have been presented, we obtained information relating to the start-up investment criterion from analyses of the costs (or budgets) of several new (or recently planned) medical schools or medical education programs (e.g., the new Spokane program for WWAMI).

Measures to Be Considered. We developed an estimate of all one-time start-up costs likely to be incurred in the implementation of each alternative. Major components of these estimates include facility construction and/or renovation costs, operating costs before students enroll, and costs incurred during the enrollment build-up phase that are above the average cost-per-student rate assumed for annual operating support.

4.7 Criterion F – Annual Operating Support Required

Description and Rationale. Over the long term, the major cost to the state for supporting a medical education program will be related to appropriations to help offset annual operating expenditures. While the state funding requirements for annual operating support per student across the various medical school alternatives fall within a relatively constrained range, the differences become greater as larger numbers of students are considered over an extended period.

Information Sources. Data used to assess the alternatives comes from the budget plans of several recently planned and new medical schools and the budgets of established medical schools of similar size and/or mission. For contracted programs, current funding rates and the budget plan for the new expanded WWAMI program in Spokane were considered.

Measures to Be Considered. The primary metric to be considered is the operating support for student instruction on a per student basis once the program reaches full capacity. Additional estimates to be considered are the projected annual requirements for 200 and 400 students (the total enrollment equivalents of first-year classes of 50 and 100 entrants). The focus will be on general fund requirements - the sum of state appropriations and student tuition - since the relationship between these two amounts is a state policy choice that can be modified at any point in the future.[1]

4.8 Criterion G – Economic Impact on State

Description and Rationale. While the first two financial criteria concern how much the state might need to invest in medical education, the last criterion considers the potential off setting economic impact that expanded medical education might have on the state. The various expansion alternatives have differing potential for contributing to the growth of the state economy.

Information Sources. Data from reports periodically published by the AAMC on the economic impact of medical schools will be augmented by analyses of in-state versus out-of-state spending and economic impact analyses of similar programs.

Measures to Be Considered. Detailed economic impact estimates of the various alternatives are beyond the scope of the current study, but we will be able to introduce information about the relative potential levels of economic impact.

[1] Funding of medical schools typically involves a complex array of resources, including appropriations, tuition, research grants, gifts and clinical income. Our focus on general fund revenue recognizes that state decision makers have little influence over other sources of revenue.

5.0 ALTERNATIVES FOR EXPANDING ACCESS TO MEDICAL EDUCATION

5.0 ALTERNATIVES FOR EXPANDING ACCESS TO MEDICAL EDUCATION

The state of Idaho is fortunate to have a choice among several alternative strategies for expanding student access to medical education. In this chapter, we identify a number of different opportunities and then focus on the four alternatives that we think merit serious consideration by state leaders.

5.1 Alternatives Considered

The State of Idaho faces a wide array of approaches for expanding access to medical education for the state's current and potential students. Most alternatives focus on opportunities to earn a professional degree (e.g., the M.D.). Other alternatives address educational opportunities for advanced training in medicine through residency and fellowship programs.

Chapter 6.0 of this report offers our analyses of the four most promising alternatives that we believe state leaders should consider:

- Alternative I – Establishment of a New, University-Operated Medical School Based on the Distributive Model of Medical Education
- Alternative II – Expansion of the Package of Contracted Programs With Medical Schools in Other States
- Alternative III – Development of a New Joint Medical School From Current Medical Education Resources at the Three State Universities
- Alternative IV – Expansion of Graduate Medical Education Programs Based in the State

These alternatives and their variations are described in the remainder of this chapter.

In early phases of the study, we considered an even greater number of alternatives. Although nearly all of the approaches that we considered could be found in practice somewhere in the U.S., we determined that some had less potential for success in Idaho, namely:

- ***Establishment of a free-standing health sciences university.*** The Oregon Health and Science University (OHSU) is an example of this approach, which was dropped from consideration due to the excessive cost of building and operating a large teaching hospital that would be in competition with established healthcare providers in the community (the overall OHSU budget is more than $1.2 billion). Another significant disadvantage is the need to establish duplicative programs in several other health professions (e.g., pharmacy, nursing) or to transfer existing programs from other institutions in the effort to build a comprehensive health sciences university.

- ***Establishment of an osteopathic medical school.*** The Oklahoma State University College of Osteopathic Medicine in Tulsa and the Ohio University College of Osteopathic Medicine in Athens are examples of an osteopathic medical school at a state university. This alternative, which relies heavily on support from the osteopathic medicine community within the host state, was dropped from consideration due to the limited presence of D.O.s practicing in Idaho and the relative lack of research and economic impact.

- ***Development of a four year branch of an existing medical school.*** The new Phoenix campus of the Tucson-based University of Arizona and the new El Paso campus of the Texas Tech Health Sciences Center are examples of this model, which was dropped from consideration due to lack of known interest of an existing out-of-state program to expand into Idaho.

While the cited programs clearly do, or will, meet the needs of the residents of the states where they are located, different circumstances in Idaho make these models less attractive for potential implementation in the state.

5.2 Alternative I – Establishment of a New, University-Operated Medical School Based on the Distributive Model of Medical Education

Description. The new medical school would admit approximately 80-100 new students per year to a four year training program leading to the Doctor of Medicine (M.D.) degree. The first two years of the four year curriculum would take place on the campus of an established university, where the students would concentrate on developing the knowledge of the basic sciences that is needed to understand human medicine. Additionally, students would begin their clinical training and would have weekly exposure to patients, with physicians from nearby communities serving as preceptors.

During the third and fourth years of the curriculum, students would be "distributed" among several clinical campuses in communities across the state for clinical training. The current clerkship sites in Boise used by the WWAMI program would likely form the basis for the first clinical campus. Each clinical campus would be staffed by a small cadre of full-time university personnel and a larger number of local physicians who would be retained as community faculty and compensated on a part-time basis. Extensive use of video conferencing and other technology-assisted forms of instruction and internal communication would be employed.

The third year would focus on the core clinical rotations in family medicine, internal medicine, pediatrics, obstetrics-gynecology, surgery, and psychiatry. Elective rotations would be served during the fourth year with students either staying at their third year sites or relocating to other clinical campuses. Additionally, the new school would offer a rural track, which would provide opportunities during the third and fourth year for those students seeking to develop an understanding of the challenges and rewards of practicing in rural areas.

Examples. Sixteen of the 22 most recently accredited medical schools in the U.S. rely on the community-based or distributive model of medical education. Notable examples include the programs at Michigan State University, Texas A&M University, the University

of North Dakota, and the University of South Dakota. The College of Medicine at Florida State University (the newest program to be accredited by the Liaison Committee on Medical Education [LCME]) also has successfully implemented the distributive model with community-based partners in six locations across the state.

Many long-established medical schools now operate a traditional program on campus and support one or more tracks on a distributive basis. The WWAMI program of the University of Washington (UW) is a prime example of a medical school employing both a traditional and a distributive approach to medical education. Similarly, the University of Illinois medical school operates several smaller distributed sites in addition to its large academic medical center in Chicago. Many other established medical schools are now adapting the distributive model to enable enrollment growth without the need to expand their teaching hospitals.

Typical Start-up Investment and Operating Support Requirements. A new distributive model medical school would require both capital investment and start-up operating support before the first class was admitted and ongoing financial support once fully operational. The new medical school at Florida State University, with 120 students per class, recently occupied a new 330,000-gross-square-foot facility that cost $60 million to construct.[1] The original business plan estimated that expenditures would average approximately $80,000 per student per year when the school became fully operational and be funded from a combination of state appropriations, student charges, and other sources. During the first six years of the new school's existence, approximately $40 million was expended above the $80,000 per student rate to support operations before students arrived, provide advance funding and start-up support for faculty positions in anticipation of enrollment growth, establish clinical campuses, and undertake similar developmental activities.

Several new medical schools based on the distributive model are currently in the planning phase in Florida, California, and Pennsylvania. Expected operating costs at these schools typically range from $60,000 to $80,000 per student per year. The one exception is found in the preliminary plan for the University of California Merced, where significant resources are planned for research programs. Capital investment plans call for buildings and equipment in the $60 million range and above. It is important to note that the budget data for the planned programs are subject to further funding actions and the assessment of adequacy of resources by LCME accrediting teams.

The annual operating support requirements for more established distributive model medical schools follow a similar pattern and range from roughly $60,000 to $100,000 per student with one exception. The operating support and initial capital investments for selected medical schools are summarized in **Exhibit 5-1**. Higher costs at the University of Nevada are likely based on expansion plans that call for duplicating many functions in Las Vegas that are already found on the Reno campus.

[1] Costs of building materials and labor have increased considerably since that construction contract was bid, and costs of a similar facility in Idaho could be expected to be greater.

EXHIBIT 5-1
FINANCIAL COMPARISONS OF COMMUNITY-BASED MEDICAL SCHOOLS

Medical Schools	Operating Support per Student	Capital Investment
New Medical School		
Florida State University	$ 80,000	$ 60,000,000
Recently Planned Medical Schools		
Northeast Pennsylvania	$ 64,222	$ 71,000,000
University of Central Florida	$ 77,789	$ 58,000,000
Florida International University	$ 67,145	$ 64,000,000
Univesity of California, Merced	$ 173,689	$ 56,000,000
Established Medical Schools		
Eastern Virginia Medical School	$ 64,451	*n.a.*
Northeastern Ohio Universities College of Medicine	$ 60,031	*n.a.*
University of Nevada Reno	$ 142,790	*n.a.*
University of North Dakota	$ 84,914	*n.a.*
University of South Dakota	$ 102,727	*n.a.*
Summary		
Average	$ 91,776	$ 61,800,000
Median	$ 78,895	$ 60,000,000

Assumptions. If this alternative were to be pursued, the Idaho Board of Education would assign one of the three universities the responsibility for developing the new school. The selection process would take into account campus missions, experience in medical education, availability of appropriately qualified faculty already in place, availability of suitable campus facilities, plans to recruit clinical partners, availability of clinical facilities, availability of clinical material, opportunities for development of integrated graduate medical education programs, community support, and similar criteria.

If approved and funded by the Legislature, the development of the new medical school would require 3-5 years of planning before provisional accreditation would be granted and the first students could be admitted. During this period, the new school would hire the founding dean and faculty, design the curriculum, establish formal operating agreements with community teaching partners, develop both on-campus and off-campus facilities, implement a student admissions process, and seek provisional accreditation.

The initial classes would likely enroll a smaller number of students than the school's eventual planned capacity during the first few years of operation. The WWAMI and the

University of Utah (UU) contracts would be continued in the interim, but would begin to be phased out when the new school was able to admit an equivalent number of first-year students.

Variations. The major variations of this alternative relate to the number of students to be served. A smaller class size would likely require a somewhat lower capital investment in facilities, but perhaps a higher expenditure per student due to less economy of scale. A larger class size would likely require greater capital investment and annual financial support, and might result in more difficulty in recruiting sufficient numbers of qualified applicants. These potential issues, however, could be offset by making some of the slots available to students from other states.

5.3 Alternative II – Expansion of the Package of Contracted Programs With Medical Schools in Other States

Description. The state of Idaho currently provides funding for 28 entering medical students per year with continued support over the four year curriculum for each entering class. Under this alternative, Idaho would provide access to medical education for an additional 32 students (resulting in 60 new students each year) through expansion of existing contracts with UW, UU, and, as necessary, additional schools of medicine.

The medical education programs at UW and UU have each expressed a willingness to consider expansion of the numbers of students served under existing contracts. While no specific proposals are pending, officials at UW would likely consider increasing the number of Idaho students from 20 to 40 per class, and UU could consider increasing its complement of Idaho students from 8 to 12 if its own expansion program is approved by the Utah State Legislature.

New partners are also a potential under this alternative. The OHSU has indicated its potential interest in contracting with Idaho for approximately 10-20 seats per year. Also, officials at the Western Interstate Commission on Higher Education (WICHE) have contacted medical schools in the region and believe Idaho students could be accommodated by the expanding programs at the University of Colorado and the University of Arizona through the Professional Student Exchange Program (PSEP).

Examples. The concept of contracted programs is well understood by the state's leaders and medical students. Idaho has been a member of the WWAMI medical education compact since the 1970s, and the UU contract has existed since the 1980s. Additionally, Idaho participated in the WICHE PSEP for a number of years prior to entering into the UU contract.

Typical Start-up Investment and Operating Support Requirements. As described in Chapter 2.0, the dollar amounts for the WWAMI (UW) and UU medical education contracts are adjusted annually to reflect the number of students enrolled and inflationary increases. Although the state funds allocated to the two programs are in total dollar amounts, the rate per student per year can be readily computed. Additionally, Idaho students pay tuition to their respective medical schools.

For the current 2007-08 academic and fiscal year, the average rates per student at the two schools are as follows:

- University of Washington
  - $48,210 state support per student[2]
  - $17,902 tuition and fees per student[3]
  - $66,112 total supported cost per student
    - (new WWAMI Spokane program is budgeted at $69,306 per student)
- University of Utah
  - $34,025 state support per student4
  - $20,692 tuition and fees per student[5]
  - $54,717 total supported cost per student

The potential rate for students contracted with OHSU is assumed to be in the same range as the WICHE rate since the institution is a participant in that program for students from other states.

- WICHE (OHSU as example)
  - $26,500 state support through PSEP per student
  - $20,184 tuition and fees per student
  - $46,684 total supported cost per student

Assumptions. Since this alternative involves an expansion of the overall package of contracted programs, a number of assumptions are necessary.

- Students per class
  - WWAMI – 40 (up from current 20)
  - Utah – 12 (up from current 8)
  - OHSU or WICHE – 8 (all additions to current package)
- Cost per student
  - WWAMI – $66,112
    - Start-up operating cost of $5 million for new site
  - Utah – $54,717
  - OHSU or WICHE – $46,684
- Program delivery model
  - WWAMI – The contract would continue to offer the first year in Idaho, but an additional location with 20 students (in either Boise or Pocatello) would

[2] FY 2008 appropriation is $3,664,000 for 76 students. Idaho Legislature, *Senate Bill 1201* http://www3.state.id.us/oasis/S1201.html
[3] Total reflects resident tuition plus health/immunization fee. UW School of Medicine Financial Aid Office Web site http://www.uwmedicine.org/uwmed
[4] FY 2008 appropriation is $1,088,800 for 32 students. Idaho Legislature, *Senate Bill 1201* http://www3.state.id.us/oasis/S1201.html
[5] Total reflects resident tuition and fees. UU Income Accounting and Student Loan Services http://www.acs.utah.edu/tuition/t-med1234.html

be established to match the current location in Moscow. Second-year students would attend classes in Seattle. Additional opportunities for third- and fourth-year students would be made available in Idaho, with the goal of providing 40 slots within the state in each of the clerkship years.

- Utah – The program would continue to operate under the current model, with virtually all components being delivered in Salt Lake City.
- OHSU or WICHE – The program would be delivered at the main site of the medical school selected, with only minimal instructional experiences being offered in Idaho.

Variations. An unlimited number of variations on this model are possible, including:

- A smaller number of seats being contracted.
- A different mix in the number of seats offered through each partner school of medicine.
- Establishment of two additional locations instead of one under the WWAMI alternative.

A significant variation that state leaders might want to consider under the contracted programs alternative is the development of one or more incentive programs to encourage graduates of the program to return to Idaho for their medical practice. Such a feature is part of Wyoming's participation in the WWAMI program, though evidence of the success of the strategy is mixed given the state's relatively recent entry into the WWAMI compact.

5.4 Alternative III – Development of a New Joint Medical School From Current Medical Education Resources at the Three State Universities

Description. The new medical school would admit approximately 100 new students per year to a four year training program leading to the M.D. degree. Rather than assigning sole responsibility to one of the state universities to develop the program (as in Alternative I), a consortium of the three state universities would be created to establish and operate the new medical school. Like Alternative I, however, the new school would be based on the distributive model.

The first two years of the four year curriculum would be based at each of the three cooperating universities, where separate cohorts of approximately 20-40 students each would concentrate on developing the knowledge of the basic sciences that is needed to understand human medicine. Additionally, students would participate in an introduction to medicine program that would involve weekly exposure to patients, with physicians from nearby communities serving as preceptors.

During the third and fourth years of the curriculum, students would be further "distributed" among several communities in the state for clinical training, with each university providing oversight for 1-2 clinical campuses. Each clinical campus would be staffed by a small cadre of full-time medical school personnel and a larger number of local physicians who would be retained and compensated on a part-time basis. The third

year would focus on the core clinical rotations in family medicine, internal medicine, pediatrics, obstetrics-gynecology, surgery, and psychiatry. Elective rotations would be served during the fourth year, either at the same location or elsewhere. Additionally, the school would offer a rural track, which would provide opportunities during the third and fourth year for those students seeking to develop an understanding of the challenges and rewards of practicing in rural areas.

Examples. No existing programs are an identical match to the model described above, but examples of all of the essential elements can be found elsewhere. For instance, the Indiana University School of Medicine's first two years are spread among nine sites in cooperation with other universities such as Purdue and Notre Dame. The third and fourth years of the Michigan State University program are offered in their entirety at six campuses across the state.

Variations. The Northeastern Ohio Universities Colleges of Medicine and Pharmacy (NEOUCOM) is a community-based, public institution that provides interdisciplinary training in the health professions, including the M.D. degree. The NEOUCOM educational consortium, based at its Rootstown, Ohio campus, includes the University of Akron, Kent State University, and Youngstown State University, eight community teaching hospitals, ten associated hospitals, and two health departments. Unlike Alternative III, however, NEOUCOM is a separately accredited *institution* as well as having an accredited medical education *program*, and is independent from the accreditation of the three sponsoring state universities. NEOUCOM and the three universities have a joint early admissions, accelerated M.D. program and several joint Ph.D. programs in the biomedical sciences.

Typical Start-up Investment and Operating Support Requirements. The cost per student at the joint medical school would likely exceed the costs under the first alternative due to the need to coordinate multiple locations and possibly duplicate some of the program support and infrastructure.

Given the limited number of additional students to be accommodated at either Boise State University or Idaho State University (30-40 students each), the need for investment in new buildings would likely be minimal since existing facilities might be available. The University of Idaho would be expected to continue to serve at least 20 students using the current WWAMI facilities.

The NEOUCOM is perhaps the closest comparator with three universities jointly operating the medical school. Its general fund cost per student in FY 2007 was $60,031.

Assumptions. If approved by the Board of Education and the Legislature, the development of the new medical school would require 3-5 years of planning before the first students could be admitted. The initial classes would probably enroll a smaller number of students during the first few years of operation than the school's eventual capacity. Most likely, only one additional location would be placed into service at a time. The WWAMI and UU contracts would be continued in the interim, but would begin to be phased out when the new school admitted its first students.

5.5 Alternative IV – Expansion of Graduate Medical Education Programs Based in the State

The fourth alternative differs from the first three in that it would expand access to graduate medical education (GME) rather than increasing the number of medical seats available to Idaho students. *This option should not be considered as mutually exclusive of the first three alternatives. Indeed, Alternative IV should be considered in tandem with the preferred option for expanding medical school access.*

Description. The most efficient response to the national deficit of physicians is an increase in GME and an increase in the number of residency positions. GME comprises the second phase of the formal education process that prepares physicians for the practice of medicine and includes residencies and fellowships. Increasing residencies is also the best way to retain doctors in specific areas, with more than 47 percent of residents staying in the place of training.[6]

Medicare is the major funding source for residency programs. Medicaid also funds some residency programs, and the Veterans Administration funds residents who are trained in its hospitals. Currently, Medicare funding of GME prevents those hospitals that already have programs from starting new programs or adding new positions. Hospital residency programs do not need considerable hospital resources. Moreover, residency programs are an important added benefit to patient care and hospital growth.

Examples. In 2003, some 713 institutions sponsored 7,954 different specialty programs that trained over 100,000 residents. As described in Chapter 2.0, the only residency programs currently based in Idaho are the Family Medicine Residency of Idaho (Boise) and the Idaho State University Family Medicine Residency (Pocatello). Additionally, rotations of several UW residency programs occur in the state, including the Internal Medicine Residency Program (Seattle and Boise), Psychiatry Residency Program (Seattle and Boise), and the Pulmonary/Critical Care Fellowship Training Program (Seattle and Boise).

Typical Start-up Investment and Operating Support Requirements. GME programs are difficult to fund because of the very heavy reliance on restricted federal funds. GME is primarily financed by Medicare and Medicaid. Some states also make small contributions, as do a number of hospitals and medical schools, which in some areas contribute to satisfying the needs of the programs in different ways. There is a cap on new residency positions for hospitals that already receive federal money. There is no cap for hospitals and universities that do not have existing residency programs or that are willing to finance the direct and indirect costs of training. And for a window of three years, these institutions can develop and fund as many residency slots as they wish, subject always to Accreditation Council for Graduate Medical Education (ACGME) approval.

Medical and surgical services furnished by residents outside of their training programs or outside of the facilities where they train are covered as physician services and are paid on a fee schedule or reasonable basis. Medical and surgical services provided by residents within the scope of their training programs are covered as provider services. It

[6] Association of American Medical Colleges. *Key Physician Data by State.* 2006. Figure 7.

is generally accepted that residents can generate between two and three times their stipends in clinical revenues. Residents may perform diagnostic and therapeutic procedures (e.g., start intravenous lines, insert catheters or tubes, assist at surgery, transport patients, collate patient information, participate in patient resuscitation).

Medicare funds GME in two ways: direct and indirect payments. Direct GME payments cover the direct education cost of residents and fellows and include salary and fringe benefits, supervising physicians' compensation, etc. The total amount of Medicare funding for direct costs in 2004 was $2.7 billion. The U.S. average standard salary per resident is approximately $55,000 with 20 percent fringe benefits, but may vary according to geographic region.

Indirect GME payments from Medicare are for costs associated with residents. Such expenses include ordering of additional tests, extra supplies, longer patient stays, and sicker patients. The total amount of Medicare funding for indirect payments in 2004 was $5.8 billion. Indirect funding also helps offset the care of indigent patients, who are more commonly found in teaching hospitals.

The amount of indirect payment to hospitals per resident varies widely across the country, and many hospitals consider indirect payments as other revenue streams. It is impossible to estimate what a given hospital will generate in indirect payments without knowing the number of residents, number of Medicare patients, number of total patients, and other components of the reimbursement formula.

During the past several years, attitudes have begun to change among many healthcare organizations, which are now more interested in exploring the development of other sources of funding, including hospitals' own budgets and direct state appropriations. Physician recruitment is a problem everywhere and is becoming increasingly costly, with some institutions spending hundred of thousands of dollars per doctor. Also, because the physician shortage is a national problem, the competition among institutions is becoming more intense. Many healthcare executives now understand that residency programs not only improve quality of care and the marketing of institutions, but also may be a cost-efficient alternative to the traditional way of recruiting physicians. Residents trained in an institution will tend to remain there and are prepared to begin delivery of health services as soon as they become certified.

The state of Idaho has a 30+ year history of supporting residency training programs. For the 2007-2008 fiscal year, the two Idaho-based family medicine residency programs received approximately $1.57 million in state appropriations. This amount averages about $32,000 per resident.

6.0 ANALYSIS OF ALTERNATIVES

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In Chapters 4.0 and 5.0, we introduced seven criteria that we would used to assess the four alternatives to expand access to medical education in Idaho. In this chapter, we examine how well the various alternatives meet each criterion.

6.1 Impact on Opportunity for Idaho Students

For the student access criterion, our concern is how many first-year medical students can be accommodated by the alternative. Although we suggested a state goal of supporting 80-100 new medical students per year, the student access criterion also can be applied to other target numbers of students that are determined by state leaders.

A new medical school based on the distributive model could easily be designed to handle 80-100 entrants per class. Current first-year enrollments at the existing community-based schools average 81 students, and the median is 72 students. If the state's student access goal fell below this range, the new school alternative would be less viable.

The current package of contract programs for medical education could be expanded to support up to 60 students in neighboring states (Washington, Utah, and perhaps Oregon). Expansion beyond this number would require the development of numerous contracts, which would likely become cumbersome to administer and a challenge to market to students.

Like the new distributive model medical school alternative, a joint medical school that evolved from existing university resources could be designed to handle 80-100 entrants per class. This model becomes less attractive if the total number of students to be served is not large enough to support multiple locations for the first two years of the curriculum.

Expanding access to graduate medical education (GME) programs would have no direct impact on increasing access for students seeking the Doctor of Medicine degree. If plans for providing clinical training to M.D. students were integrated with plans for expanding graduate medical education, stronger clinical training sites for both programs would result. Proposals to expand GME, of course, will compete for dollars that could be used to increase access to undergraduate medical education.

6.2 Impact on State Physician Workforce

The physician workforce criterion relates to the number of physicians who are expected to practice in the state after completing the program.

A new state medical school based on the distributive model would permit greater control over how to align educational investment and workforce needs. For instance, Idaho medical educators would oversee the selection of medical students and develop the

curricula, enabling them to design the program in ways that might encourage students to pursue careers in primary care or rural medicine.

The impact of contract programs on physician access would vary according to which medical schools were selected as partners and how the contracts were structured. For instance, an expanded WWAMI program in one or more additional locations, and especially with more in-state clerkship opportunities, would increase the likelihood that graduates would practice in Idaho. The WWAMI program also has had favorable impact on the Idaho physician workforce through placement in Idaho of graduates from other member states. Contracts with other medical schools would have relatively modest impacts on the Idaho workforce unless those schools provided significant instructional opportunities in Idaho or the state developed new incentive programs to encourage medical graduates to return to the state.

A new joint medical school potentially would permit many students to retain connections to their home regions of the state and make them more likely to choose to practice in those areas. Like the new distributive medical school model, a new joint medical education program could design the admissions process and the curricular experiences in ways that would increase the likelihood of graduates practicing in Idaho.

The location of a physician's GME program (i.e., residency training) is thought to be the single most important predictor of practice location. Further, the state could influence the composition of its physician workforce by the types of medical specialties that it chose to sponsor for residency programs.

6.3 Challenges to Gaining Accreditation

The accreditation criterion is an assessment of the perceived difficulty the proposed program would face in gaining needed professional accreditation. In one sense, this criterion addresses the practicality of the alternative.

Recent experiences with the Liaison Committee on Medical Education (LCME) suggest that a new state-supported medical school based on the distributive model of medical education could become accredited after a 3-5 year planning effort. The vast majority of medical schools that have become accredited over the past several decades employ variations of the distributive model, and the merits of this educational approach are recognized by accreditation officials. The difficulty of gaining accreditation could vary somewhat based on which state university was selected to develop the medical education program and the resources that it had available.

No significant accreditation challenges would be expected if the state decided to expand its package of contract programs for medical education. All of the partner schools are already accredited and would face only minimal issues in expanding modestly to accommodate additional Idaho students. The most significant challenge would be for the University of Washington if it agreed to establish an additional site in Idaho. Given the long history of success of the WWAMI program, this challenge would likely prove easy to overcome.

A new joint medical school would probably face considerable challenges, even after the typical 3-5 year planning effort. Barriers to accreditation would be most likely to arise if the new school could not articulate a clear governance relationship among the sponsoring state universities and/or could not assure LCME that equivalent educational experiences were available at multiple sites during both the first two years of the curriculum and the final two years (existing accredited programs have at least some common experiences, such as the second year of the WWAMI program in Seattle).

The state-supported expansion of GME programs into additional areas of medical specialization would require multiple accreditations since each program is separately accredited. Nonetheless, no major obstacles are likely to be encountered.

6.4 Time Required for Full Implementation

The time required criterion refers to the number of years that would be required before the planned program produced a full complement of graduates. This includes both the time spent planning and gaining accreditation and the time spent phasing in the program to full planned capacity.

A new state medical school would probably take 12-15 years to reach full capacity. This estimate is based on the sum of 3-5 years for planning, 4 years for a student to progress through the curriculum, and several years of ramping up entering class sizes to full planned capacity. The time required to reach full size is especially related to the time-consuming endeavor of setting up multiple clinical campuses and selecting community faculty in multiple locations.

By contrast, the time required to expand the number of students served through contract programs would likely be relatively brief, perhaps in the 6-8 year range. Modest growth could be handled almost immediately by WWAMI and the University of Utah. Reaching the full planned capacity of 60 entrants per year would take somewhat longer as WWAMI developed an additional site in Idaho, or as the University of Utah gained its legislative approval for overall expansion of the School of Medicine. The time required to develop a totally new relationship with additional partner institutions would likely be only a couple of years unless the partner institution's ability to handle Idaho students was contingent on completion of its own expansion program.

A new joint medical school would take at least as long to develop as a new distributive school operated by a single state university. Additional time would likely be needed to articulate how the three universities would work together on the joint endeavor and share oversight responsibility for numerous community-based training locations. Moreover, accreditation issues could cause further delay.

The time required to expand GME programs would likely be 2-3 years for start-up for program development, accreditation, and listing with the National Residency Matching Program. Depending on the medical specialties covered by the residencies, an additional 3-5 years would be necessary for a cohort of students to complete the cycle of training.

6.5 Start-Up Investment Required

We define start-up costs as the dollar amount of capital investment that would be required for buildings and major equipment as well as a variety of one-time operating expenses that might be needed for program planning and implementation until full enrollment capacity was reached.

A new state-supported medical school based on the distributive model would likely require a significant investment for program start-up. The average start-up costs of recently opened or planned new programs are in the $60 million range for facilities and an additional $25-$50 million for planning and program development costs above the typical per-student funding rate. The actual amount required from state appropriations for an Idaho university to start a medical school would depend on the possible availability of existing facilities and potential for private giving. Experience elsewhere suggests that the need for start-up support should not be underestimated.

Start-up costs for an expanded package of contract programs would be comparatively limited. Depending on the partner medical schools and the nature of the contracts, relatively modest legal and travel expense might be incurred. If the WWAMI agreement were modified to serve the increased number of students in a new location, approximately $5 million in start-up funding for operations and $1 million for facility renovations could be needed.

A new joint medical school would face a similarly high requirement for start-up funding as a new distributive medical school. Depending of the availability of space at the three universities, the capital investment required might be lower than for developing a larger program at a single location. That is, any of the three universities would be more likely to be able to accommodate 30-35 additional students within existing facilities than it could 100. Moreover, coordination among the three universities would require extra operating expenditures for start-up.

Expansion of GME programs would probably require approximately $2 million in state support for start-up costs. Relatively little dedicated space would need to be developed with state dollars since the programs would be delivered in existing healthcare settings.

6.6 Annual Operating Support Required

The unit of measurement for assessing annual operating support requirements is the projected general fund revenue per student once the program reaches full enrollment capacity. For the purposes of this analysis, we consider the sum of required state appropriations and student tuition and fees.

The annual funding per student from state appropriations and tuition in a new state-supported medical school based on the distributive model is projected to be in the $65,000 - $85,000 range. This projection draws on the experience of established community-based medical schools, recently opened schools, and those that are in the advanced stages of planning. The overall amount of funding for operating support would likely grow in a stair-step fashion, with significant increments of new dollars being

required each time an increase in the entering cohort took place or a new community clinical campus began operation.

Each partner in the package of contract medical education programs has its own set of operating support requirements. The current rate for the University of Utah program is $54,717 per student per year, and the current rate for the WWAMI program is $66,112. Contracts with other medical schools would likely fall in the same price range. One advantage of contract programs is that the state investment can be scaled to a specific number of positions each year rather than involving a long-term commitment for a fixed production level.

The operating support requirements for a joint medical education program would likely be similar to those for a new distributive-model program at a single university. As noted earlier, the typical cost per student per year for these programs is in the $65,000 - $85,000 range. The costs of a joint program might be minimally higher due to additional costs of program coordination.

The funding to expand GME programs are based on the *net* cost per resident instead of the cost per medical student. Residents receive stipends and fringe benefits, and instructional costs (e.g., faculty and program administration) also are incurred. However, these costs are partially offset by revenue generated from the clinical services residents perform. The requirement for state support of the two residency programs based in Idaho averages approximately $32,000 per resident per year.

6.7 Economic Impact on State

The final criterion is based on our assessment of the relative level of positive impact that each alternative might have on the state economy. The economic impact might come from job growth directly related to the instructional program, from the ripple effect as spending by the additional students and employees enters the state economy, from the ability to attract federal and other out-of-state dollars for sponsored research, and eventually from the spin-off activities that would develop based on research results. Additional economic impact would come from the increased numbers of physicians practicing in the state, which has been projected to be in the $800,000 and above range.

The economic impact of a new state-supported medical school based at a single university would likely have the greatest impact of any of the three alternatives to expand access to M.D. training. Not only would most of the state and student dollars be expended in Idaho (either directly or through the ripple effect), but the potential to attract sponsored research dollars would be greatest if the basic scientists could benefit from the synergy of being located in proximity from one another. Unfortunately, schools using the distributive model for clinical training have not been as successful in attracting research support for clinical research as have major academic health science centers. Recent policy changes at the National Institutes of Health, however, are expected to result in a more equitable distribution in the coming years.

By contrast, an expanded package of contract medical education programs would probably have the least economic impact. Since a significant portion of the instruction would take place in other states, much of the faculty and student spending would also

take place outside of Idaho. Importantly, any research activity and spin-off business start-up would likely occur at the home campus of the partner institution. The WWAMI contract leads to more economic activity within Idaho than the University of Utah contract, but its economic impact still falls short of that which would be possible from an in-state medical school.

A new joint medical school should contribute about the same amount of direct and indirect in-state spending for the instructional program as would one based at a single university. Due to the inherent inability to develop large numbers of faculty researchers in a single location, the joint medical school would likely have less potential to attract external research funding.

Expanded GME programs would help keep the dollars spent on the healthcare needs of state residents in the state as the numbers and areas of specialization of the state's physicians developed. If the development of GME programs were closely coordinated with the development of a new in-state medical school, the GME faculty and residents would likely become much more active in research activity.

7.0 SUMMARY OF FINDINGS

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In response to the Idaho Legislature's directive to "engage the services of an external, independent consultant to undertake a comprehensive study of the feasibility and viability of offering a medical degree," the State Board of Education enlisted MGT of America, Inc., to assist in the analysis of various approaches to meet student demand for medical education and the state's need for physicians. This report has provided an overview of American medical education, described medical education resources available in the state, and presented comparative statistics on the state's needs for both increased student access to medical education and a larger physician workforce.

In this summary, we review potential state goals related to medical education, describe alternatives for expanding access and the criteria that we used to assess them, and summarize the advantages and disadvantages of the four most promising alternatives.

7.1 Findings Related to Need for Access

As documented in previous chapters, we analyzed both qualitative and quantitative data on the demand for physicians and medical education in Idaho in preparation for formulating potential state goals for medical access. In summary, evidence from these qualitative and quantitative analyses reveals that:

- Access to physicians and medical education is *extremely* limited in Idaho, as compared to the nation as a whole and selected state groups.
- Idaho ranks high in the number of physicians age 55 and over, suggesting that retirements over the next ten years will further reduce access to physicians at the same time that a national shortage of physicians occurs.
- The Idaho population base is sufficient to support the clinical components of a medical education program.
- Highly qualified Idahoans are applying to medical schools in greater numbers than are now served by contracted programs in other states.
- Idaho applicants have one of the lowest rates of entrance among students across the 50 states. Given the stronger than average academic qualifications of Idaho applicants, a likely interpretation is that Idaho students are pursuing too few seats in the region to have a high probability of admission.
- Nationally, Idaho ranks ahead of only one state in number of residency seats per capita or in the residency seats per first-year medical school seat. The lack of opportunity for graduate medical education (GME) in Idaho is even more evident when one considers the limited range of core program offerings.
- A number of states less populous than Idaho have supported medical schools for many years, and Idaho is the most populous state without its own medical school.

- Although healthcare is becoming an increasingly important component of the national economy, it is relatively underrepresented in the Idaho gross state product. It appears that a disproportionate share of spending on healthcare is leaving the state rather than being retained in Idaho to help build the state economy.

- With its limited investment in medical education, Idaho is ill-prepared to compete for its share of the rapidly expanding biomedical industry.

7.2 Review of Numeric Goals

Based on our analysis of qualitative and quantitative data, we recommend that Idaho's leaders consider establishing state goals for its:

- Physician workforce.
- Sponsorship of medical school students.
- Sponsorship of medical residents.

Based on an extensive analysis of trends in Idaho's population and comparisons of medical school seats, GME seats, and physicians per capita across the 50 states, we suggest the following goals for consideration:

- Idaho should seek to increase its physician workforce to reach the median of the 50 states. As the state's population ages, the current physician shortage will become even more acute. At recent population and workforce levels, achieving this goal would require a 42 percent increase in the number of physicians. Projected population growth would require additional new physicians to maintain the median rate per capita.

- Idaho should provide medical education opportunities that are adequate to fill two-thirds of the expected vacancies in the physician workforce each year, with the balance being recruited from an increasingly tight national market. Once the workforce reaches the national median, accomplishment of this goal will require support for 80-100 new medical students each year as the state's population continues to increase. This number of medical school seats not only would be aligned with physician workforce needs, but also would provide opportunities for talented Idaho students who are now excluded from medical education.

- Idaho should provide GME (i.e., residency) opportunities at a level commensurate with its support of physician graduates. Otherwise, the state's investment in medical education will be placed at risk as graduates go to other states for residency training with no guarantee that they will return. Support for 80-100 new residency slots will be required each year to achieve this goal.

We recognize that these goals are aggressive and represent significant increases over current levels. Even if state leaders determine lesser goals are more appropriate, we believe the adoption of goals is a critical step in measuring progress toward achieving desired levels of student and physician access in a rapidly growing state.

7.3 Review of Criteria and Alternatives

A number of potential alternatives for expanding access to medical education were considered, and four were evaluated in greater depth:

- ***Establishment of a new, university-operated medical school based on the distributive model of medical education.*** This approach assumes that a single state university would be assigned responsibility to develop a new medical education program that would enroll 80-100 students per class. Students would take introductory courses on the university campus for the first two years of the curriculum and would then be distributed to several clinical training sites across the state for clerkships during the third and fourth years.

- ***Expansion of the package of contract programs with medical schools in other states.*** This approach is an expansion of the current contracts with the WWAMI program of the University of Washington and the medical school at the University of Utah. The current number of seats per year for program entrants would increase from 28 to 60. Contracts with additional medical schools would likely be necessary to handle the increased number of students.

- ***Development of a new joint medical school from current medical education resources.*** This approach would draw on the medical education resources of the three state universities which would work cooperatively to create a new medical education program. Under this model, 80-100 new students per year would be admitted. Other than the cooperative governance arrangement and the offering of the first two years of the curriculum in multiple locations, the resulting medical education program would be similar to the distributive model described as the first alternative.

- ***Expansion of graduate medical education programs based in the state.*** This approach should be considered regardless of the alternative selected to serve undergraduate medical (M.D.) students. It calls for the state to support the establishment of residency programs across 5-10 of the medical specialties in greatest demand in the state and to sponsor 80-100 new residents per year in these and the existing programs. The residency programs should be integrated closely with the selected alternative for medical school training.

To provide a structured assessment of the four alternatives, we applied a series of seven criteria. The first two criteria relate directly to the ability of the alternative to have impact on state goals related to medical education:

1. ***Impact on Opportunity for Idaho Students*** – as measured by the potential number of first-year seats that could be made available in an accredited medical school to Idaho residents.

2. ***Impact on State Physician Workforce*** – as measured by the potential number of graduating physicians who would practice in the state, especially in areas of geographic shortage and in needed specialties.

The second two criteria address implementation challenges and, to some degree, consider the likelihood of success.

3. ***Challenges to Gaining Accreditation*** – as measured by the study team's insight into the likely challenges that a medical education program would encounter in gaining status to admit medical students.

4. ***Time Required for Full Implementation*** – as measured by the likely number of years that would be required for the medical education program to produce the planned number of graduates each year.

The final three criteria relate to financial concerns—both the cash outlays that would be required to fund the alternative and the economic benefits that would derive from its implementation.

5. ***Start-Up Investment Required*** – as measured by the expected dollar amount needed for facilities construction and renovation, major equipment, and costs of program development and ramp-up before full enrollment levels are reached.

6. ***Annual Operating Support Required*** – as measured by the combined amount of state appropriations and student tuition that would be required per student per year.

7. ***Economic Impact on State*** – as measured by the study team's assessment of the relative amount of economic activity that would occur in Idaho as a direct or indirect result of the expansion of medical education in the state.

7.4 Advantages and Disadvantages of Each Alternative

Through the establishment of a new, university-operated medical school based on the distributive model of medical education, Idaho would be able to meet a potential state goal of sponsoring 80-100 school students per class. Importantly, the state would gain the ability to implement admissions practices and to develop special curricular and support programs that would be designed to meet Idaho's physician workforce needs and to keep a higher proportion of state-funded students in the state to practice. No major accreditation issues would be expected, but the process of establishing a new medical school is relatively time consuming, and the program would not be fully implemented for 12-15 years. A new medical school, even using the distributive model, could be expected to require a significant start-up investment and to have reasonable demands for ongoing state appropriations and student tuition. A new medical school hosted by a single university would likely have the most favorable economic impact on the state through attracting private and federal research dollars and developing the healthcare infrastructure.

Expansion of the package of contracted programs with medical schools in other states would permit the state to support approximately 60 students per class, assuming the current WWAMI and University of Utah contracts could be expanded and at least one additional relationship be developed with another medical school. This strategy would

entail only minimal accreditation issues, be fastest to implement, involve $5-6 million in start-up investment, and require reasonable levels of state appropriations and student tuition to offset operating costs. The primary shortcoming of this strategy would be the difficulty of linking state investment in medical education to state workforce needs since it is often difficult to attract students back to Idaho after they train in other states and to implement educational experiences targeted at physician shortage areas. Further, this approach would likely result in the least economic growth for Idaho since a substantial portion of the state's investment would be expended in neighboring states.

A new joint medical school that would be developed from current medical education resources in the state's three universities could also meet the potential state goal of 80-100 entering seats per year. Moreover, it would help keep Idahoans in the state after they complete medical school and address the state's physician workforce needs since many students might not even need to leave their own regions of the state to attend college and then medical school. A joint medical education program would likely face the most difficulty in gaining accreditation and, as a result, require the longest time to implement fully. Due to the need to offer introductory courses in multiple locations, significant start-up investment should be expected, and the annual requirement for state appropriations and tuition support would also be somewhat greater than for a medical school hosted by a single university. Finally, the dispersed nature of the delivery model would make it more difficult to assemble a core of faculty sufficient to attract large research grants.

While the expansion of Idaho GME programs would make little direct contribution to any state goal regarding medical school seats, this strategy would have the most favorable impact on the size and composition of the state's physician workforce. Accreditation issues would be unlikely, and the time to implement the programs and see results would be the shortest among the four alternatives. The expansion of residency training programs would entail relatively minimal start-up investment (perhaps $2 million per program area) since current healthcare facilities would serve as the primary training sites. The requirement for state appropriations to offset program operating costs would be modest, due to clinical income generated by the residents and the potential for reimbursement from Medicare and other sources. Expanded GME programs would help build the healthcare infrastructure of Idaho and retain a greater portion of current healthcare spending in the state.

Exhibit 7-1 presents a summary comparison of the key features of the current and potential approaches to medical education.

EXHIBIT 7-1
SUMMARY COMPARISON OF CURRENT AND ALTERNATIVE MODELS OF MEDICAL EDUCATION

Characteristic	Current Programs	New Distributive Model	Expanded Medical Education Contract Programs	New Joint Medical School	Expanded Graduate Medical Education Programs
M.D. Programs					
Number of Students per Class Supported	20	80-100	60	80-100	n.a.
Total Number of Medical Students Supported	74-80	320-400	240	320-400	n.a.
Annual Appropriations and Tuition	$53-$70K per student per year	$65-85K per student per year	$65-70K per student per year	$65-85K per student per year	n.a.
Start-Up Operating Support	n.a.	$10-20 million	$5 million	$10-20 million	n.a.
Start-Up Capital Investment	n.a.	$60-75 million	$1 million	$60-75 million	n.a.
GME Programs					
Number of 1st-Year Medical Residents Supported	17	n.a.	n.a.	n.a.	80-100
Total Number of Medical Residents Supported	49	n.a.	n.a.	n.a.	320-400
Annual Appropriations	$1.5 million	n.a.	n.a.	n.a.	$10-12 million
Start-Up Investment	n.a.	n.a.	n.a.	n.a.	$8-10 million
Access to Physicians					
Impact on State Physician Workforce	Less Than Half Graduates Return	Greater Impact	Similar to Current Impact	Greater Impact	Greatest Impact
Economic Impact					
Potential Growth in State Economy	Minimal Current Impact	Greatest Impact	Least Impact	Greater Impact	Greatest if Integrated with M.D. Program

Note: GME program expansion should be considered in concert with M.D. program expansion.

7.5 Observations on Optimizing Each Alternative

In order to assess each of the alternatives, we needed to make certain assumptions about how the program would operate. These assumptions were based on how similar programs in Idaho and elsewhere currently operate and on interviews with state leaders and medical educators who are familiar with potential program activities.

The potential number of variations within each alternative is infinite. Each alternative, as described, represents a relatively straightforward approach to implementing the model with few optional features. Each one, however, might be made more attractive from Idaho's perspective through changes in the current or planned program delivery model once the state determines its desired course of action.

Should the state choose to pursue a new medical education program to be hosted by a single university, the selected university should work with WWAMI officials to develop a long-term contractual and financial relationship whereby the new program could be supported by the resources of the University of Washington (UW). Idaho has made a significant investment in the WWAMI program over the years, and the UW school of medicine is highly regarded. To the extent possible, Idaho and the new program should continue to capitalize on this relationship.

If the further expansion of contracted programs is to be pursued, Idaho should negotiate for its leaders to play a greater role in admissions and programming decisions, including further expansion of the third- and fourth-year clerkships available in the state. Furthermore, Idaho should consider providing more incentives for graduates of the contracted programs to return to practice in the state.

Should the state opt for a new joint medical education program to be offered cooperatively by the three state universities, one university should somehow be made the first among equals in order to provide strong leadership for the program and the efficient administration of program-wide functions. Additionally, the universities should work with the University of Washington School of Medicine to develop a long-term contractual and financial relationship, as discussed above.

While any approach to expanding GME in Idaho would likely be beneficial, the new and expanded residency programs should be developed in tandem with plans to expand medical school access. An integrated approach to undergraduate medical education and resident training will result in stronger training sites, be more efficient, and contribute to research competitiveness and, in turn, economic development.

APPENDIX:

KEY MEMBERS OF MEDICAL EDUCATION STUDY TEAM

APPENDIX
KEY MEMBERS OF MEDICAL EDUCATION STUDY TEAM

J. Kent Caruthers, Ed.D., Project Director. Dr. Caruthers is director of MGT's higher education practice and has a distinguished career in college and university planning and financial analysis. He has directed or played a key role in medical school feasibility studies in four other states. Dr. Caruthers also has an extensive background in state-level higher education and policy analysis. He holds his bachelor's and master's degrees in finance and his doctorate in higher education administration.

Nancy Stepina-Robison. Ms. Robison is a partner in MGT's higher education practice. She joined MGT after serving as vice chancellor for the Florida Board of Regents. During her tenure with MGT, she has served numerous clients, including roles as director for our medical education projects with the University of Central Florida and North Broward Hospital District and as a senior member of the project teams for Florida State University, Carilion Health System and the Synergy Medical Education Alliance.

Cynthia Balogh, Ph.D. Dr. Balogh is a partner in MGT's higher education practice and has a broad knowledge of planning, budgeting, and public policy issues. Prior to joining MGT, she dealt with a multitude of higher education related issues for the state of Florida including health professions education programs, workforce preparation, and economic development. At MGT, she has served on medical education projects for the University of Connecticut and Florida State University. Her Ph.D. is in Higher Education.

Myra Hurt, Ph.D. Dr. Hurt is currently associate dean of the college of medicine at Florida State University, after serving as the interim founding dean for more than a year when the college was first established. During her tenure with the FSU college of medicine and its predecessor, the joint UF-FSU Program in Medical Sciences, Dr. Hurt has been responsible for the basic science and clinical curriculum for first-year medical students, admissions, research administration, and outreach for underserved populations.

Carlos Martini, M.D. An independent consultant, Dr. Martini was formerly was the vice president for medical education at the American Medical Association where he was responsible for medical school accreditation. He is currently assisting the University of California, Merced on its medical school initiative. He previously directed the efforts of Florida International University in gaining approval for a new medical school and was the founder/developer of medical schools in Saudi Arabia, Argentina, Uruguay and England.

Leela Hebbar. Ms. Hebbar is a consultant in MGT's higher education practice. She has served on numerous project teams with an emphasis on program planning for workforce needs. Her project assignments include those related growth in the healthcare workforce, minority participation in the healthcare workforce, planning for a new medical school in California, and examining the feasibility of a new higher education center in rural Minnesota. She holds a master's in economics from Rutgers.

Leah Ewing Ross, Ph.D. Dr. Ross is a consultant in MGT's higher education practice. She has worked in a variety of education settings, including private colleges, state universities, and a national higher education association, and has extensive writing and editing experience. In addition, she recently completed studies of the American graduate student experience and of college presidential leadership. Dr. Ross earned her Ph.D. in Educational Leadership and Policy Studies at Iowa State University.

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REFERENCE – APPLICABLE STATUTE, RULE OR POLICY

IN THE SENATE

SENATE BILL NO. 1210

BY FINANCE COMMITTEE

AN ACT

APPROPRIATING MONEYS FROM THE IDAHO MILLENNIUM INCOME FUND AND DIRECTING THE STATE CONTROLLER TO TRANSFER MONEYS FOR THE PURPOSES AND PROGRAMS SPECIFIED FOR FISCAL YEAR 2008; APPROPRIATING MONEYS FROM THE IDAHO MILLENNIUM INCOME FUND TO THE STATE TREASURER FOR THE PURPOSES AND PROGRAMS SPECIFIED FOR FISCAL YEAR 2008; CLARIFYING THE USE OF FUNDS PROVIDED TO THE STATE BOARD OF EDUCATION FOR A MEDICAL EDUCATION STUDY; AND PROVIDING THAT CERTAIN UNEXPENDED AND UNENCUMBERED MONEYS SHALL BE REVERTED TO THE IDAHO MILLENNIUM INCOME FUND.

Be It Enacted by the Legislature of the State of Idaho:

SECTION 1. There is hereby appropriated and the State Controller is hereby directed to make cash transfers from the Idaho Millennium Income Fund to the following programs, at the request of the State Treasurer, not to exceed $2,230,700 for the period July 1, 2007, through June 30, 2008:

(a) $500,000 for the Public Health Districts to continue tobacco use cessation programs statewide through the Public Health Districts of Idaho and other nonprofit entities such as hospitals, primary care clinics and voluntary organizations. The tobacco use cessation programs should be available to any Idaho citizen, with primary emphasis on youth and pregnant women.

(b) $500,000 for the Physical Health Services Program in the Department of Health and Welfare for targeted tobacco counter-marketing programs, specific to Idaho, and to be matched by private industry funds on at least a one-to-one basis.

(c) $420,000 for the Idaho Supreme Court for its youth courts and status offender services programs as they relate to addressing tobacco and/or substance abuse issues.

(d) $94,000 for Law Enforcement Programs in the Idaho State Police to offset the cost of youth tobacco investigations.

(e) $300,000 for the State Board of Education for a medical education study to determine the need and feasibility of increased medical education opportunities in Idaho.

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INSTITUTION/AGENCY AGENDA
BOISE STATE UNIVERSITY

SUBJECT

Boise State University requests approval to proceed with the planning and design of an aquatics addition to the Student Recreation Center for an amount not to exceed $800,000

REFERENCE

April 1996	Board approves request for graduated recreation facility fee for future construction of a Student Recreation Center.
March 1998	Board approves request for construction of Student Recreation Center.

APPLICABLE STATUTE, RULE OR POLICY

Idaho State Board of Education Governing Policies & Procedures, Section V.K.2

BACKGROUND

In 1996, Boise State University's student body leadership initiated a recreation facility fee to support construction of a new Student Recreation Center ("Rec Center"). Original design plans for the Rec Center included an aquatics complex. However, because of cost increases and problems with construction, the University elected to delay construction of the aquatics complex until sufficient recreation facility fees could be accumulated to fund the project. Accordingly, design plans for the Rec Center were modified to accommodate the addition of an aquatics complex at a future date.

In January of 2007, Boise State University initiated a feasibility study to examine a series of options for constructing an aquatics complex connected to the current Rec Center. The study process involved a planning team with broad representation from all areas of the campus community. Outside architects and consultants were retained to conduct a comprehensive assessment of campus aquatics needs. Once compiled, these needs were translated into a program of proposed facilities, alternative concept designs and cost estimates for the various options. The University used this information to evaluate its options and determine the most appropriate course of action.

Five (5) alternative concepts were developed, each addressing different aspects of the desired aquatics program. Cost estimates were developed for each of the concept schemes. After reviewing all of the needs expressed in the programming process, the planning team selected the option (referenced as Option 2B, Version 2) that best addresses the program needs in light of the available funding. This option will serve as the basis for a complete design to be undertaken by a consultant design team.

DISCUSSION

The proposed addition consists of a 17,000 square foot aquatics complex to be constructed on the south side of the existing Rec Center. As currently envisioned, the aquatics complex will include a 6-lane, 25 yard indoor lap pool, a 3,200 square foot indoor recreation pool with an adjacent spa, and associated support spaces. The project also includes the construction of new locker rooms to serve the aquatics complex and to alleviate the demand on locker rooms in the Rec Center. Locker facilities will include additional lavatories and showers. As planning proceeds, the University will also consider the feasibility of increasing the lap pool to 8 lanes to provide practice space for the women's swimming team with funding provided by the athletics department.

IMPACT

The cost of planning and design of the aquatics addition is between $700,000 and $800,000. Total project costs, including construction costs, contingency, design and engineering fees, equipment costs, miscellaneous testing, surveying, and reports is estimated to be between $7,500,000 and $8,500,000. The range of costs relates to continued uncertainty in the current construction marketplace, especially for competitively bid public sector work. This estimate also includes escalation costs for 18 months, the minimum duration for project approval and design. A project schedule is attached. The source of funds for this project is revenue bond fund reserves. A final budget will be presented to the Board when the project is brought for construction approval.

ATTACHMENTS

STAFF COMMENTS AND RECOMMENDATIONS

The bond reserves are from the $65 Rec Center fee of which a portion of the fee pays for the bonds already issued on the Center and a portion was set aside (into a reserve account) to save up for the Aquatics Complex that could not be built at the time, but was part of the original plan. The Aquatics Complex was delayed due to construction problems with the Rec Center that have since been settled and resolved. Staff recommends approval.

BOARD ACTION

A motion to approve the request of BSU to proceed with the planning and design of the aquatics complex addition to the Student Recreation Center for a cost not to exceed $800,000.

Moved by _____ Seconded by _____ Carried Yes _____ No _____

Office of the Idaho State Board of Education
Capital Project Tracking Sheet
Nov-07

History Narrative

Institution/Agency: Boise State University **Project:** Aquatics Complex addition to Student Recreation Center

Project Description: Planning and design of an aquatics complex addition to the existing Student Recreation Center. The proposed addition consists of a 6-lane, 25-yard indoor lap pool, a 3,200 square foot indoor recreation pool and spa, as well as locker rooms to serve the aquatics complex.

Project Use: Recreational swimming for students, faculty, and staff

Project Size: Approximately 17,000 square feet.

	Sources of Funds				Use of Funds			
	PBF	ISBA	Other *	Total Sources	Planning	Use of Funds Const	Other	Total Uses
Initial Cost of Project	$ -	$ -		$ -	$ 800,000	$ 6,000,000	$ 1,200,000	$ 8,000,000
Total Project Costs	$ -	$ -	$ -	$ -	$ 800,000	$ 6,000,000	$ 1,200,000	$ 8,000,000

			* Other Sources of Funds					
History of Funding:	PBF	ISBA	Institutional Funds	Student Revenue	Other	Total Other	Total Funding
Requested 12/2007	$ -	$ -			$ 800,000	$ 800,000	$ 800,000
						$ -	$ -
					-	-	-
Total	$ -	$ -	$ -	$ -	$ 800,000	$ 800,000	$ 800,000

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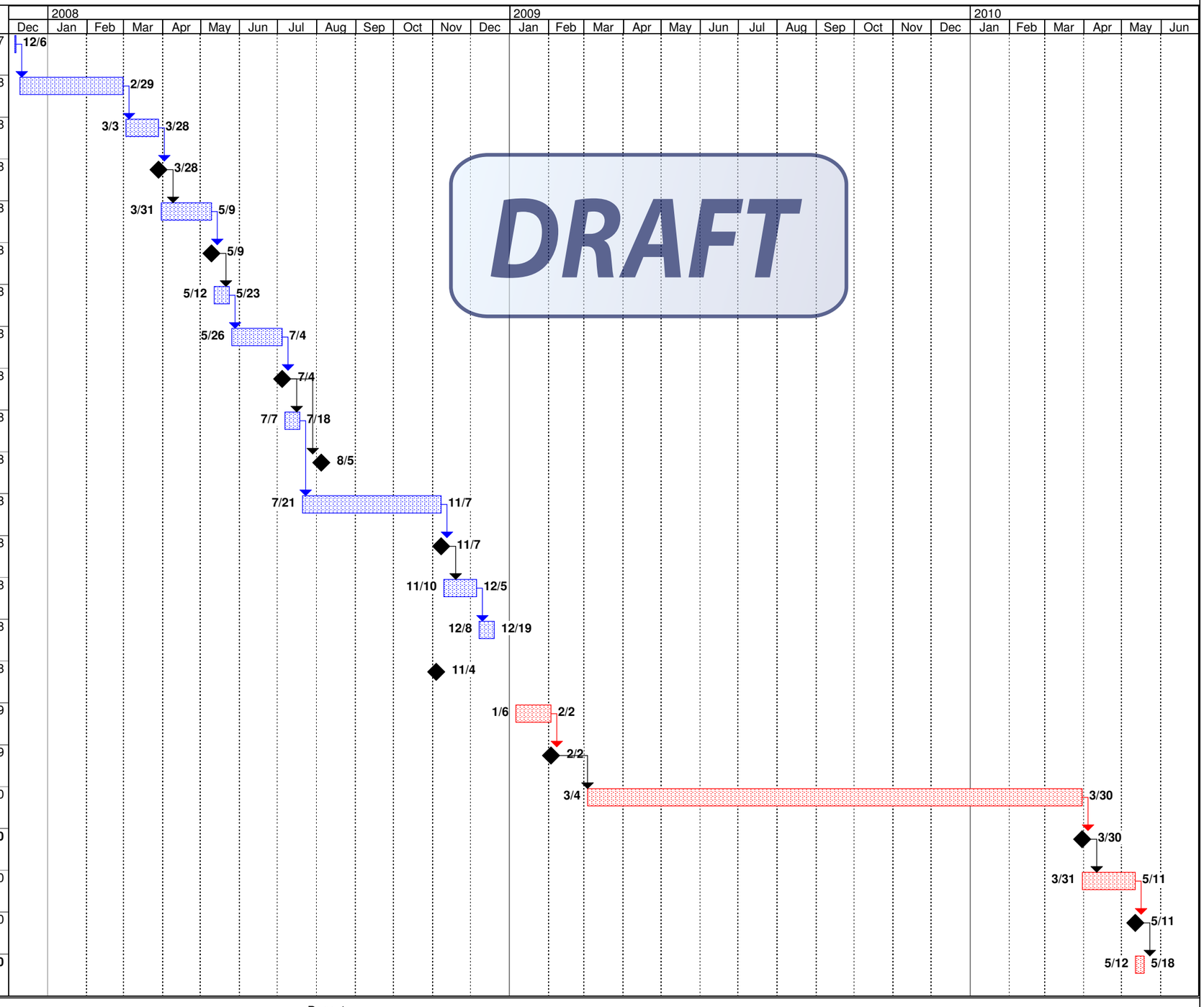
Aquatic Center, Student Recreation Center

October 8, 2007

Project Schedule

ID	Task Name	Duration	Start	Finish
1	SBOE Presentation and Approval	1 day	Thu 12/6/07	Thu 12/6/07
2	Consultant Selection & Contracting	12 wks	Mon 12/10/07	Fri 2/29/08
3	Programming	4 wks	Mon 3/3/08	Fri 3/28/08
4	Programming Review and Approval	0 days	Fri 3/28/08	Fri 3/28/08
5	Schematic Design	6 wks	Mon 3/31/08	Fri 5/9/08
6	Schematic Design Submittal	0 days	Fri 5/9/08	Fri 5/9/08
7	Schematic Design Review	2 wks	Mon 5/12/08	Fri 5/23/08
8	Design Development	6 wks	Mon 5/26/08	Fri 7/4/08
9	Design Development Submittal	0 days	Fri 7/4/08	Fri 7/4/08
10	Design Development Review	2 wks	Mon 7/7/08	Fri 7/18/08
11	PBFAC - DD Approval	0 days	Tue 8/5/08	Tue 8/5/08
12	Construction Documents	16 wks	Mon 7/21/08	Fri 11/7/08
13	Construction Document Submittal	0 days	Fri 11/7/08	Fri 11/7/08
14	Construction Document Review	4 wks	Mon 11/10/08	Fri 12/5/08
15	Consultant Comment Pickups	2 wks	Mon 12/8/08	Fri 12/19/08
16	PBFAC - Construction Approval	0 days	Tue 11/4/08	Tue 11/4/08
17	Bidding	4 wks	Tue 1/6/09	Mon 2/2/09
18	Bid Opening	0 days	Mon 2/2/09	Mon 2/2/09
19	Construction	56 wks	Wed 3/4/09	Tue 3/30/10
20	**Substantial Completion**	0 days	**Tue 3/30/10**	**Tue 3/30/10**
21	Punch List Items	6 wks	Wed 3/31/10	Tue 5/11/10
22	Furniture / Equipment Installation	0 wks	Tue 5/11/10	Tue 5/11/10
23	**Move-In**	1 wk	**Wed 5/12/10**	**Tue 5/18/10**



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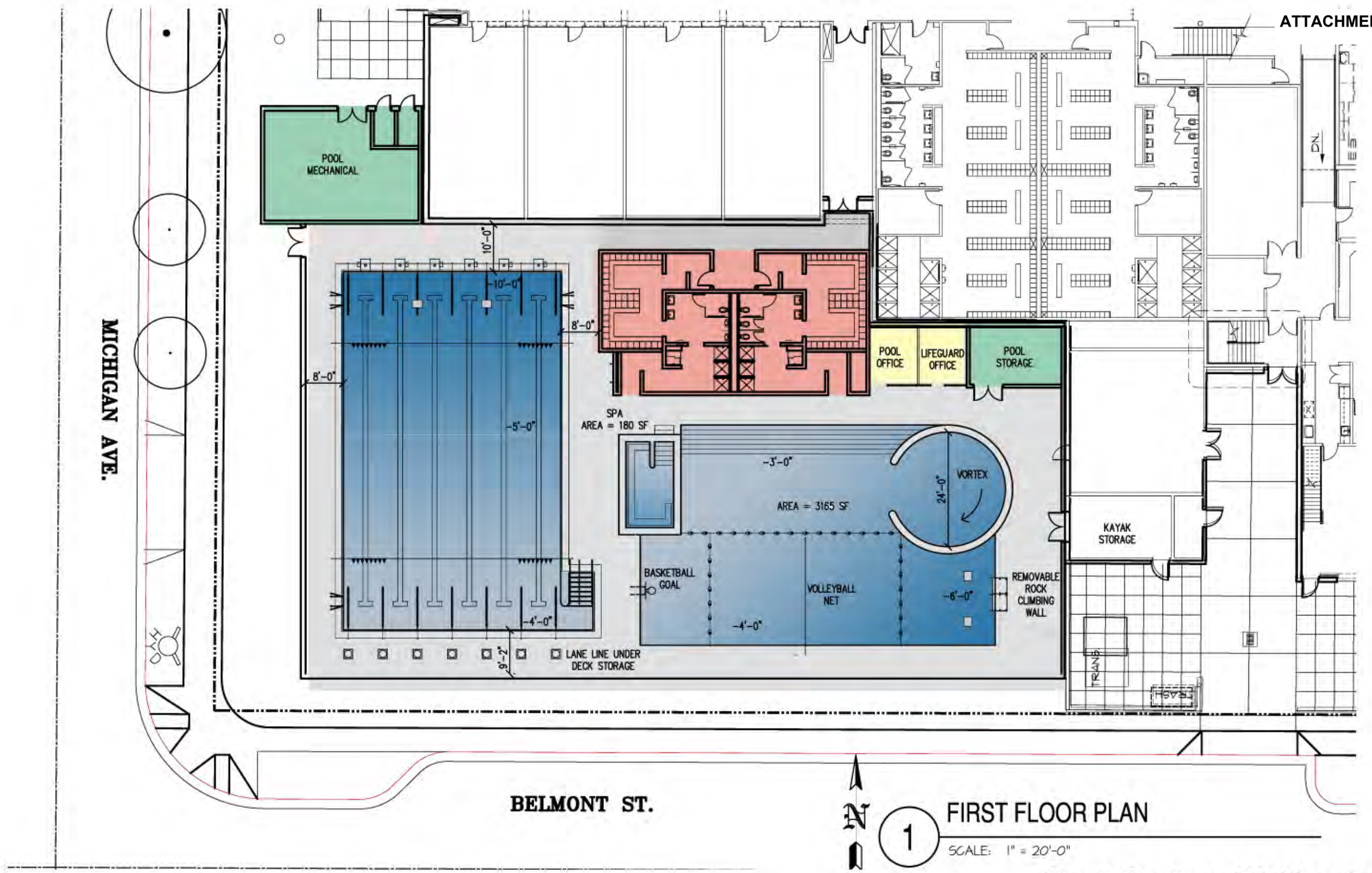

1 FIRST FLOOR PLAN

SCALE: 1" = 20'-0"

Pool Option 2B Version 2

Design Concepts

February 5, 2007

BOISE STATE UNIVERSITY

AQUATIC ADDITION STUDY

COUNSILMAN HUNSAKER *The Ultimate Aquatics Advantage*

SINK COMBS DETHLEFS ARCHITECTS

OPTION 2B – Version 2

Option 2B – Version 2 features an indoor lap pool with dimensions of approximately 75'-1 ½" x 45' with a minimum depth of 4 feet and a maximum depth of 10 feet. Six 7' - 0" wide lanes will be marked with black floor markers across the pool. An 18" deep rollout gutter system will be provided around the perimeter of the pool for recirculation of pool water. Wall targets and floor markers will be provided for a competitive race course. Race courses will have buffer lanes at the sides measuring at least 1'-0". Rope anchors will be provided in the pool for floating lane lines. Under deck storage containers will be provided for storage of the floating lane lines. A stair alcove system for easy entry and exit will also be provided. Equipment to be provided will include (not all inclusive): starting blocks, deck mounted water polo goals, movable guard stands, pace clocks, handicap lift, maintenance equipment, and safety equipment.

Option 2B – Version 2 features an indoor recreation pool that will be approximately 3,165 Sq Ft and have the following amenities: water volleyball, water basketball, rock climbing wall, vortex, and numerous social spaces. The pool will have a minimum depth of 3'-0" and a maximum depth of 6' - 0". A 12" deep deck level gutter system will be provided for recirculation of pool water. A large stair system will be provided. Equipment to be provided will include (not all inclusive): movable guard stands that are 42" tall, one handicap lift, maintenance equipment, and safety equipment. An emergency shut off switch will be provided near the pool to control the recirculation pump. The water temperature in this pool will be kept between 84-86 degrees.

Example Photo

Option 2B – Version 2 also features a spa that will be approximately 180 Sq Ft and accommodate approximately eighteen users. The spa will be 2'-8" deep. The spa will be raised approximately 18" above the deck level. Skimmers will be provided for recirculation of spa water. An emergency shut off switch and timer will be provided near the spa. The water temperature in the spa will be kept between 100-104 degrees.

REFERENCE – APPLICABLE STATUTE, RULE OR POLICY

Idaho State Board of Education
GOVERNING POLICIES AND PROCEDURES
SECTION: V. FINANCIAL AFFAIRS
Subsection: K. Construction Projects **April 2002**

K. Construction Projects

2. Project Approvals

Without regard to the source of funding, proposals by any institution, school or agency under the governance of the Board to make capital improvements, either in the form of renovation or addition to or demolition of existing facilities, when the cost of the project is estimated to be between two hundred fifty thousand dollars ($250,000) and five hundred thousand dollars ($500,000), must first be submitted to the executive director for review and approval. Without regard to the source of funding, proposals by any institution, school or agency under the governance of the Board to make capital improvements, either in the form of renovation or addition to or demolition of existing facilities or construction of new facilities, when the cost of the project is estimated to exceed five hundred thousand dollars ($500,000), must first be submitted to the Board for its review and approval. Project cost must be detailed by major category (construction cost, architecture fees, contingency funds, and other). When a project is under the primary supervision of the Board of Regents or the Board and its institutions, school or agencies, a separate budget line for architects, engineers, or construction managers and engineering services must be identified for the project cost. Budgets for maintenance, repair, and upkeep of existing facilities must be submitted for Board review and approval as a part of the annual operating budget of the institution, school or agency.

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INSTITUTION / AGENCY AGENDA
BOISE STATE UNIVERSITY

SUBJECT

Boise State University requests approval to replace the artificial turf in Bronco Stadium for a total cost not to exceed $750,000.

REFERENCE

October 2001	Board approved request to replace artificial turf for a cost not to exceed $800,000.

APPLICABLE STATUTE, RULE, OR POLICY

Idaho State Board of Education Governing Policies & Procedures, Section V.B.8.

BACKGROUND

Bronco Stadium was built in 1970 with an Astroturf surface. Weather, maintenance costs, and frequency of use played into the decision to install turf rather than a natural surface. While Astroturf is superior to a natural playing surface in many respects, it must be replaced, on average, every six to eight years. The Board last approved a request to replace the turf in October of 2001. Because installation can only be done during the off season, the turf was replaced in the summer of 2002. That turf now shows excessive wear in the heavy traffic areas near the center of the field. To ensure player safety, the existing turf should be replaced during the next off season, the summer of 2008.

DISCUSSION

Turf replacement is necessary to ensure that the institution is providing a high quality, safe playing surface for Division I-A football, post season bowl games, and local high school games and playoffs. The replacement turf is a mat of grass-like material made from high-tech plastics in-filled with small rubber granules to provide loft for the imitation grass blades while providing cushion to the playing surface. This type of turf is of the highest industry standard with respect to playing conditions and player safety.

The replacement project will also address the condition of the materials underlying the field. The existing “E-Layer” rubberized pad directly beneath the turf, and the asphalt layer below, will be evaluated and repaired or removed based on specifications and warranty requirements of the new turf being installed.

IMPACT

Estimated total project costs range from $600,000 to $750,000. This estimate includes the cost of removing the existing turf and will vary in range depending on the exact turf and field specifications. A formal bid process for the project will occur through the State Department of Administration, Division of Public Works.

Funding is available from the institution's Bond Fund reserve account. No appropriated funds will be used for this project.

STAFF COMMENTS AND RECOMMENDATIONS

Staff recommends approval.

BOARD ACTION

A motion to approve Boise State University's request to replace the artificial turf in Bronco Stadium for a cost not to exceed $750,000.

Moved by _____ Seconded by _____ Carried Yes _____ No _____

REFERENCE – APPLICABLE STATUTE, RULE OR POLICY

Idaho State Board of Education
GOVERNING POLICIES AND PROCEDURES
SECTION: V. FINANCIAL AFFAIRS
Subsection: B.Budget Policies **April 2002**

B. Budget Policies

8. Major Capital Improvement Project -- Budget Requests

For purposes of Item 8., the community colleges (NIC and CSI), the State Historical Society, and the State Library are included, except as noted in V.B.8.b. (2).

a. Definition
A major capital improvement is defined as the acquisition of an existing building, construction of a new building or an addition to an existing building, or a major renovation of an existing building. A major renovation provides for a substantial change to a building. The change may include a remodeled wing or floor of a building, or the remodeling of the majority of the building's net assignable square feet. An extensive upgrade of one (1) or more of the major building systems is generally considered to be a major renovation.

b. Preparation and Submission of Major Capital Improvement Requests

(1) Permanent Building Fund Requests
Requests for approval of major capital improvement projects to be funded from the Permanent Building Fund are to be submitted to the Office of the State Board of Education on a date and in a format established by the executive director. Only technical revisions may be made to the request for a given fiscal year after the Board has made its recommendation for that fiscal year. Technical revisions must be made prior to November 1.

(2) Other Requests
Requests for approval of major capital improvement projects from other fund sources are to be submitted in a format established by the executive director. Substantive and fiscal revisions to a requested project are resubmitted to the Board for approval. This subsection shall not apply to the community colleges.

c. Submission of Approved Major Capital Budget Requests
The Board is responsible for the submission of major capital budget requests for the institutions, school and agencies under this subsection to the Division of Public Works. Only those budget requests which have been formally approved by the Board will be submitted by the office to the executive and legislative branches.

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INSTITUTION / AGENCY AGENDA
BOISE STATE UNIVERSITY

SUBJECT

Boise State University requests authorization to redirect certain bond proceeds from the Series 2007A.

REFERENCE

October 2003	Approval to spend $450,000 to proceed with planning and design of an Environmental Science and Policy Center
October 2005	Board approved 2005 Campus Master Plan Update
June 2006	Approval of project planning, design and architectural services for a total project authorization of $1,680,000
January 2007	Authorization to Issue General Revenue Bonds, Series 2007A

APPLICABLE STATUTE, RULE OR POLICY

Idaho State Board of Education Governing Policies & Procedures, Section V.F.5.
Idaho Code Title 33, Chapter 38

BACKGROUND

In anticipation of building the Student Health, Wellness, Counseling and Nursing Building, Boise State University issued approximately $22,900,000 in General revenue Bonds in January of 2007 as Series 2007A.

As noted in the Norco Naming Request item in the Planning, Policy & Governmental Affairs Consent agenda, the University received donations for the project in addition to the bond funds. In order to comply with the donor's intent and with provisions of the IRS tax code regarding the tax-free nature of the University Bonds, the donations have been allocated to the Student Health, Wellness, Counseling and Nursing Building. The result is that the University has to reallocate approximately $3,000,000 of bond proceeds to another State Board of Education (SBOE) approved bond eligible project.

The only current capital project that has SBOE approval is the Center for Environmental Science and Economic Development (CESED). CESED was approved for planning and design by SBOE in October 2003 and June of 2006 under its previous title of Environmental Science and Policy Center.

Reallocations of Bond proceeds such as this occur periodically. In August 2006, SBOE approved the University's request for reallocation of bond proceeds from the Student Services Center to the new parking deck.

DISCUSSION

The University is requesting approval to allocate the remaining $3,000,000 in bond proceeds from the Series 2007A issuance to the CESED project. No funds will be expended until further SBOE approval is received to do so. This is only approval to allocate such funds to the project.

In order to make such an allocation, SBOE needs to find that the CESED project is a qualified project, meaning a finding under the Bond Act that the project is necessary for the proper operation of the University and is economically feasible.

Under the University's master bond resolution and the supplemental resolutions for the Series 2007A Bonds, bond proceeds may be reallocated to a different project subject to 1) the Board's designation of the new projects as a "project" under the Revenue Bond Act and 2) the reallocation of bond proceeds not having an adverse effect on the tax exempt status of the Series 2007A Bonds.

The motion below will satisfy point (1). The University has already obtained an opinion of bond counsel to satisfy point (2).

IMPACT

Redirecting the proceeds will allow the University to allocate those funds to the CESED project. If SBOE approves the project to proceed to construction phase, then the redirected proceeds can be used for the project. If SBOE does not approve the CESED project for eventual construction, SBOE can redirect the proceeds to a different project in the future.

ATTACHMENTS

STAFF COMMENTS AND RECOMMENDATIONS

According to the university, the building is estimated to cost between $35 and $42 million. The previous ten-year debt projection provided by BSU showed a cost of $35 million. $31 million of the cost will be financed using currently available debt capacity. The remainder will be from federal funds and anticipated state appropriation. In October 2007, the Permanent Building Fund Advisory Council recommended that the State provide $10 million funding in the 2008 session for this building. Therefore, BSU would not finalize the construction cost until after it is determined if the State funds are appropriated.

The CESED project was the number three priority in the University's 10-year debt projection in January 2007 after the Stadium Suites. The projection showed the project was economically feasible using the Strategic Facility Fee, and the projected debt service as a percentage of operating budget was under 8%.

Staff recommends approval.

BOARD ACTION

A motion that the Board finds that the Center for Environmental Science and Economic Development is a project that is necessary for the proper operation of the University and is economically feasible; and to authorize the allocation of $3,000,000 in bond proceeds from Series 2007A Bonds, and related interest earnings, originally allocated to the Student Health, Wellness, Counseling and Nursing Building to the Center for Environmental Science and Economic Development project.

Moved by _____ Seconded by _____ Carried Yes ____ No ____

[Roll call vote required.]

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CHAPMAN AND CUTLER LLP
MEMORANDUM

April 13, 2007

To: Stacy Pearson
Jo Ellen Dinucci
Kevin Satterlee

RE: Boise State University
General Revenue and Refunding Bonds, Series 2007A–
Nursing Building Naming Rights

We understand that you have recently become aware that, before the above-referenced bonds (the *"Bonds"*) were issued, Boise State University (the *"University"*) entered into a naming rights agreement (the *"Agreement"*) with respect to the nursing building that was financed with a portion of the Bond proceeds. The University entered into the Agreement with Norco in consideration for a $2 million donation. The Agreement requires the nursing building to be named after Norco (a private medical company), to include signage indicating the name, and to include a display area in the lobby or other prominent area for the purpose of displaying Norco products and advertising. The Agreement also requires the University to recognize the donation in various forms of media and provides certain other rights with respect to the building. Accordingly, the Agreement clearly gives rise to private use. Excluding the Agreement, the expected combined private use for the nursing building and the Student Union Building projects was 7.3% under the original allocation, which provided a cushion of approximately $1.5 million. Assuming that $2 million reflects the fair market value of the naming rights, the additional private use would, absent a reallocation, cause the total private use for the two projects to exceed the 10% limit under the tax rules.

We also understand that the University has received, or will receive, an additional $2.3 million of donations that were not previously included as equity in the private use analysis. Since the Bond proceeds have not been spent, the University can correct the situation (without having to redeem Bonds under the remedial action rules) by allocating the additional donations as equity to be used for the cost of the private use portion of the nursing building and reallocating an equivalent portion of the Bond proceeds to additional qualified projects. This conclusion is based on the following assumptions, adjustments and recommendations:

- The value of the naming rights does not exceed $2.8 million (such amount represents the maximum amount of the (i) additional $2.3 million of donations, plus (ii) the $500,000 donation that was previously allocated to public use costs of the nursing building that can be allocated to nursing building private use without affecting the original 7.3% private use percentage (we previously allocated the $500,000 to public use because the donation is restricted to use for the nursing building and we previously thought the nursing building would be 100% public use).

- The cost of space allocated to the Norco display area will not exceed $2.8 million or cause the value of the naming rights to exceed $2.8 million. (This assumption is

presumably easy to satisfy since, for example, a 100-square-foot display area would only cost approximately $37,000 based on a total project cost of $26.1 million and total square footage of 70,000.)

• Because the Supplemental Resolution specifies the projects on which the Bond proceeds may be spent, the University should obtain SBOE approval of $2.8 million of additional qualified projects (*i.e.*, projects, or portions thereof, that are 100% public use). Since the University will need the SBOE to adopt a Supplemental Resolution in connection with the Series 2008 Bonds in any case, approval of the additional projects could easily be included in the Supplemental Resolution in order to avoid the need for a special resolution. The University could reduce the amount of 2008 Bonds to reflect the additional $2.8 million of available Bond proceeds. Alternatively, the University could obtain special approval for the additional projects outside the context of the Series 2008 Bonds.

The net result would be that the same percentage of Bond proceeds (7.3%) would be used for private use as under the original allocation. A revised copy of the first page of the private use allocation based on these assumptions is enclosed.

Please do not hesitate to call me or Jim with any questions you may have.

REFERENCE – APPLICABLE STATUTE, RULE OR POLICY

Idaho State Board of Education
GOVERNING POLICIES AND PROCEDURES
SECTION: V. FINANCIAL AFFAIRS
Subsection: F. Bonds and Other Indebtedness **April 2002**

F. Bonds and Other Indebtedness

5. Expenditure of Excess Revenue

Expenditure of project revenues over and above that pledged or otherwise encumbered to meet the indebtedness is limited to expenditures for projects identified in the bond's Official Statement. Expenditure of excess revenue for other projects requires prior Board approval. Expenditures between two hundred fifty thousand dollars ($250,000) and five hundred thousand dollars ($500,000) require prior approval from the executive director and expenditures greater than five hundred thousand dollars ($500,000) require prior Board approval.

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REFERENCE – APPLICABLE STATUTE, RULE OR POLICY – continued

Idaho Statutes
TITLE 33
EDUCATION
CHAPTER 38
STATE INSTITUTIONS OF HIGHER EDUCATION BOND ACT

33-3805. Authorization, issuance, maturity, interest and sale of bonds. When the board shall find the proposed project or projects to be necessary for the proper operation of the institution and economically feasible and such finding is recorded in its minutes, the bonds therefore shall be authorized by resolution of the board. The bonds may be issued in one or more series, may bear such date or dates, may be in such denomination or denominations, may mature at such time or times, not exceeding forty (40) years from the respective dates thereof, may mature in such amount or amounts, may bear interest, at such rate or rates to be determined by the board, may be in such form, either coupon or registered, may carry such registration and such conversion privileges, may be executed in such manner, may be payable in such medium of payment, at such place or places, may be subject to such terms of redemption, with or without premium, as such resolution or other resolutions may provide. The bonds may be sold at a public or private sale at not less than par and accrued interest, in a manner to be provided by the board. The bonds shall be fully negotiable within the meaning and for all purposes of the Uniform Commercial Code.

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INSTITUTION / AGENCY AGENDA
BOISE STATE UNIVERSITY

SUBJECT

Boise State University requests approval to enter into a contract to purchase a Nuclear Magnetic Resonance spectrometer upon completion of the solicitation process for an amount not to exceed $836,000.

APPLICABLE STATUE, RULE, OR POLICY

Idaho State Board of Education Governing Policies & Procedures, Section V.I.3.

BACKGROUND

Nuclear Magnetic Resonance (NMR) spectroscopy is an essential tool for determining the structures of molecules and materials, examining the folding and intramolecular interactions of biomolecules, and evaluating the intermolecular interactions of two or more compounds. NMR spectroscopy is widely used for applications that range from characterizing synthesized compounds and materials to solving the three dimensional structures of proteins and other macromolecules. Accordingly, NMR instrumentation has become fundamental to research in the disciplines of chemistry, molecular biology, materials science, polymer science, and engineering. At Boise State University (BSU), there are currently twelve faculty members in four different departments who have used or are using NMR spectroscopy as part of their research programs.

DISCUSSION

The use of NMR spectroscopy at BSU is foundational to several research projects dealing with organic synthesis, materials development, polymer chemistry, and protein structure/function studies. The sophistication and quantity of such research is experiencing enormous growth at BSU due to the overall growth in research and the receipt of infrastructural grants, including the Idaho INBRE from the NIH.

This instrument will support students in emerging and existing Bachelors, Masters, and Ph.D. programs at BSU in Chemistry, Biology, Biomolecular, Physics, Electrical and Computer Engineering, and Materials Science Engineering. In addition, there is a growing need for faculty at BSU to foster ties with the industrial community. This instrument exceeds the capabilities of any other in the state and can benefit researchers at Micron Technologies, Boise Technologies Inc., VA Medical Center, and Idaho National Laboratory to name a few. Thus, the new NMR spectrometer will provide training to undergraduate and graduate students, facilitate collaboration with local industry, and assist Boise State faculty in becoming more competitive at securing external funding for projects of increased quality and scope.

IMPACT

Upon approval, the Department of Purchasing will initiate the solicitation process for the NMR spectrometer. The primary funding source for the spectrometer is a National Science Foundation grant of $500,000. Other funding sources include a $10,000 ESPCoR Grant and $326,000 of institutional funds.

STAFF COMMENTS AND RECOMMENDATIONS

This purchase will use grant and institutional funds. Staff recommends approval.

BOARD ACTION

A motion to authorize Boise State University to enter into a contract to purchase an NMR spectrometer for an amount not to exceed $836,000.

Moved by _____ Seconded by _____ Carried Yes ____ No ____

REFERENCE – APPLICABLE STATUTE, RULE OR POLICY

Idaho State Board of Education
GOVERNING POLICIES AND PROCEDURES
SECTION: V. FINANCIAL AFFAIRS
Subsection: I. Real and Personal Property and Services April 2002

I. Real and Personal Property and Services

3. Acquisition of Personal Property and Services

   a. Purchases of equipment, data processing software and equipment, and all contracts for consulting or professional services either in total or through time purchase or other financing agreements, between two hundred fifty thousand dollars ($250,000) and five hundred thousand dollars ($500,000) require prior approval by the executive director. The executive director must be expressly advised when the recommended bid is other than the lowest qualified bid. Purchases exceeding five hundred thousand dollars ($500,000) require prior Board approval.

   b. Acquisition or development of new administrative software or systems that materially affect the administrative operations of the institution by adding new services must be reviewed with the executive director before beginning development. When feasible, such development will be undertaken as a joint endeavor by the four institutions and with overall coordination by the Office of the State Board of Education.

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INSTITUTION / AGENCY AGENDA
BOISE STATE UNIVERSITY

SUBJECT

Boise State University requests approval to enter into a contract to purchase an x-ray photoelectron spectrometer for an amount not to exceed $564,000

APPLICABLE STATUE, RULE, OR POLICY

Idaho State Board of Education Governing Policies & Procedures, Section V.I.3.

BACKGROUND

An x-ray photoelectron spectrometer (XPS) is a highly sensitive elemental analysis tool with the capacity to determine the chemical/oxidation states of elements, chemical bonding, and diffusion of atoms and ions. Several Boise State University researchers who use this equipment must travel to centers with this technology to support their research in highly promising areas of spintronics, semiconductors, nanotechnology, ceramic oxides, polymers, magnetic materials, nano-biotechnology and nanomedicine.

Some of the crucial problems that require the use of the XPS include (1) determination of the oxidation state and concentrations of doped transition metals ions and their surface diffusion in magnetic semiconductors; (2) characterization of the interfaces of materials during processing, coating deposition, and interfacial reactions during oxidation and corrosion; (3) mechanism of sensing reactive gases magnetically using antiferromagnetic oxides; (4) chemical and physical phenomena at the polymer-biomolecule interface; (5) development of novel nanosensors, antibacterial agents and nanomedicinal applications using the size-dependent properties of nanoparticles; (6) surface characterization of the biomolecular nanowires/nanosensors; (7) dopant states of titania electrodes in dye-sensitized solar cell; (8) dopants, defects and ion diffusion in pure and doped chalcopyrite materials and devices; and (9) characterization of conductive polymer surfaces of chemical sensors.

DISCUSSION

XPS is a technique covered in several graduate and undergraduate courses offered at BSU and its availability will allow efficient integration of research and education through hands-on student training. Availability of this technology at the University will strengthen developing PhD programs and enhance active research and training collaborations with numerous microelectronic companies, including Micron Technology and Hewlett Packard, and bio-medical centers, such as the Veteran's Affairs Medical Center and Mountain State Tumor Research Institute. Furthermore, because there is no multi-user XPS facility in the Pacific Northwest, researchers from Idaho State University (ISU), University of Idaho (UI), Northwest Nazarene University (NNU) and Washington State University (WSU) have expressed interest in collaborated research using the XPS.

IMPACT

Upon Board approval, the Department of Purchasing will initiate the formal solicitation process for BSU. The source of funds is a National Science Foundation grant. In accordance with the terms of the grant, the maximum cost of the equipment cannot exceed $564,000. Outside institutions who wish to use the XPS will pay a fee commensurate with their level of use.

STAFF COMMENTS AND RECOMMENDATIONS

This purchase will use grant funds. Staff recommends approval.

BOARD ACTION

A motion to authorize Boise State University to enter into a contract to purchase an x-ray photoelectron spectrometer for an amount not to exceed $564,000.

Moved by _____ Seconded by _____ Carried Yes ____ No ____

REFERENCE – APPLICABLE STATUTE, RULE OR POLICY

Idaho State Board of Education
GOVERNING POLICIES AND PROCEDURES
SECTION: V. FINANCIAL AFFAIRS
Subsection: I. Real and Personal Property and Services April 2002

I. Real and Personal Property and Services

3. Acquisition of Personal Property and Services

   a. Purchases of equipment, data processing software and equipment, and all contracts for consulting or professional services either in total or through time purchase or other financing agreements, between two hundred fifty thousand dollars ($250,000) and five hundred thousand dollars ($500,000) require prior approval by the executive director. The executive director must be expressly advised when the recommended bid is other than the lowest qualified bid. Purchases exceeding five hundred thousand dollars ($500,000) require prior Board approval.

   b. Acquisition or development of new administrative software or systems that materially affect the administrative operations of the institution by adding new services must be reviewed with the executive director before beginning development. When feasible, such development will be undertaken as a joint endeavor by the four institutions and with overall coordination by the Office of the State Board of Education.

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INSTITUTION / AGENCY AGENDA
UNIVERSITY OF IDAHO

SUBJECT

Capital Project Design Phase Authorization Request, Kibbie Dome Life Safety Improvements

REFERENCE

First hearing for Capital Project Design Phase Authorization

August 2006	Information Item, Technical Assessment & Feasibility Study, Proposed University of Idaho Events Pavilion and ASUI Kibbie Activity Center Improvements.
November 2006	Discussion, Replace Artificial Turf, ASUI Kibbie Activity Center
February 2007	Information Item, UPDATE: Technical Assessment & Feasibility Study, Proposed UI Events Pavilion and ASUI Kibbie Activity Center Improvements. Notification of the Immediate Code Compliance, Guest and Participant Safety Issues Documented in the Technical Assessment & Feasibility Study.
April 2007	Capital Project Authorization, Replace Artificial Turf, ASUI Kibbie Activity Center

APPLICABLE STATUTE, RULE, OR POLICY

Idaho State Board of Education Governing Policies & Procedures, Section V.K.1

BACKGROUND

In 2006, the University initiated a Technical Assessment & Feasibility Study of a proposed Events Pavilion and of the ASUI Kibbie Activity Center (KAC). A team of consultants headed by Opsis Architecture and Hastings-Chivetta conducted a technical evaluation of the facility and identified a series of life safety improvements necessary for the KAC.

One safety improvement authorized by the Board in April 2007, and subsequently completed, was the installation of a new turf play surface in the KAC. Further improvements are needed to address the collection of code deficiencies identified in the report.

A further series of needed renovations identified as part of the technical evaluation will serve to significantly improve the 35 year old facility, enhancing the functionality and seating capacity of the facility, and improving spectator

comfort and revenue through concession and seating upgrades and expansions. These non-life safety renovations are the subject of a companion Board agenda item, presented separately.

DISCUSSION

Project Description

Life safety improvements to be implemented include replacement of the two timber end-walls, installation of a smoke exhaust system, expansion of the fire sprinkler and alarm system, enhanced exiting, and improvements to the air handling and electrical distribution systems. Code compliance improvements are also included for the north and south concourse restrooms. The life safety project costs are estimated in the range of $16M to $17M, subject to refinement and improvement in the course of project design and development. This element of the project is slated to be funded through a general revenue UI bond issue in 2008 as part of the University's strategic long term debt plan.

This project directly supports the University's Strategic Plan and its education and outreach goals. It is fully consistent with the Uiversity's Long Range Campus Development Plan (LRCDP), and the Campus Infrastructure Master Plan. The KAC is an iconic structure which serves a wide variety of campus and community needs, supporting general education, recreational, athletic, and community events. It also serves as a staging and response center in regional emergencies.

Project Design

The design phase for the life safety element is anticipated to cost approximately $2,000,000 and will be developed over the course of 2008. The University intends to initially fund the design effort through an internal loan, with intent to repay the self-funded loan once the bond sale is executed. The internal loan will come from existing UI resources in the plant fund reserve accounts. The loan funds are available as the result of the bond refunding approved by the Board in October 2007 which will result in a debt service savings for FY 2008 of approximately $2,000,000.

The University seeks Board authorization for the design phase at a value of up to $2000,000 for the life safety element. The University will proceed with design of the life safety element immediately, using the internal loan.

Project Implementation

The life safety improvements could potentially be implemented as a single project with the non-life safety renovations, or could be carried out separately, depending on the timing and availability of private funding. This holds true for both the design and construction phases of the project. The University intends to proceed with correction of the life safety needs, fully funded through the bond

measure, regardless of our success in private fundraising in support of the non-life safety renovations.

The tentative design and construction timeline for the life safety element is as follows:

Milestone	Date
SBOE Authorization for $2M Design Phase for Life Safety Improvements	Dec, 2007
Initiate RFQ and design process	Dec, 2007
Complete construction bid package	Dec, 2008
SBOE Authorization for $17M Bonding and Construction Contract	Dec, 2008
Initiate Bid and Construction process	Dec, 2008
Construction complete	Dec, 2009

The projected timeline for life safety improvements is tentative and subject to change as the project is better defined through the design process. A revised set of milestones will be reviewed with the Board prior to authorization of the construction phase for life safety needs.

IMPACT

Funding		**Estimate Budget**	
State	$ 0	Construction	$ 0
Federal (Grant):	$ 0	A/E & Consultant Fees	$ 2,000,000
Other (UI/Bond)	$ 2,000,000	Contingency	$ 0
Private	$ 0		
Total	$ 2,000,000	Total	$ 2,000,000

UI will pay for the design phase using debt service savings from the 2007A Series refinancing as an internal loan: $1,864,000 in FY08 and $176,000 in FY09 (if needed). This totals $2.04 million in available and unencumbered funding for the internal loan. UI will repay this internal loan from project financing proceeds in FY09 as a reimbursement from the anticipated bond proceeds. UI anticipates issuance of $14 to $17 million in Bonds for the Kibbie Life Safety project in the December 2008 to April 2009 time frame. Since the internal loan funding from bond interest savings is unencumbered, delays in issuance of Kibbie Life Safety bonds will not adversely affect UI's finances.

ATTACHMENTS

Capital Project Tracking Sheet Page 5

STAFF COMMENTS AND RECOMMENDATIONS

The life safety issues addressed above have also been identified by the Division of Building Safety, which prioritized the exit doors at the west end of the dome as the highest priority. This item has been included by the University as "enhanced exiting" in the Project Description.

The $14 to $17 million bond issuance is in line with the estimate of $14 million contained in the 10-year debt projection provided to the Board at the October meeting. Staff recommends approval.

BOARD ACTION

A motion to approve the request by the University of Idaho to implement the design phase for the life safety improvements in the ASUI Kibbie Activity Center, at a cost not to exceed $2m.

Moved by _____ Seconded by _____ Carried Yes _____ No _____

Office of the Idaho State Board of Education
Capital Project Tracking Sheet
As of October 25, 2007

History Narrative

1 **Institution/Agency:** University of Idaho **Project:** Kibbie Dome Life Safety Improvements, Moscow, ID

2 **Project Description:** Implement upgrades and improvements to the Dome. Life safety improvements include replacement of timber end walls, installation of a smoke exhaust and fire sprinkler system, and enhancements to the HVAC and electrical distribution systems.

3 **Project Use:** Corrects code deficiencies within the Dome.
4 **Project Size:** N/A

5
6

	Sources of Funds				Use of Funds			
7						Use of Funds		
8	PBF	ISBA	Other	Total Sources	Planning	Const	Other	Total Uses
9 **Initial design phase authorization - Dec2007**	$ -	$ -	$ 2,000,000	$ 2,000,000	$ 2,000,000	$ -	$ -	$ 2,000,000
10			$ -	$ -	$ -	$ -	$ -	$ -
11								
12			$ -	$ -	$ -	$ -	$ -	$ -
			$ -	$ -	$ -	$ -	$ -	$ -
13								
14 **Total Project Costs**	$ -	$ -	$ 2,000,000	$ 2,000,000	$ 2,000,000	$ -	$ -	$ 2,000,000

15
16

			Other Sources of Funds				
17 **History of Funding:**	PBF	ISBA	Institutional Funds (Gifts/Grants)	Student Revenue	Other	Total Other	Total Funding
18 Initial Authorization Request - design phase life safety element - Dec 07*	$ -		$ 2,000,000			$ 2,000,000	$ 2,000,000
19	$ -		$ -			$ -	$ -
20	$ -		$ -			$ -	$ -
21						-	-
22						-	-
23 Total	$ -	$ -	$ 2,000,000	$ -	$ -	$ 2,000,000	$ 2,000,000

24

25 * UI will seek construction authorization from the Regents prior to initiating construction for life safety improvements.

REFERENCE – APPLICABLE STATUTE, RULE OR POLICY

Idaho State Board of Education
GOVERNING POLICIES AND PROCEDURES
SECTION: V. FINANCIAL AFFAIRS
Subsection: K. Construction Projects **April 2002**

K. Construction Projects

1 Major Project Approvals – Proposed Plans

Without regard to the source of funding, before any institution, school or agency under the governance of the Board begin formal planning to make capital improvements, either in the form of renovation or addition to or demolition of existing facilities, when the cost of the project is estimated to exceed five hundred thousand dollars ($500,000), must first be submitted to the Board for its review and approval. All projects identified on the institutions', school's or agencies' six-year capital plan must receive Board approval.

INSTITUTION / AGENCY AGENDA
UNIVERSITY OF IDAHO

SUBJECT

Capital Project Design Phase Authorization Request, Kibbie Dome Non-Life Safety Improvements

REFERENCE

First hearing for Capital Project Design Phase Authorization

August 2006	Information Item: Technical Assessment & Feasibility Study, Proposed University of Idaho Events Pavilion and ASUI Kibbie Activity Center Improvements
November 2006	Discussion: Replace Artificial Turf, ASUI Kibbie Activity Center
February 2007	Information Item: UPDATE: Technical Assessment & Feasibility Study, Proposed UI Events Pavilion and ASUI Kibbie Activity Center Improvements. Notification of the Immediate Code Compliance, Guest and Participant Safety Issues Documented in the Technical Assessment & Feasibility Study
April 2007	Capital Project Authorization: Replace Artificial Turf, ASUI Kibbie Activity Center

APPLICABLE STATUTE, RULE, OR POLICY

Idaho State Board of Education Governing Policies & Procedures, Section V.K.1

BACKGROUND

In 2006, the University initiated a Technical Assessment & Feasibility Study of a proposed Events Pavilion and of the ASUI Kibbie Activity Center (KAC). A team of consultants headed by Opsis Architecture and Hastings-Chivetta conducted a technical evaluation of the facility and identified a series of life safety improvements necessary for the KAC, as well as recommended renovations.

One safety improvement authorized by the Board in April 2007, and subsequently completed was the installation of a new turf play surface in the KAC. Further improvements are needed to address the collection of code deficiencies identified in the report. These life safety issues are the subject of a companion Board agenda item, presented separately.

The series of recommended renovations identified as part of the technical evaluation will serve to significantly improve the 35 year old facility, enhancing

the functionality and seating capacity of the facility, and improving spectator comfort and revenue through concession and seating upgrades and expansions. These renovations will extend the useful life of the KAC, the most often and widely used facility on campus, and will generate important, reoccurring revenue streams.

DISCUSSION

Project Description

Non-life safety facility renovation needs identified in the technical audit include (1) lowering the playing field to improve sight lines and adding an additional 3,600 seats, bringing capacity in the KAC to over 20,000; (2) improving and expanding concourse concessions and restrooms facilities; (3) improving the pressbox; (4) creating Hall of Fame and Clubroom spaces; and (5) creating new seating configurations that include suite, loge, and club seating. The University intends to fund these non-life safety renovations and expansion elements with private contributions. By funding the project through private contributions, the University will be able to direct the additional incremental revenue generated by expanded and premium seating to support and enhance programs that utilize the KAC, rather than having to direct such revenue to debt service on bonds. Such additional revenue for Athletics, for example, will enhance its ability to attract and retain coaches, support student scholarships, and to be competitive in the 16 Division 1A sports in which they compete. Furthermore, the expanded seating allows the Athletic Department to comply with the Western Athletic Conference (WAC) requirement to increase revenues by 8%. Achieving this goal will require bringing in nationally competitive opponents who require larger stadiums and the larger revenues those stadiums generate. This project will also support the Lionel Hampton International Jazz Festival by allowing the festival to use premium seating as a way to generate revenue for the festival. Athletics only uses the KAC 22% of the time. The other 78% of the time, the KAC is used for important campus activities like Vandal Friday and Commencement as well as a variety of community activities.

These renovations and enhancements will cost an estimated $35 million; the cost estimate is subject to further refinement through the design process. Again, the University intends to fund these renovations entirely through private donations.

This project directly supports the University's Strategic Plan and its education and outreach goals. It is fully consistent with the University's Long Range Campus Development Plan, and the Campus Infrastructure Master Plan. The KAC is an iconic structure that serves a wide variety of campus and community needs, supporting general education, recreational, athletic, and community events. It also serves as a staging and response center in regional emergencies.

Project Design
The design fees for the amenity renovation element are expected to be in the range of $4.2 - $4.5 million. Design phases such as schematic design, or design development or the subsequent preparation of construction documents would only be initiated if private funding were in hand to fully cover the cost of the respective design phase.

The University seeks Board authorization for the design phase at a cost not to exceed $4.5M, subject to availability of private funding.

Project Implementation
The non-life safety renovations could potentially be implemented as a single project with the life safety improvements, or could be carried out separately, depending on the timing and availability of private funding. This holds true for both the design and construction phases of the project. The University intends to proceed with correction of the life safety needs, subject to Board authorization under a separate, but related board agenda item, regardless of our success in private fundraising in support of the non-life safety renovations. There are cost savings to be captured by doing these projects in tandem.

The tentative design and construction timeline for non-life safety renovations is as follows:

Milestone	**Date**
SBOE Authorization for $4.5M Design Phase for Life Safety Improvements	Dec, 2007
Initiate RFQ and design process (subject to funding availability)	Dec, 2007
Complete construction bid package	Jan, 2009
SBOE Authorization for Construction Contract (subject to funding availability)	Feb, 2009
Initiate Bid and Construction process	Feb, 2009
Construction complete	Dec, 2010

The projected timeline for non-life safety renovations is tentative and subject to change as the project is better defined through the design process. A revised set of milestones will be reviewed with the Board prior to authorization of the construction phase for non-life safety renovations.

IMPACT

8*

State	$ 0	Construction	$ 0
Federal (Grant):	$ 0	A/E & Consultant Fees	$ 4,500,000
Other (UI/Bond)	$ 0	Contingency	$ 0
Private	$ 4,500,000*		
Total	$ 4,500,000	Total	$ 5,400,000

* Private funding yet to be developed

The University will initiate each design phase (e.g., schematic design, design development, etc.) only once the necessary private funds are available, and in hand. Thus, the design phases will not adversely affect the University's budget.

ATTACHMENTS

Capital Project Tracking Sheet Page 5

STAFF COMMENTS AND RECOMMENDATIONS

This project will use private funds when available. Staff recommends approval.

BOARD ACTION

A motion to approve the request by the University of Idaho to implement the design phase for non-life safety renovations in the ASUI Kibbie Activity Center, at a cost not to exceed $4.5M, and subject to availability of private funding.

Moved by _____ Seconded by _____ Carried Yes _____ No _____

Office of the Idaho State Board of Education
Capital Project Tracking Sheet
As of 7 November 2007

History Narrative

Institution/Agency: University of Idaho **Project:** Kibbie Dome Non-Life Safety Renovations, Moscow, ID

Project Description: Implement upgrades and improvements to the Dome. Renovations include lowering of the play field, installation of additional seating, concessions improvements, and construction of a Hall of Fame and Clubroom.

Project Use: Improves sightlines and comfort amenities for spectators. Increased seating capacity supports additional revenue income

Project Size: N/A

	Sources of Funds				Use of Funds			
	PBF	ISBA	Other	Total Sources	Planning	Use of Funds Const	Other	Total Uses
Initial design phase authorization - Dec2007*	$ -	$ -	$ 4,500,000	$ 4,500,000	$ 4,500,000	$ -	$ -	$ 4,500,000
			$ -	$ -	$ -	$ -	$ -	$ -
			$ -	$ -	$ -	$ -	$ -	$ -
			$ -	$ -	$ -	$ -	$ -	$ -
Total Project Costs	$ -	$ -	$ 4,500,000	$ 4,500,000	$ 4,500,000	$ -	$ -	$ 4,500,000

	Other Sources of Funds						
History of Funding:	PBF	ISBA	Institutional Funds (Gifts/Grants)	Student Revenue	Other	Total Other	Total Funding
Initial Authorization Request - design phase amenity renovations - Dec 07*	$ -		$ 4,500,000			$ 4,500,000	$ 4,500,000
	$ -		$ -			$ -	$ -
	$ -		$ -			$ -	$ -
						-	-
						-	-
Total	$ -	$ -	$ 4,500,000	$ -	$ -	$ 4,500,000	$ 4,500,000

* To be privately funded. UI will proceed with design for non-life safety renovations only once adequate private funding is in hand. UI will seek construction authorization from the Regents prior to initiating construction of non-life safety renovations.

REFERENCE – APPLICABLE STATUTE, RULE OR POLICY

Idaho State Board of Education
GOVERNING POLICIES AND PROCEDURES
SECTION: V. FINANCIAL AFFAIRS
Subsection: K. Construction Projects **April 2002**

K. Construction Projects

1 Major Project Approvals – Proposed Plans

Without regard to the source of funding, before any institution, school or agency under the governance of the Board begin formal planning to make capital improvements, either in the form of renovation or addition to or demolition of existing facilities, when the cost of the project is estimated to exceed five hundred thousand dollars ($500,000), must first be submitted to the Board for its review and approval. All projects identified on the institutions', school's or agencies' six-year capital plan must receive Board approval.

INSTITUTION / AGENCY AGENDA
UNIVERSITY OF IDAHO

SUBJECT

Capital Project Authorization Increase Request, HVAC and Roof Upgrades, the Joe Marshall Potato Research Building and Aberdeen Research & Extension Center

REFERENCE

June, 1999	Initial Authorization for Feasibility and Evaluation Study
November, 1999	Initial Capital Project Authorization for Planning, Design and Construction Implementation

APPLICABLE STATUTE, RULE, OR POLICY

Idaho State Board of Education Governing Policies & Procedure, Section, V.K.1. & V.K.2.

BACKGROUND

This is a revised request for increased Regent's Authorization to implement upgrades and improvements to the HVAC and roofing systems at the Joe Marshall Potato Research Building and Aberdeen Research & Extension Center in Aberdeen, Idaho.

DISCUSSION

This project to make needed and required HVAC Improvements and Upgrades was included as a component of the 1999C Bond Issue. The intent of that bond issue was to make miscellaneous research infrastructure improvements at various University of Idaho sites distributed across the State of Idaho.

The Initial Regents' Authorization level was set at $50,000 for Feasibility and Evaluation during the June 1999 Regular Board meeting. This was increased by $350,000 to the current Regents' Authorization level of $400,000 for Design and Construction Phase implementation during the November 1999 Regular Board Meeting.

During the course of the design of the project, it was determined that the scope of work was significantly greater than originally anticipated due to unforeseen conditions of the existing systems. This delayed the project significantly, as it was necessary to implement and complete the other projects intended as scope of the 1999C bond issue to verify if sufficient funds were available to cover the increase in scope.

At this time, the University and the College of Agricultural and Life Sciences have determined that sufficient series 1999C bond proceeds remain to allow the project to proceed. The University is therefore ready to proceed with the construction implementation of the full complement of all desired and recommended scope elements of the project. The project is design complete and ready to advertise for construction bids.

The current total project estimate based upon the Architect's recent estimate of construction costs for this effort is $800,000. The University will report any variations or deviations from this project cost estimate based upon bids received.

The project is fully consistent with the University's Strategic Plan, specifically, Goal 2, Scholarly and Creativity Activity and Goal 3, Outreach and Engagement.

IMPACT

Immediate fiscal impact of this effort is $800,000. The project fund source is remaining series 1999C bond proceeds.

Funding		**Estimate Budget**	
State	$ 0	Construction	$ 610,000
Federal (Grant):	0	A/E & Consultant Fees	65,000
Other (State & UI)	800,000	Contingency	125,000
Total	$ 800,000	Total	$ 800,000

ATTACHMENTS

Capital Project Tracking Sheet Page 3

STAFF COMMENTS AND RECOMMENDATIONS

This project will be funded from the remaining series 1999C bond proceeds under which the project was originally a component. Staff recommends approval.

BOARD ACTION

A motion to approve the request by the University of Idaho to increase the Capital Project Authorization for the HVAC and Roof Upgrades, the Joe Marshall Potato Research Building and Aberdeen Research & Extension Center, University of Idaho, Aberdeen, Idaho, from $400,000 to $800,000 to allow for the full implementation of the construction phase.

Moved by_____ Seconded by_____ Carried Yes_____ No_____

Office of the Idaho State Board of Education
Capital Project Tracking Sheet
As of October 25, 2007

History Narrative

Institution/Agency: University of Idaho **Project:** HVAC and Roof Upgrades, the Joe Marshall Potato Research Building, Aberdeen Research & Extension Center, University of Idaho, Aberdeen, Idaho

Project Description: Implement upgrades and improvements to the HVAC and Roofing systems at the Joe Marshall Potato Research Building, Aberdeen Research & Extension Center, Aberdeen, Idaho.

Project Use: Replaces and upgrades existing HVAC and Roofing systems that are at the end of their life cycle.

Project Size: N/A

	Sources of Funds				Use of Funds			
	PBF	ISBA	Other	Total Sources	Use of Funds* Planning	Use of Funds* Const	Other**	Total Uses
Initial Cost of Project (Feasibility & Evaluation)	$ -	$ -	$ 50,000	$ 50,000	$ -	$ -	$ 50,000	$ 50,000
History of Revisions:								
Initial Design & Construction Authorization (Nov 1999)			$ 350,000	$ 350,000	$ 35,000	$ 275,000	$ 40,000	$ 350,000
Revised Design & Construction Authorization (Dec 2007)			$ 400,000	$ 400,000	$ 30,000	$ 335,000	$ 35,000	$ 400,000
Total Project Costs	$ -	$ -	$ 800,000	$ 800,000	$ 65,000	$ 610,000	$ 125,000	$ 800,000

	* Other Sources of Funds						
History of Funding:	PBF	ISBA	Institutional Funds (Gifts/Grants)	Student Revenue	Other	Total Other	Total Funding
Initial Authorization Request - Feasibility & Evaluation, Jun 99	$ -		$ 50,000			$ 50,000	$ 50,000
Initial Capital Project Authorization Request, Nov 99	$ -		$ 350,000			$ 350,000	$ 350,000
Revised, Increased Capital Project Authorization Request, Dec 07	$ -		$ 400,000			$ 400,000	$ 400,000
						-	-
						-	-
Total	$ -	$ -	$ 800,000	$ -	$ -	$ 800,000	$ 800,000

* Series 1999C Bond Funds. UI will report back to the Board of Regents any resulting revisions to the project estimate resulting from the bid process and seek additional project authorization as may be required.

** Initial Feasibility & Project Contingency

REFERENCE – APPLICABLE STATUTE, RULE OR POLICY

Idaho State Board of Education
GOVERNING POLICIES AND PROCEDURES
SECTION: V. FINANCIAL AFFAIRS
Subsection: K. Construction Projects **April 2002**

K. Construction Projects

1 Major Project Approvals – Proposed Plans

Without regard to the source of funding, before any institution, school or agency under the governance of the Board begin formal planning to make capital improvements, either in the form of renovation or addition to or demolition of existing facilities, when the cost of the project is estimated to exceed five hundred thousand dollars ($500,000), must first be submitted to the Board for its review and approval. All projects identified on the institutions', school's or agencies' six-year capital plan must receive Board approval.

2 Project Approvals

Without regard to the source of funding, proposals by any institution, school or agency under the governance of the Board to make capital improvements, either in the form of renovation or addition to or demolition of existing facilities, when the cost of the project is estimated to be between two hundred fifty thousand dollars ($250,000) and five hundred thousand dollars ($500,000), must first be submitted to the executive director for review and approval. Without regard to the source of funding, proposals by any institution, school or agency under the governance of the Board to make capital improvements, either in the form of renovation or addition to or demolition of existing facilities or construction of new facilities, when the cost of the project is estimated to exceed five hundred thousand dollars ($500,000), must first be submitted to the Board for its review and approval. Project cost must be detailed by major category (construction cost, architecture fees, contingency funds, and other). When a project is under the primary supervision of the Board of Regents or the Board and its institutions, school or agencies, a separate budget line for architects, engineers, or construction managers and engineering services must be identified for the project cost. Budgets for maintenance, repair, and upkeep of existing facilities must be submitted for Board review and approval as a part of the annual operating budget of the institution, school or agency.