

2016 Medical Education Committee Report

Purpose and Process

The State Board of Education (SBOE) Medical Education Committee was re-convened by the SBOE in response to a request from the Governor’s “State of the State and Budget Address” on January 11, 2016, in which he stated in his remarks related to improving Idaho’s healthcare system: ***“I’m asking the Board of Education to work with our medical community and higher education institutions to develop a new plan for addressing future demand for healthcare providers.”*** In response to the Governor’s request, the SBOE President reactivated the Board’s earlier Medical Education Study Committee, which had completed a comprehensive study on medical education needs in 2009. Appointed to the new Medical Education Committee were subject matter experts, medical leaders, and key stakeholders from across the state. [A list of Committee members is provided in the appendices to this report.] The Committee’s mandate was to develop recommended action areas to address Idaho’s pressing healthcare needs.

The committee deliberated and ultimately defined its charge as assessing issues affecting Idaho citizens’ access to medical care. The Committee deliberately focused on healthcare assets that affect access to primary healthcare providers—physicians, nurse practitioners, and physician assistants—and those factors which affect their training, recruitment, and retention. It is understood that other important healthcare issues also play a role in access (especially rural access) to medical care, and some of these issues are being (or will be) worked elsewhere, for example, Idaho students’ access to medical school and the relative supply of other healthcare professionals in the State (including, but not limited to: physical therapists, occupational therapists, pharmacists, clinical laboratory scientists, nurses, nutritionists, social workers, psychologists, counselors, health care administrators, and others).

The context for the committee’s work included an assessment of the implementation of the recommendations from the 2009 Medical Education Taskforce report, as well as changes in the environment since the 2009 report. In offering its recommendations, the Committee focused on the supply, recruitment, and retention of health professionals. While the supply dimension is driven to a large extent by national and state medical education opportunities, the recruitment and retention of health professionals is also affected by factors tangential to, or even outside, the direct influence of education. Factors such as competition with other states in the region, market levels for compensation, work environments, and other factors also have significant influence on access to medical services in Idaho. The Committee’s recommendations are intended to guide both short-term and medium-term planning with respect to medical education and primary provider recruitment, retention, and distribution in Idaho.

In addition to reviewing the recommendations of the previous medical education taskforce report from 2009, the Committee worked diligently to gather data and work with stakeholders to assess the current state of healthcare access throughout Idaho. The committee met in May 2016 to launch initial studies, and then met monthly since August 2016 to hear from experts and discuss reports submitted on specific topics of interest by informed task force members. Reports were drawn from credible national data sources, including the Association of American Medical Colleges (AAMC), the American Association of Colleges of Osteopathic Medicine (AACOM), as well as Idaho-specific survey work done by professional associations and state agencies. The Committee worked with stakeholders and representatives from the University of Washington-led Washington, Wyoming, Alaska, Montana, and Idaho (WWAMI) program; the University of Utah School of Medicine (UUSOM); the Idaho College of Osteopathic Medicine (ICOM) medical education program; Physician Assistants and Nurse Practitioner professionals; physicians in training; heads of the major Idaho health systems;

and rural hospital and physician representatives with extensive experience in meeting the health challenges of rural Idaho.

At the conclusion of the Committee's deliberations, a sub-committee, led by the Committee's chairman, Ed Dahlberg, drafted potential recommendations which were then reviewed, finalized, and prioritized by the full Committee at its meeting in December 2016. The prioritization of recommended action items was based on the potential impact the proposed actions would have on improving access to medical service to Idahoans in all regions of the State. While the Committee appreciated that there could be a significant financial impact in implementing some of the recommendations, the potential cost of actions was not the primary driver in prioritizing the recommendations.

General Findings

The findings—and subsequent recommendations—of the Committee fall into three principal areas:

1. Supply factors.
2. Maldistribution of medical/health professional providers.
3. Lack of mental health providers throughout the state (urban as well as rural areas). This critical shortage compounds the pressure to recruit, support, and retain primary medical/health providers, especially in rural areas.

Supply

National data confirm that Idaho's citizens are underserved in primary health care (as well as mental health resources) due to a low number of physicians per capita, compounded by uneven distribution, particularly in terms of low service coverage in rural areas. A further complication is that Idaho is surrounded by states which are facing their own physician shortages and which are aggressively working to recruit additional physicians, creating additional pressures on Idaho providers, including medical school graduates with high student loan debts who may be lured by higher compensation rates and more robust support infrastructure in nearby states. The circumstances are similar for Physician Assistants (PAs) and Nurse Practitioners (NPs). This is especially true for NPs where the current supply of trained professionals in the State does not meet the replacement rate needed to backfill retirees (34% of incumbents are over age 55)—a shortage which is being exacerbated by an aggressive competitive market in neighboring states.

Significant progress has been made since 2009 in expanding one segment of the physician pipeline—namely, medical school training (undergraduate medical education). In 2009, Idaho had only 20 WWAMI medical school slots each year, and only 6 University of Utah School of Medicine (UUSOM) positions per year. For FY2017, there are 40 annual WWAMI slots for entering Idaho-sponsored students, and there are 10 UUSOM slots for Idaho. As a result of recent curriculum revisions, WWAMI students will now remain in Idaho for a greater percentage of their four-year programs. The Idaho College of Osteopathic Medicine (ICOM) plans to receive its first entering class of 150 students (drawn from Idaho and four other neighboring states) in 2018. Washington State University (WSU) has received preliminary accreditation for a new medical school in Spokane, which may also provide additional undergraduate medical education opportunities for Idaho students. The primary effects of these changes are:

- Increased numbers of MD and DO training opportunities for Idaho students.
- Increased competition for physician preceptors to support student training.
- Increased competition for the limited number of currently-available Graduate Medical Education (GME) residency slots.
- Challenges for Idaho's primary, secondary, and post-secondary school system pipeline to produce enough qualified students to fill the newly-available positions. With the increased accession rate to WWAMI and

UUSOM over the past few years, there has been a gradual decrease in entrance exam scores to the point that some students are being accepted with scores below the level traditionally considered the standard for prediction of successful completion of medical school. The Committee noted that the quality and preparation of college graduates who plan to enter medical school would be improved if Idaho's colleges and universities were to establish and promote pre-med tracks within their undergraduate program offerings. Likewise, expansion in the number and size of other undergraduate health professions training programs should be considered by Idaho post-secondary institutions.

- (Even) greater demand for the supply and engagement of qualified preceptors for 3rd and 4th year medical student training.

With respect to the overall medical education pipeline, the greatest current shortfall—and the area of greatest potential positive impact—lies in the number and types of residencies (Graduate Medical Education) available in Idaho. Studies consistently show that the highest predictor of a physician's ultimate practice location is the area in which they complete their residency training, particularly for residents in primary care specialties. Recent investments by the state in the expansion of the WWAMI and University of Utah programs, as well as the anticipated development of ICOM, provide sufficient MD/DO training opportunities (Undergraduate Medical Education) for qualified Idaho citizens. However, graduates of these programs, as well as physicians trained outside Idaho, must be provided with access to residency programs in Idaho to be effectively retained.

Idaho's allied health professional training has been largely separated from its MD training. This separation does not facilitate integrated healthcare team training. Better coordination, particularly in the patient experience portion of training, could enhance these programs.

Maldistribution of Professional Providers:

Ninety-four percent (94%) of Idaho's counties are classified as primary care Health Professional Shortage Areas (HPSAs) under federal criteria. All 44 of Idaho's counties are considered HPSAs for mental health services. Assuring access to health services in rural areas will require multiple approaches. New models of healthcare delivery, such as broader implementation of telemedicine with appropriate reimbursement and integrated healthcare teams—including physicians, nurse practitioners, physician assistants, pharmacists, and mental health professionals—will be critical to healthcare delivery in rural areas. Residency and practicum programs that expose students intentionally to rural practice may enhance physician recruitment to rural areas. Loan repayment and other financial incentives, as well as more effective support for practicing physicians, especially with respect to community mental health, may also enhance rural physician recruitment and retention.

Another significant issue, related by rural physicians who testified to the Committee, is that potential providers in the training pipeline are dissuaded from practicing in rural areas because of concerns over the perceived and actual isolation of rural practices, lack of communications/support systems with colleagues in major metropolitan areas, low compensation rates (a factor in paying off medical school loans), and lack of robust K-12 education opportunities for their children in some rural communities.

Lack of Mental Health Providers:

Idaho is very underserved with respect to mental health professionals as well as most other primary care providers, such as Nurse Practitioners, Physician Assistants, Pharmacists, Social Workers, and Clinical Psychologists. Lack of support, particularly with regard to mental and behavioral health issues, is a key stress factor for rural physicians and medical service providers, whose workload and resources are pushed to the limit when trying to address mental health issues in addition to their medical responsibilities.

Specific Recommendations:

The Committee determined that each of the recommendations listed below would have a significant positive impact in addressing Idahoan’s access to medical care. While not necessarily listed in sequential priority order, there was a consensus among all Committee members that the first two recommendations listed below (growth of residencies and coordination of GME planning and initiatives) were the top, time-critical priorities.

Continue to grow the number of accredited residencies.

- Top priority is primary care residencies (Family Medicine, Internal Medicine, and Pediatrics).
- Next priority is specialty residencies (General Surgery, Psychiatry, Psychologists).
- Leverage state support of expanded residency capacity with Medicaid and external resources.

Designate a coordinator to support statewide GME expansion efforts and flesh-out action plans to implement the Medical Education Committee’s recommendations.

- Establish a standing GME Council to help coordinate efforts over the next 10 years.

Grow the supply of qualified preceptors to support training of healthcare providers.

- Consider state tax breaks for preceptors.
- Explore enhanced Medicaid and commercial coverage rates for preceptors.

Sustain programmatic and infrastructure support funding for WWAMI and UUSOM.

- Continue support for medical school slots at UW and UUSOM, Targeted Rural Underserved Track (TRUST) program, and WWAMI facility improvements in Idaho.

Improve support to providers in rural areas.

- Explore/expand *locum tenens* staff support arrangements for underserved areas.
- Enhance training in and support of telemedicine capabilities.
- Support integrated healthcare team operations, including mental health providers.

Increase financial incentives and reimbursement to support recruitment and retention of rural healthcare providers.

Enhance loan repayment programs/options for rural physicians (establish parity with surrounding states).

Expand healthcare provider training opportunities that include rural exposure.

Implement and expand specific undergraduate medical sciences curricula (including “Pre-Med” programs) and other health career opportunity tracks to feed the pre-medical and pre-health professions pipelines.

Establish scholarship programs for Idaho students (admitted to any accredited medical school) who agree to serve for four years in underserved rural areas.

Develop programs in K-12 system to encourage and prepare students for future careers in medical/health professions.

Encourage recruitment of high-quality International Medical Graduates (IMGs) for underserved areas.

- Streamline and coordinate J-1 visa procedures and state licensure policies.
- Explore targeted recruitment programs and incentives.

Appendix I—Medical Education Committee Team Members

Ed Dahlberg—Chairman	Former CEO, St. Luke’s
Don Soltman	State Board of Education
Chuck Staben	President, University of Idaho
Tony Fernández	President, Lewis-Clark State College
Jacob Hornby	Division of Natural Science and Mathematics, Lewis-Clark State College
Mark Rudin	Vice-Pres. (Research & Economic Development) Boise State University
Rex Force	Vice-Pres. (Health Sciences) Idaho State University
Dr. Ted Epperly	CEO, Family Medical Residency of Idaho (FMRI)
Dr. David Schmitz	Program Director of Rural Training Track (FMRI)
Dr. Bridgette Baker	Family Medicine Physician (St. Alphonse system, University of Utah)
Brian Whitlock	CEO, Idaho Hospital Association
Susie Pouliot	CEO, Idaho Medical Association