

C.L. "BUTCH" OTTER
GOVERNOR



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Chair

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Vice Chair

WORKFORCE DEVELOPMENT COUNCIL

317 West Main Street, Boise, Idaho 83735-0510

TRANSMITTAL #4

MEMORANDUM

November 18, 2010

TO: Workforce Development Council

FROM: Tony Fernandez, Chair
Idaho Health Professions Education Council
Interim President
Lewis Clark State College

SUBJECT: Idaho Health Professions Education Council
Annual Report to the Governor

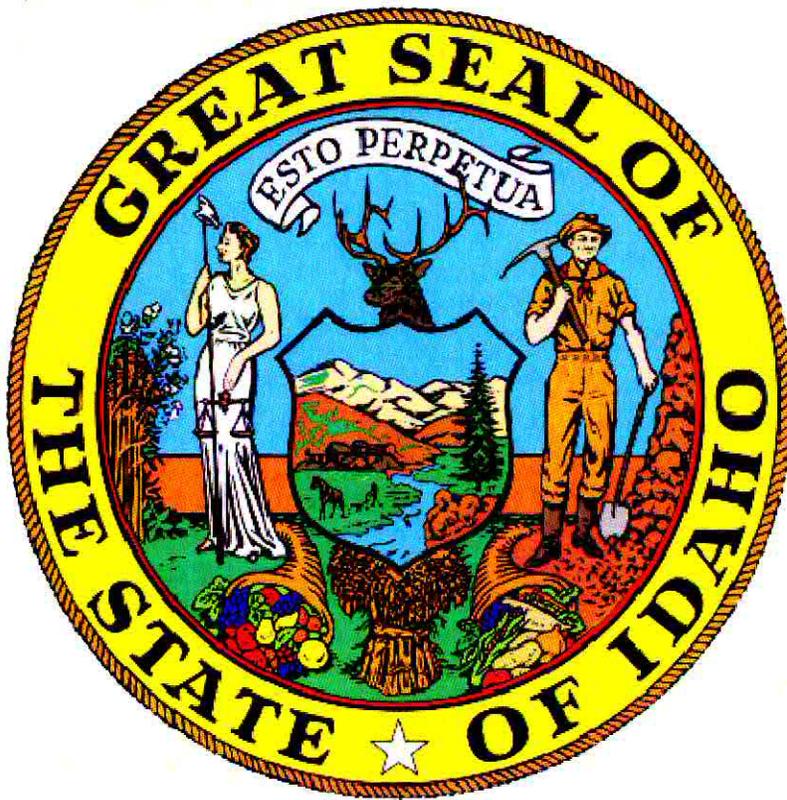
ACTION REQUESTED: None. Information Only

BACKGROUND:

I am pleased to present the Idaho Health Professions Education Council Annual Report to Governor Butch Otter. The report includes an analysis of critical medical disciplines and offers recommendations to improve access to health education and services across the state.

Attachment

**Idaho Health Professions Education Council
Annual Report to
Governor C. L. "Butch" Otter
June, 2010**



I. Introduction

Background

Following the August, 2007, Idaho Health Care Summit, Governor Otter established the Governor's Select Committee on Health Care. This committee was charged to assess the recommendations of the Summit, gather more information, and provide additional recommendations on making health care more affordable and accessible to Idahoans. In October 2008, the Governor's Select Committee on Health Care submitted its recommendations to the Governor. One of the committee's recommendations was to create an Idaho health care council similar to those found in other states, with the Utah Medical Education Council cited as an example.

During his January, 2009, State of the State address, Governor Otter announced that he would establish the Idaho Health Professions Education Council (IHPEC) and on February 26, 2009, he did so through the release of Executive Order 2009-07. Makeup of the council is representative of healthcare organizations, Idaho colleges and universities, and the public at large. There are currently nine members on the council. The charge to this group is to:

- Conduct health workforce analyses;
- Assess Idaho's capacity for training healthcare professionals;
- Advise the Governor and legislators on healthcare workforce issues;
- Develop healthcare workforce objectives for the State of Idaho and provide policy recommendations for achieving the objectives;
- Recommend strategies to address healthcare provider shortages in rural locations;
- Develop strategies to increase public/private partnerships to increase the healthcare providers for Idaho.

Since March, 2009, the Idaho Health Professions Education Council has met quarterly (6 meetings and 1 conference call) and has considered healthcare information reported to the Council concerning the education and workforce status of Idaho dentists, nurses, physician assistants, and physicians. In doing so, IHPEC has arranged meetings with the Governor's Select Committee on Health Care, the Executive Director of the Utah Medical Education Council, the Medical Education Subcommittee of the Idaho State Board of Education, representatives from the University of Washington School of Medicine, the Idaho Department of Labor, representatives from the Idaho Nursing Workforce Advisory Council, and others. What follows is a summary of the IHPEC's activities, findings, and recommendations.

Utah Medical Education Council

The Select Committee on Health Care and Governor Otter cited the Utah Medical Education Council (UMEC) as a model for the Idaho Healthcare Professions Education

Council. In June, 2009, Mr. David F. Squire, Executive Director, UMEC, briefed the IHPEC on the makeup and functions of the UMEC.

UMEC is a quasi-state agency that began its operations in 1997 and is presided over by an eight member board appointed by the Governor. UMEC is charged with bridging the gap between the public/private health care workforce and education interests. It is staffed with 5 FTE employees reporting to the Executive Director. Its core responsibilities are to:

- Assess supply and demand of healthcare professionals
- Advise/develop policy
- Seek and disburse Graduate Medical Education (GME) funds
- Facilitate training in rural locations
- Manage Utah's Graduate Medical Education demonstration project awarded by the Center for Medicare & Medicaid Services (CMS)

The UMEC develops:

- Partnerships – public/private
- Reports - health care workforce
- Models – workforce and financial
- Program(s) expansion – rural and urban

UMEC is charged to monitor and address the professional healthcare workforce needs in Utah in four specific professions: medicine, dentistry, pharmacy, and midlevel providers (physician assistants/ nurse practitioners). Other groups may be studied by contract. Data is collected from state licensing offices databases and through surveys of licensed providers in Utah. UMEC facilitates rural physician training through a special allocation of fees and supplements to programs (GME) through a \$300K special allocation for rural training rotations for residents in Utah. UMEC is funded through State appropriations, MOU's with training hospitals, a GME Medicare waiver demonstration project and other grants.

II. Workforce/Education Reports

Dentists

Quinn Dufurrena, DDS, JD, Executive Director of the Idaho Dental Association, provided IHPEC with an update on the Idaho dental workforce.

There are 984 active licensed dentists in Idaho of which 196 are specialists. This number should be sufficient to serve the 1.5 million Idaho residents, but geographic mal-distribution is a problem as there is a more than adequate supply of dentists in urban areas and a sparse supply in rural areas.

One-third of Idaho dentists are over age 55 and a significant number of these older dentists practice in rural areas, so the scarcity of dentists in rural areas will increase as these dentists retire. Compounding this is the fact that new dentists realize an average of \$250,000 in debt after graduation and the average cost of buying an existing dental practice is \$400,000. Such heavy debt loads will nearly always dictate that new dentists practice in more lucrative urban areas. Dentists should be made aware of the National Health Service Corps and other loan reimbursement programs that can help with such debt.

A changing workforce structure will occur within the next 10-15 years as aging dentists retire. New dentists may be utilized to supervise mid-level providers in rural areas using tele-dentistry techniques. However, low Medicaid reimbursement rates and the average 50% no-show rate of Medicaid patients may limit such a system.

The incidence of dental decay in Idaho is extremely high and is due to a widespread lack of good dental hygiene habits. An aggressive, State sponsored program to promote better dental health is needed, especially in the State's primary and secondary schools.

A new workforce model should encourage collaboration with other healthcare providers in rural community centers that offer bundled care. Best functioning models should be shared including an understanding of the roles of Community Health Centers in providing access to dental services in underserved areas and to underserved populations.

Nurses

The Idaho Nursing Workforce Advisory Council was formed in 2007. The Council was charged with gathering data and advising policy makers on the adequacy of the nursing workforce now and in the future. The Council had a sunset date of June 30, 2009, but Idaho Department of Labor and the Idaho Alliance for Nursing Leaders continue to collect nursing workforce data. The goals developed by the council included increasing nursing faculty, expand nursing seats by 400, incorporating innovative educational practices and encourage nursing workforce retention. On two occasions IHPEC received updates from the Advisory Council and the Idaho Department of Labor on the findings and recommendations of the council and also an update on Idaho's economy and workforce trends.

In 2007 Idaho had one of the fastest growing economies in the nation. That significantly changed in 2008. Idaho peaked at 670,000 jobs in June 2007. In January 2010, the number of jobs had declined to 589,000. The fourth quarter of 2008 was the worst period for jobs in the history of the State. However, healthcare remains a solid industry sector with abundant jobs, fast growth and high salaries. While the demand for nursing may have declined somewhat, the future demand will remain very high. Jobs requiring professional-technical training grow much faster than unskilled jobs.

Idaho's population age 55 and older will increase by 50% by 2016. Currently, Idaho's nurse to citizen ratio is 20% below the national average and 40% of all nurses are over the age of 50. According to the Advisory Council, these factors indicate a looming crisis unless action is taken now to increase the supply of nurses to care for a rapidly aging population. Nursing in Idaho is a fast growing, highly paid and abundant job opportunity. There are approximately 450 job openings annually for registered nurses. There are about 2.3 applicants for every nursing student seat in Idaho's educational institutions. The Advisory Council maintains that enrollment is limited because of state funding shortfalls for facilities, equipment and nursing faculty; the latter due to the low pay of nursing faculty compared to private industry. The Advisory Council estimated that over the next ten years, 7,500 more nurses will be needed.

IHPEC analyzed nurse practitioners and advanced practice nurses by Idaho counties. The study indicates a higher concentration of nurse practitioners and advanced practice nurses in the urban counties with fewer numbers in the rural counties. It was reported that there is a move to require the doctorate degree for nurse practitioners by 2015. This requirement will result in further training and licensing requirements and may result in a decrease in nurse practitioner graduates.

Physician Assistants

A report on the physician assistant workforce was provided by John Schroeder, former Director of the Physician Assistant Program at Idaho State University. The ISU program began with 14 students in 1995 and has grown to 120 students today. Approximately half of the students are Idaho residents with the other half from Utah, Montana and Wyoming. It started as a baccalaureate program and converted to a master's degree program in 2003. The program has graduated a total of 338 physician assistants. Nationally, about 90,000 students have graduated from PA programs, but the workforce is estimated to be about 75,000. In Idaho, there are 545 practicing PA's, less than 1% of all PA's in the nation. The program started as a predominately male profession, but has shifted and is now predominately female by 60% to 40%. Of all Idaho graduates, 63% have remained in Idaho. The mission of the program is to seek Idaho students who want to work and meet the healthcare needs of Idahoans. As with other healthcare workers, data shows that students tend to establish residence in the areas where they are trained. Nationally, about 15% of PA's work in rural areas. In Idaho, 33% of graduates work in health profession shortage areas. Nationally and in Idaho, the average PA graduate salary starts at about \$78,000. The mean salary for all PA's nationally is \$93,000. PA's in Idaho work an average of 34 hours per week. About 30% of Idaho PA's provide on-call services and approximately 60% of Idaho graduates work in primary care, compared to 30% nationally. Nationally, about 10% of PA's are in solo practice offices with one physician, compared to 24% in Idaho. Nationally, 32% and in Idaho 44% of PA's work in group physician offices. The average age of PA's is 42 years old nationally. The average age of PA students entering the ISU program is 27.

The ISU PA program does not receive State funding. The program is principally funded by student professional fees that are approximately \$6,000 per semester. (This fee is in

addition to tuition and various other fees.) With 120 students, the program budget is over \$2,150,000 annually. The student debt load at graduation is about \$60,000. The program had 519 applicants for 60 seats this year and the applicant pool has increased 15-20% annually over the last five years. Because of the sizeable applicant pool admissions is very selective and the average PA student's GPA is 3.77. ISU has a class of 30 students in Pocatello and 30 students in the ISU Meridian facility. There are 60 clinical students located statewide. About 75% of students have job offers before graduation.

Idaho State University is submitting a notice of intent to the State Board of Education to start a post graduate physician assistant certification program in emergency medicine. ISU is also in the preliminary stages of starting a certification program in mental health psychiatry and geriatrics for physician assistants. These are certificate programs, not degree programs, and will be one to two years in length.

There is always a fear of there being too many PA's. However, the program has continued expanding year after year and all PA's who want to work are employed within two months after graduation. Physicians have become increasingly accepting of PA's in medical clinics. ISU has also proposed to establish a PA program in Coeur d'Alene.

The challenge in Idaho has been to find enough suitable clinical sites to handle 60 students for eight six-week rotations. Some students have been sent out of state; for example, to emergency rooms in Seattle, Las Vegas and Utah. Another challenge is that as the PA salaries continue to rise and PA instructor salaries do not rise as fast, the instructors can leave the classroom and make substantially more money as practicing PA's. As the student's debt load increases, there becomes a disincentive for the PA to practice in rural areas because they can make higher salaries in specialty areas. Idaho licensure requires a bachelor's degree. Only two states, Indiana and Mississippi, require master's degrees for licensure. Almost 80% of PA programs have converted over to master's degree offerings.

Physicians

During the course of our deliberations we became aware of additional opportunities for loan reimbursement for rural primary care physicians in Idaho through federal grants; however, there was no identified state office capable of preparing or administering such program grants (e.g., State Loan Reimbursement Program, US DHHS). This raises the issue of no single state office charged with and funded to address issues of health professional workforce in Idaho. Current offices involved in such workforce issues are dispersed across different branches of state government and within the private, non-profit sector in Idaho. There is a lack of any coordinated effort between these groups, each of which is charged with a specific piece of health professional workforce development. This decentralized approach is inefficient and leaves small offices without the resources necessary to take advantage of new funding opportunities or commitments on behalf of Idaho.

The Idaho Rural Physician Incentive Program was established to encourage primary care physicians to practice in medically underserved areas of Idaho. Collection of funds from WWAMI and University of Utah medical students started in the fall of 2003 with disbursement of funds for loan repayment to begin in July 2010. IHPEC believes that the State Board of Education should actively explore expansion of funding opportunities (beyond medical student payments) for the Rural Physician Incentive Program in light of the fact that funds can be secured from sources other than the State treasury (Section 33-3727 Idaho Code).

In addition, the Rural Health Care Access Program in the past has benefitted Idaho communities most in need with custom-fit solutions including physician recruitment and retention, dental access and other critical health care needs. This program has seen severe reductions in funding, jeopardizing its function.

Similar to the IHPEC recommendation for increased dental student loan repayment programs, the Council recommends continued expansion of Idaho's utilization of and benefit from the National Health Service Corp (NHSC) programs for loan repayment and scholars in cooperation with the Primary Care Program, managed by the State Office of Rural Health. The State should also advocate for changes in the federal scoring systems to allow more participation from qualified Idaho communities in the NHSC scholars program

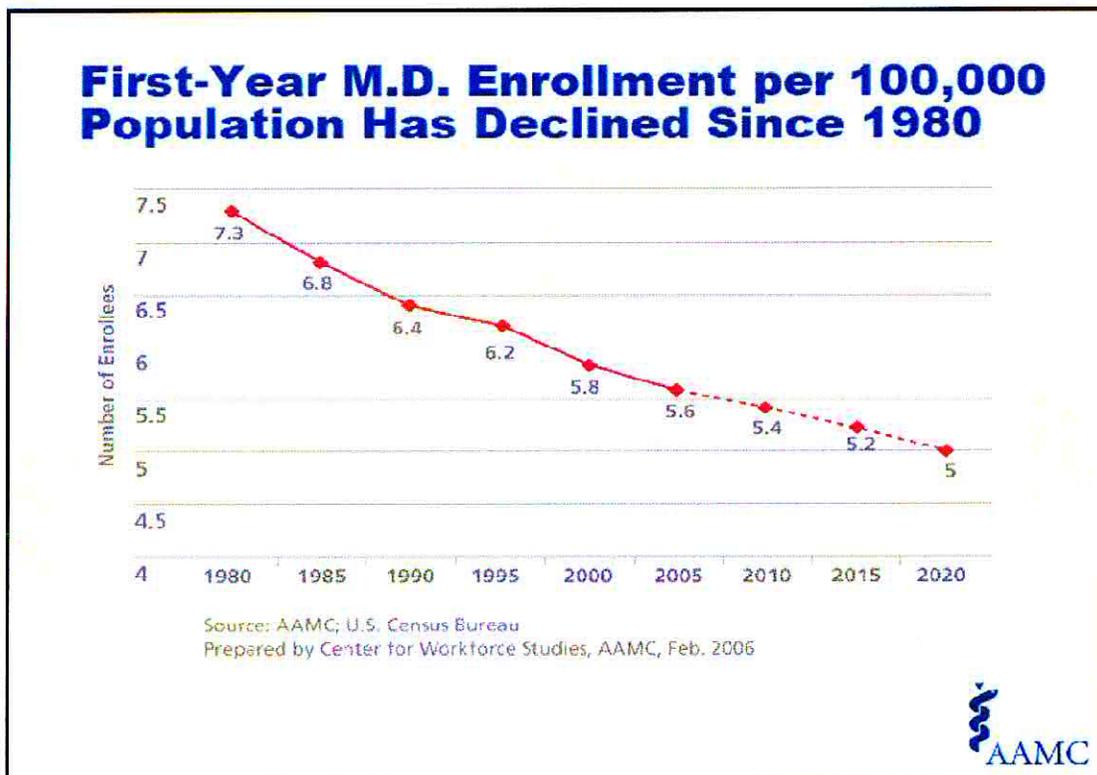
The Governor's Idaho Health Professions Education Council (IHPEC) arranged for a study of Idaho physician workforce status and needs in order to more accurately assess and make recommendations regarding the future of medical education in Idaho. Such a study is also in keeping with the current recommendations of the Idaho State Board of Education's subcommittee on medical education. While a report on medical education resources and options was completed recently for the Board of Education (MGT, 2007), accurate projections of Idaho physician workforce were lacking. The IHPEC secured the services of Center for Health Workforce Studies, in Seattle, to complete this study and present their findings to the Council. The following is an executive summary of the key points made by Mark Doescher, MD, MSPH, Director, Center for Health Workforce Studies and WWAMI Rural Health Research Center, University of Washington School of Medicine, as presented to the IHPEC on 12/15/09.

Idaho Physician Workforce Study Objectives:

- Present the current supply of physicians in Idaho.
- Determine if the State has enough physicians in the right specialties, locations, and practice configurations.
- Explore non-physician options for increasing supply
- Examine the future supply of physicians

What are the problems with the U.S. physician supply?

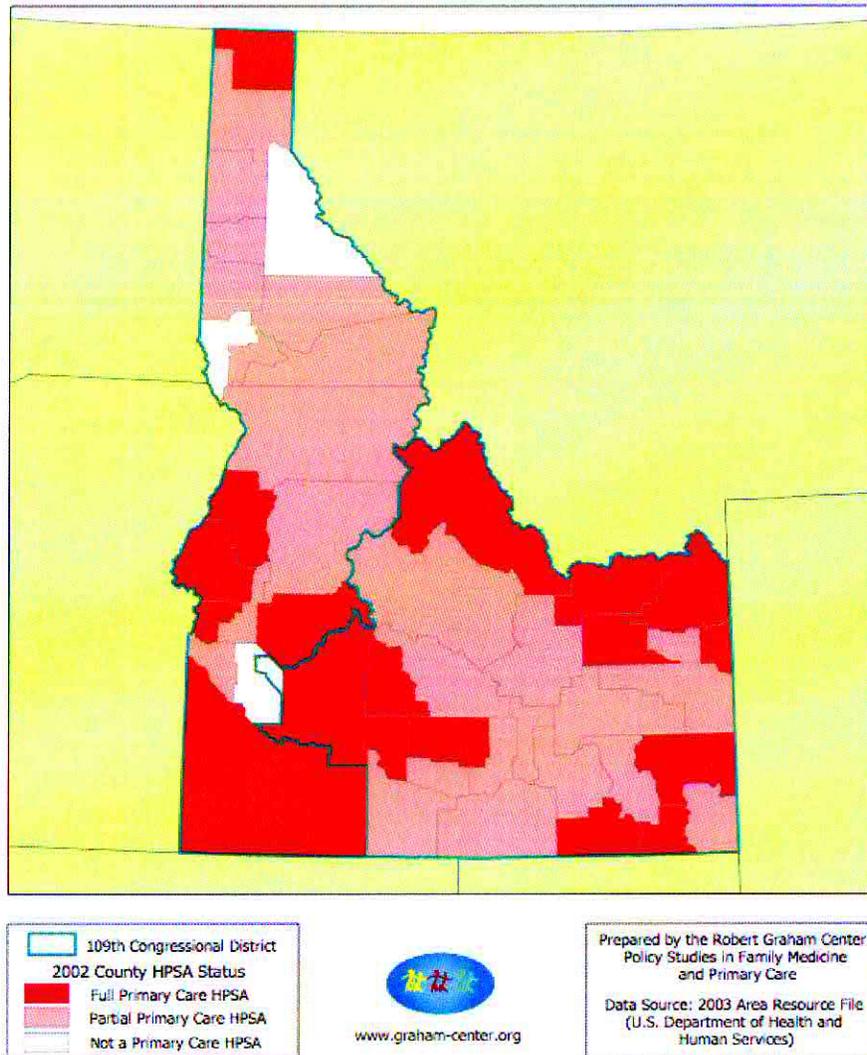
- Total physician supply (per capita) is becoming too low, especially in light of the rapidly aging population.
- Physician supply is persistently subject to specialty and geographic maldistribution.
- There has been a national decline in the number of medical students being educated compared to the U.S. population growth.



Over the past ten years, the number of physicians entering primary care residencies in the U.S. has also declined:

- Both the number of available Family residency openings and the number filled by graduating medical students has declined by nearly 15% since 1998;
- The number of graduating medical students entering general internal medicine has declined by over 30% since 1998, with more graduates selecting specialties and hospitalist positions in internal medicine.

IDAHO: PRIMARY CARE HEALTH PROFESSIONAL SHORTAGE AREAS



30 million people in the U.S. live in federally designated **Health Professional Shortage Areas (HPSA)**. In **Idaho**, all but three counties are designated primary care HPSA's.

What is the role of states and medical schools in fixing the medical education pipeline? States have an obligation to meet the health care needs of their populations. Yet U.S. per capita physician supply is declining and shortages of primary care providers and general surgeons threaten to exacerbate the rural healthcare workforce crisis.

- Enrolling more students who are from rural, underserved, or high need locations is a highly effective way to train new physicians who are more likely to return to these high need areas.
- When a community or county is short on physicians, local hospitals and medical centers struggle or close, decreasing local access to healthcare.

- Employers have trouble recruiting workforce to communities with low healthcare access, and families are often disrupted by having to seek care at a distance for both young and elderly family members.
- Decreased access to healthcare leads to less early treatment of disease and increased development of chronic and critical health conditions.

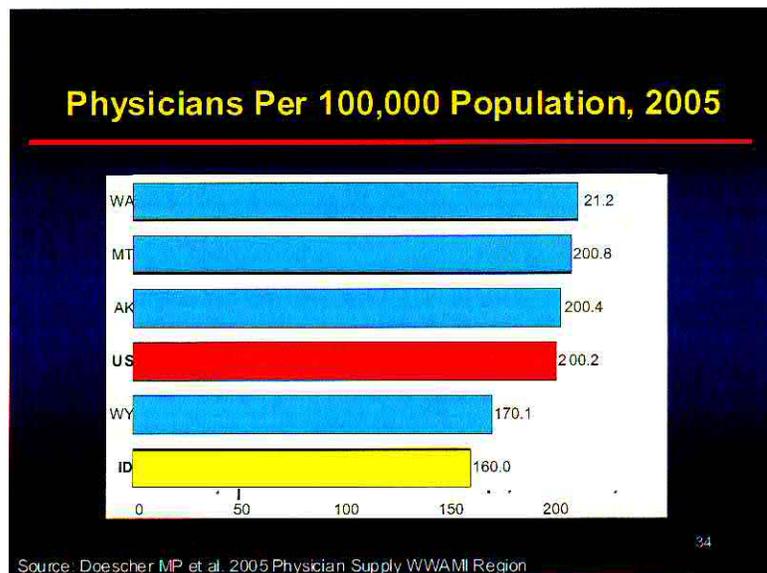
What is the current Idaho physician supply and the medical student pipeline?

- Idaho has one of the lowest medical student enrollments in the nation (2009: 28/year – Utah and WWAMI)
- This number is less than one-third of the per capita national average.
- And yet Idaho has one of the most qualified medical school entering classes in the nation (based upon grades and medical school admission scores)

Idaho’s population is predicted to increase 24% by 2025, much faster than the national projection of 14%. At the same time, Idaho’s aging population (over 65) is predicted to grow 82%, compared with a national growth rate of 61%.

What are the best estimates of Idaho’s medical and mid-level professional workforce per 100,000 population, and how does that compare with national estimates?

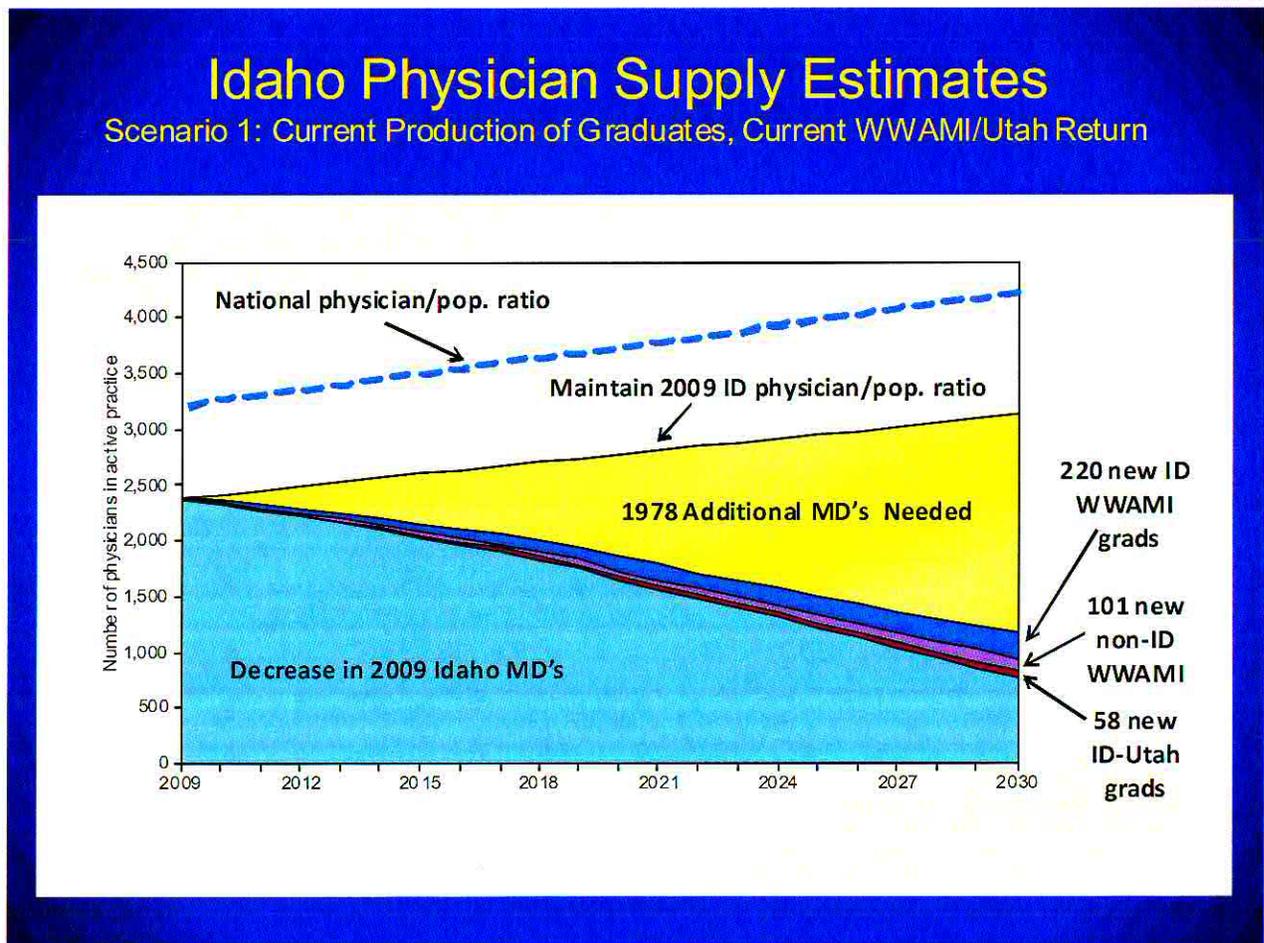
- Physicians (Idaho has one of lowest numbers):
 - Idaho: 160/100k
 - US: 202/100k
- Physician Assistants (Idaho is above other states):
 - Idaho: 33/100k
 - US: 24/100k
- Nurse Practitioners (Idaho is below other states):
 - Idaho: 40/100k
 - US: 48/100k



What are our current estimates of physician vacancies in Idaho and what specialties and in what regions are they located?

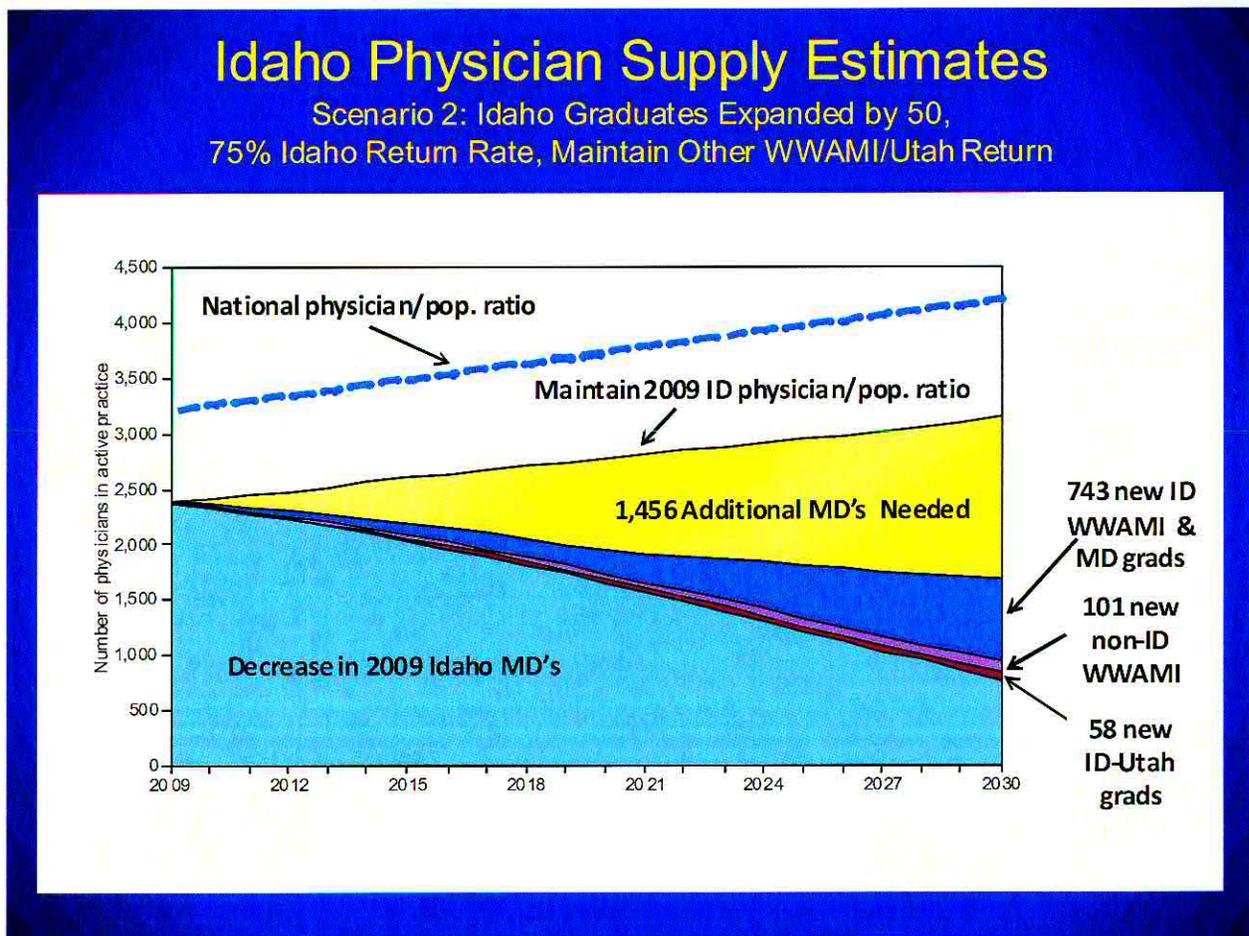
- Currently 30 Idaho physician vacancies posted on the 3RNet website (National Rural Recruitment & Retention Network - www.3rnet.org) 25 of these Idaho vacancies are identified as primary care openings.
- Of these 25, ten vacancies are also listed in Idaho Primary Care Health Professional Shortage Areas

Given Idaho’s population growth predictions and projected healthcare needs, if there is no change in the present levels of support for medical education, Idaho will continue to fall even further behind in its shortage of physicians to care for its citizens. The following slide depicts the continuing decline in Idaho physicians per population, due to retirements of current workforce and increased patient demand, over the next twenty years. At current levels of support, Idaho’s reliance on out-of-state physician recruitment grows to more than half of the expected overall need. In addition, under current levels of support, Idaho continues to lag substantially behind the national level of physicians to population ratios.



What difference can Idaho make in the state’s physician supply by increasing its support of medical education?

Currently, the Idaho State Board of Education has recommended doubling the size of the WWAMI medical student entering class each year, from the current 20 to 40, over a two year period (currently, further increases in Idaho students in the Utah class are not available). In addition, the State Board has recommended additional expansion of total medical student admissions to 60 or 90, when resources are available for such an additional expansion. **The following slide depicts the impact of state support in expanding the number of Idaho medical students by 50, while at the same time increasing the overall return rate of medical graduates to 75%, through increased incentives such as the Idaho Rural Physician Incentive Program.** These two actions alone would decrease Idaho’s reliance on recruiting out-of-state doctors to meet its physician supply needs by over 25%.



Summary Points:

- Compared to other states, Idaho produces very few physicians.
- The State has no shortage of qualified applicants for medical school.

- Expanding the medical education program in Idaho by 50 physicians per year would reduce the reliance on out-of-state physicians to meet the state's physician workforce needs
- Expanding graduate medical education (residencies) would produce the quickest return on investment
- Efforts to retain more graduates in Idaho would further help reduce the need to import physicians.
- Like most states, including Washington, Idaho will continue to be an importer of physician workforce.

III. Overall Recommendations of the IHPEC for Workforce Development in the Health Professions

Dentists

- Begin programs to recruit and admit dental students from rural areas of Idaho.
- Insure that graduating dental students are aware of the National Health Service Corps and other loan reimbursement programs.
- Start an aggressive, State sponsored program to promote better dental health in the State's primary and secondary schools.

Nurses

- Implement the Nursing Workforce Advisory Council's recommendations, especially as they pertain to retaining and increasing nursing faculty to meet the growing demand for educating the nursing workforce.

Physician Assistants

- Continue to regionalize Physician Assistant training programs. Establish smaller classes across the State. Diversify the funding model to increase support for faculty across regional program sites.

Physicians

- Support planned, steady annual growth in medical student education, utilizing Idaho's academic and health care resources, regional medical education partners and private business, following the recommendations of the Idaho State Board of Education.
- Increase access to medical education opportunities for applicants from rural communities and underserved groups.
- Increase State funding support for Graduate Medical Education (GME)/residency programs.
- Expand rural training tracks in existing Family Medicine residencies and create additional Idaho primary care medical residency programs in Internal Medicine (Boise) and Family Medicine (Coeur d'Alene).

- Evaluate the creation of an Idaho GME office to provide oversight in the expansion and future funding of Idaho medical residency programs.
- Evaluate allowing licensed physician residents in Idaho's residency programs to participate in debt repayment through an expanded Idaho Rural Physician Incentive Program. This would provide increased incentives for new physicians to begin their residency training in Idaho.
- Expand funding sources for the Idaho Rural Physician Incentive Program to include private and professional groups who have a vested interest in Idaho physician recruitment and retention. A serious commitment to fully endow the IRPIP will contribute greatly to rural physician recruitment and may allow expansion reimbursement to other health professionals (P.A.'s, NP's, etc.) in rural areas.

All Health Professions

- Improve tracking and access to current State data on all healthcare and medical graduates in Idaho programs through collaboration with the Idaho Department of Labor.
- To retain the highest quality program faculty, salary and benefits support in all health care disciplines must be competitive.

Idaho Health Professions Education Council

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