HEALTH CARE TASK FORCE
MINUTES

Wednesday, November 1, 2006
JFAC Room, State Capitol, Boise, Idaho

The meeting was called to order at 9:00 a.m. by Cochairman Senator Dean Cameron. Other committee members present were Cochairman Representative Bill Deal, Senators Dick Compton, Tim Corder and Kate Kelly, and Representatives Max Black, Sharon Block, Gary Collins, Kathie Garrett and Margaret Henbest. Senators Joe Stegner and John Goedde were absent and excused.

Others present included: Teresa Watkins, Nanette Byerly and Kjeranna Rimmel, Boise State University (BSU) Nursing Students; Suzanne Allen, WWAMI; Julie Taylor and Woody Richards, Blue Cross of Idaho; Steve Millard and Toni Lawson, Idaho Hospital Association; Carol Ashton, Idaho State University School of Nursing; Sandy Evans, Board of Nursing; Robert Vande Merwe, Idaho Health Care Association; Brianne Childers, BSU; Corey Surber and Jeremy Pisca, Saint Alphonsus; Pam Springer, BSU; Bonnie Lind, Idaho Nursing Workforce Center; Sharon Stoffels Strand, Idaho Nurses Association; Bob Seehusen, Idaho Medical Association; Ken McClure, Givens Pursley; Christine Rood, University of Phoenix; Maribeth Connell, AARPCCTF; Nancy Kerr, Mary Lemard and Cathleen Wagnold-Morgan, Board of Medicine; Rakesh Moran and Ned Parish, Office of Performance Evaluations; Therese Bishop, Regence Group; Jesus Blanco, Katrina Hoff and Rachel Wheatley, Idaho Primary Care Association; Bryan LaPray; Kent Kunz, Idaho State University; and Larry Dewey, M.D., VA Medical Center.

After opening remarks from **Senator Cameron, Matt Ellsworth** from the **Governor's Office** gave an overview of the Governor's Nursing Initiative. **Mr. Ellsworth** explained that the initiative was the result of recommendations and findings of the Nursing Task Force. He said that the first charge of the Nursing Task Force was to focus on the industry of nursing rather than individual colleges. He said that throughout the process, the Nursing Task Force was committed to looking at the nursing shortage at an Idaho level.

Mr. Ellsworth continued by stating that the second charge was to identify problems in Idaho's nursing crisis that can be addressed. He said one problem identified is how to educate future nurses. He said when they visited colleges and universities, the presidents continually said they need help retaining nursing faculty.

The Nursing Task Force held three meetings and its members want to continue working on the issues. He noted that there are currently 500 jobs open and 800 students who are qualified to enter the classroom, but Idaho cannot meet the need. The Nursing Task Force was charged with

finding innovative ways to deal with the gap in the short term. They want to also deal with the long term issues. He noted that they did not discuss building issues.

Steve Millard, Idaho Hospital Association, was the next speaker. He stated that he was part of the Nursing Task Force and agreed that it is a priority issue. He recognized the hard work of the Task Force and said that the final product includes recommendations that will serve the health care industry well in the future. **Mr. Millard** then discussed the issue of health care shortages in hospitals. He commented that when he surveyed members, a workforce shortage was the top issue. As a result of that, he did a survey to identify the level of those shortages. The complete presentation is available at the Legislative Services Office.

Mr. Millard explained that it was a two-part survey. Physicians were asked to rank the top 10 positions of concern. Based on the results of the physician survey, a vacancy and turnover survey was conducted. These were both done online. **Mr. Millard** explained that for calculating the vacancy rate, vacancy positions were divided by fully-staffed positions. Turnover occurs when employees leave an organization and have to be replaced. The turnover calculation is the number of employee separations between January 2, 2005 and January 1, 2006, divided by the total number of employees on June 30, 2005. The following are the statewide rankings for the positions of concern (1 is the highest concern):

- 1 - Staff Nurse (RN)
- 2 - Medical Technologist (ASCP)
- 3 - Physical Therapist
- 4 - Pharmacist
- 5 - Respiratory Therapist (Registered)
- 6 - ICU Nurse
- 7 - Director of Nursing Services
- 8 - Ultrasound Technologist
- 9 - Housekeeper
- 10 -Transition/Float Pool Nurse

He noted that staff nurse is the first or second top concern in both northern Idaho, southern Idaho and southeastern Idaho hospitals. The vacancy and turnover survey included staff nurse (RN), medical technologist (ASCP), physical therapist, pharmacist, respiratory therapist (registered), ICU nurse, Director of Nursing Services, ultrasound technologist, housekeeper, radiology technologist (ARRT) and medical records coder. The presentation includes graphs showing statewide top vacancy turnover rates and number of employee vacancy and turnovers. It also shows staff RN and ICU nurse vacant positions and rates.

Mr. Millard said that the staff RN vacancy rate is 8%; the turnover rate is 14%. His information shows that vacancy and turnover are highest for physical therapists and Directors of Nursing Services. He explained that there were 337 staff RN vacancies in September in Idaho hospitals and the number of turnovers was 613. One area of concern, according to **Mr. Millard,** is the average age of Idaho's health care providers. The statewide average age for staff RN is 42.6 years; Director of Nursing Services is 50.3 years.

Representative Black asked if any analysis was done regarding what age group would have the most turnover. **Mr. Millard** said he did not know but noted that nursing loses many older nurses due to the physical demands of the job.

Mr. Millard continued by stating that the survey included the following list of the most common reasons hospital employees leave their jobs. The responses range from 1 (the most common reason for leaving) to 10 (the least common).

- 1. Quit to move out of area
- 2. Another job
- 3. Family/personal circumstances
- 4. Return to school
- 5. Discharged
- 6. Dissatisfied salary
- 7. Dissatisfied working conditions
- 8. Illness/medical
- 9. Quit without notice
- 10. Lay off

Mr. Millard summarized his presentation by stating:

- Idaho hospitals comprise over 20,000 employees. RNs make up approximately 27.7 percent of hospital employees.
- The top position of concern for hospitals statewide in terms of vacancy is staff RN.
- As of September 2006, hospitals had approximately 383 vacant nursing positions statewide. The average rate has been increasing over the past few years. The average nursing vacancy rate in hospitals across the nation is 10%.
- The vacancy rate of 17% for ICU Nurses in southwest Idaho is of particular concern.
- The age of current employees in shortage positions is a factor (currently 40 to 50 years). As they near retirement by 2020, Idaho's population is projected to grow 29% while the population aged 65 years and over is projected to grow 117%, according to HRSA data. The complexity of an increasing population combined with the issues of an aging population present challenges that will continue to put a strain on the current shortage.

Senator Compton said he would like information regarding how many nurses there are who are both above and below the average age. **Mr. Millard** said he would get that information.

Senator Corder asked what vacancy percentage would be considered safe. **Mr. Millard** said percentages are difficult because in looking at them, there does not seem to be a problem. The problem becomes more obvious in looking at the raw numbers. He said a lot of resources are being put into workforce shortages as a result of this survey. **Senator Corder** asked how much turnover is a result of wage competition among hospitals. **Mr. Millard** said he did not know but noted that wages were given as a reason for leaving employment.

Representative Block asked for specifics regarding how the nursing shortage affects the quality of health care. **Mr. Millard** said that shortages can affect the quality of health care but, in his

opinion, hospitals are still providing high quality health care at the cost of burning out the nurses. He said it will probably get worse before it gets better and quality could become an issue.

Senator Cameron asked how hospitals, particularly rural hospitals, handle a shortage or vacancy in those positions. **Mr. Millard** said nurses work overtime or the hospitals use traveling nurses or agency nurses. He said this is a new trend where companies hire nurses to fill in when hospitals have vacancies on a temporary basis. He said this is a very expensive proposition because the agency nurses cost hospitals a lot more than employed nurses. **Senator Cameron** asked how much of the shortage (particularly in southwest Idaho) is created by the rampant buildup of hospital beds and whether there is anything to compare the vacancy of those beds with the shortage of nurses. In other words, is there a shortage because there are more beds available than are actually filled or is the shortage due to more beds being filled? **Mr. Millard** said that he thinks it is a combination. Hospitals are trying to keep up with the population by adding beds and there are more health care facilities coming online that employ nurses. As the population grows, so does the need for health care services.

Senator Cameron introduced the nursing panel and noted that the panel members served on the Governor's Nursing Task Force. The first panel member to speak was **Bonnie Lind, PhD, Director of Research, Idaho Nursing Workforce Center**.

Dr. Lind first noted that in response to **Representative Block's** question regarding the quality of health care and the nursing shortage, she said that there is research showing that inadequate nurse staffing leads to longer hospital stays and more complications. She began her presentation by explaining that her primary research area at the Idaho Nursing Workforce Center is the supply and demand for nurses and noted this is an extremely complex part of the problem. Her complete presentation is available at the Legislative Services Office and covered the following:

- Shortage from the employer perspective (Demand side)
  - Hospitals
  - Long-term care
  - Doctor office & clinic
- Shortage from the nursing education perspective (Supply side)
  - Limits to nursing program capacity
- Projections: What does the future hold?
- Presentations from nursing program directors

Dr. Lind discussed a chart showing information on the age distribution of nurses in hospitals and in long term care. She said that once nurses in hospitals reach ages 50 through 55, they tend to leave due to the demanding nature of the work. Currently, there is a large group of nurses between the ages of 45 to 55 and as they age, many of them will leave the hospitals, causing a large jump in the need for nurses. Almost 60% of nurses in hospitals are over 40 years old and over 60% in long term care are over 40. **Dr. Lind** also included a chart showing a projection given the current age of nurses and what would happen if they retire at age 60 or age 65: If they retire at 60, by the year 2019, 50% of the current nurses will be gone.

Dr. Lind spoke to the effects hospitals and long term care facilities are seeing today due to nurse vacancies and the nursing shortage. In long term care, managers are caring for patients instead of managing, there is low staff morale and increased overtime and increased costs. This shortage also means more patients per nurse which can lead to lower quality of care. The shortage also leads to the use of "temps" or traveling nurses. In hospitals, 50% said the shortage leads to increased costs to deliver care. Almost 25% admitted they have had increased incidents or errors reported. One in five hospitals turned away patients because they did not have nurses to care for them. Hospitals have also reduced or eliminated services. **Dr. Lind** stated that all of these issues lead to a spiral of increased turnover.

Dr. Lind went on to discuss what is being done to supply new nurses to meet this demand. She said there are a variety of nursing programs throughout the state. These include licenced practical nurses, associate degree nurses (AD) and bachelor of science degree nurses (BS). Someone can become a registered nurse by getting a BS or an AD. Four-year, two-year and private colleges all offer nursing programs and Idaho currently offers one masters program at ISU. **Dr. Lind** said the current programs cannot meet the need for qualified nurses. The number of qualified applicants is much higher than the number that are actually admitted to nursing programs mostly due to space issues. Most of the programs are at maximum capacity.

Dr. Lind stated that in her opinion, one of the most troubling issues is that the average age of faculty in Idaho is 50-55 year of age. When this information was gathered in the fall of 2005, there were only two programs that had any faculty under age 40. She noted that in order to become faculty, a person needs to be a registered nurse with a Masters in Nursing. Another issue is that during the past school year, 20% of the full-time faculty left nursing departments statewide with the number one reason for leaving being salary. Masters level nurses can go to hospitals and make at least 75-100% more than they make as professors. The low faculty salaries, in her opinion, are the main reason Idaho has 23 job openings and only had 31 qualified applicants.

Dr. Lind's presentation also included charts showing projections that the population growth for people over 65 years of age will almost double by 2030, greatly increasing the need for health care professionals and the number of new nurses that would be needed to fill newly created jobs due to growth and jobs that need to be replaced due to nurses leaving. This number is about 6,000, and at the current rate of graduation, there will only be about 4,000 by that time.

In summary, **Dr. Lind** stated that:

- Idaho does not have the capacity to produce the nurses needed to fill demand.
- Increasing the capacity of nursing programs will help: 85% of graduates stay in Idaho.
- "Increasing capacity" is a multifaceted issue. To increase capacity, Idaho must:
  - Increase faculty salaries to retain current faculty.
  - Develop additional Masters and Doctorate in Nursing programs so new faculty can be produced in state.
  - Create additional capital space for nursing programs.
  - Provide alternative clinical placement avenues (*e.g.*, simulation)

In response to a question from **Representative Henbest** regarding admissions versus graduates, **Dr. Lind** explained that increased admissions only started in 2002 and those are for four-year programs, so graduate rates should begin to increase somewhat in the next year or so.

Senator Compton asked how the use of information technology could improve health care and help health care providers. He said he realizes there is no substitute for nursing care, but asked what tools could be provided to nurses to increase their productivity. **Pam Springer, BSU**, said there have been significant improvements in technology in hospitals to help aging nurses stay at bedsides. These include automatic IV pumps and PDAs.

In response to a request from **Senator Kelly**, **Mr. Ellsworth** provided a copy of the Nursing Task Force recommendations.

Pam Springer, RN, PhD, BSU, was the next speaker. She agreed with **Dr. Lind's** presentation and stated that BSU offers all levels of nursing programs and currently admits and hopes to graduate 120 nursing students per year. This will increase by 30 over the next three years. She agreed that faculty salaries are the biggest issue at BSU. Out of 38 nursing faculty members, she began the year down three and lost seven faculty last year. Six losses were due to salary. Masters degree nurses teaching at BSU who make $42,000 can make $88,000 at a local hospital.

Dr. Springer said that facilities are the next biggest issue at BSU. There is no more office space and they are out of classroom space. BSU is on a capital campaign to raise money for facilities for a new nursing building. She explained that space in hospitals for clinical experience is the third issue. BSU is exploring the use of simulation labs and hopes to get funding to put these in and to partner with ISU to augment and maybe even replace 1/3 to ½ of the need for clinical placements in valley hospitals.

Representative Black asked what the source is for additional faculty and how they are recruited. **Dr. Springer** said she was not successful in attracting faculty last year and noted that BSU lost four applicants to whom offers were made due to salary. She said that BSU fills in with adjunct or part-time faculty. Nurses from facilities are sometimes hired to take a group of clinical students into the facility. She added that some of the clinical facilities have actually paid salaries of their staff to act as clinical adjunct faculty. **Dr. Springer** said people become faculty because they love education and want work to prepare the next generation of nurses and think they can do it until they realize they cannot afford it.

Claudeen Buettner, RN, EdD, College of Southern Idaho (CSI) was the next presenter. She said that the CSI nursing program is employing employer-driven solutions and thinking outside of the box. CSI has been working to increase the number of nursing graduates. In 2002, CSI graduated 41 RN students and 30 LPNs and in May 2006, CSI graduated 84 RNs and 60 LPNs. They did this by doubling the program capacity. **Dr. Buettner** explained that CSI is very active in seeking both state and national grants. Their current grant fund source is the Rural Partnerships Solutions for Health Occupation Shortages from which they received a $1.4 million

grant over a three-year period. CSI decided it was necessary to recruit people into health care and nursing. As a result of that decision, a very strong dual-credit program was developed. She distributed a brochure on this program that outlines the health care opportunities available to high school juniors and seniors to advance place through CSI. She noted that there are currently 480 high school students taking these college-level health care courses.

Dr. Buettner continued by stating that CSI is also streamlining career ladders via fast-tracks for LPNs to RN. LPNs who finish their education in one year and have the general education requirements for the RN program can enter the RN program and finish in two semesters. She noted that CSI is admitting 100 students (50 per semester) into the RN program using existing space and partner locations to maximize capacity via expanded onsite training, simulator technology, virtual IVs, and multiple clinical labs.

Dr. Buettner said CSI develops its faculty pool using "grow your own" strategies. They also have ISU on campus so a person can finish their degree on the CSI campus and go on to get their masters as well. Employees at CSI only pay $5.00 per credit for graduate credits. Students are also given stipends from the CSI Foundation to use budget items such as books and gas. **Dr. Buettner** said that this success story be shared with multiple end users regionally, statewide and nationally.

According to **Dr. Buettner**, CSI outputs over the next three years include:

- 270 RNs graduate and become employed
- 150 LPNs graduate and become employed
- 90 LPNs are fast-tracked into the RN program
- 90 CNAs are fast-tracked into the LPN program
- 30 Paramedics are fast-tracked into the RN program
- Over 1,200 CNAs graduate
- 85% retention in employment for RNs and LPNs

CSI's action items include $500,000 in support from the Governor and Legislature. She said that private industry has pledged $250,000 per year for five years. If the state were to appropriate the $500,000, that would bring the total up to $750,000 per year for five years and allow them to continue with their plans.

Senator Corder asked for clarification of the time frame involved in becoming a nurse. His wife studied for her RN and it took four years to meet all of the requirements. Today, someone can become an RN with a two-year associates degree. He asked whether this means that the curriculum is being watered down. **Dr. Buettner** said there are many different ways to get into health care and nursing; nurses' aid is a good starting point as is being a CNA. She noted that the CNA program is a state-approved program that requires 120 hours. The LPN program can either be an 11 months or two-year program depending upon the certificate or degree the course offers. An RN can be obtained through either an associate degree, a four-year program and a masters program. She said that the license for a two-year graduate and a four-year graduate is the same.

Senator Corder said it still appears that the programs are being watered down when it used to take 3-4 years and now it only takes two years. He asked why that wouldn't impact health care. **Dr. Buettner** said, in her opinion, the programs have not been watered down. Three-year programs in past years had very strong clinical components and those students worked 40 hours at hospitals plus classes. CSI hopes that they are preparing a nurse and graduate who can think critically, diagnose and get help when necessary and give safe, quality care. In her opinion, if students are passing national licensing boards at 90% or above the first time, they are safe to be practicing nursing. She said she is not saying an associate degree is the same as a baccalaureate degree, but an LPN or a person with an associate degree who enters into nursing has the ability to move into the baccalaureate and masters programs.

Representative Block asked how CSI was able to hire three faculty members under the age of 40 and how will it keep them. She also asked for more information regarding difficulties CSI is experiencing with clinical facilities. **Dr. Buettner** stated that CSI advertises locally for job openings and noted that these openings were not due to someone leaving but rather an expansion of the program. CSI has a continual pool of adjunct faculty that are enrolled in graduate study as well as a continuous advertisement on the CSI website. CSI also sends letters to graduate schools. In her opinion, CSI hires the strong clinical person in the 35-40 year range. It could be someone who has finished the baccalaureate degree a few years ago and worked in a hospital. She said they have partnered with hospitals and CSI pays essentially the same wage as the hospital and also pays faculty to attend graduate school. Some of the expansion to the programs has been affordable due to a reallocation of resources. **Dr. Buettner** said that universities have a harder time reallocating due to how their allocations are figured. CSI has more ability to move money from a program that is not full or is undersubscribed to a program in higher demand. She noted that CSI does not have a large faculty turnover.

In response to **Representative Block's** question about clinical placement, **Dr. Buettner** said CSI used to run Monday/Wednesday or Tuesday/Thursday 7:00-12:00 or 7:00-2:00. Currently, they are working every day of the week with double shifts using rural hospitals. They currently have nine hospitals and seven nursing homes. CSI has also opened a second simulation lab and uses distant labs in other locations.

Carol Ashton, PhD, Idaho State University (ISU) was the next speaker. She distributed a handout that lists the current nursing programs available at ISU and also what is being done to respond to the nursing shortage with these programs. **Dr. Ashton** stated that ISU also has challenges with maintaining current faculty. ISU lost four senior-level associate professors and professors this past year due to retirement. Replacing that level of knowledge and senior level role models within a faculty is very difficult. There are people interested in faculty positions at ISU but these people do not become employed due to salary issues. She said that this shows that salary equity for current faculty is absolutely critical.

Dr. Ashton went on to discuss some initiatives ISU has put in place to respond to the shortage. She noted that ISU is almost at capacity without additional assistance. These initiatives include:

C Associate Degree RN Program (ADRN): This program was initiated to respond to the

needs of rural hospital administrators. It has just graduated its first class of 13 students. Many of the classes were offered to rural nurses online and included a more intense series of clinical supervision.

- Bachelor of Science (BS) Nursing: This includes accelerated pathways for LPNs and associate degree nurses who want a baccalaureate degree. There is also an accelerated second degree program in Boise for students with degrees in other fields. Once they complete their science prerequisites, they can complete a baccalaureate degree in four semesters. **Dr. Ashton** said ISU currently has 20 students per year graduate into the market who stay primarily in the Boise area. These are highly sought after graduates.
- Masters Degree Nursing: ISU reinitiated its nursing education options so that students who pursue nursing studies are prepared for faculty roles. All of the masters programs are fully online giving access to graduate nursing to people anywhere in the state.

Dr. Ashton stated that enrollment has increased in this program due to the fact that ISU has national accreditation standards for certain clinical specialties. ISU is also accepting its very first class of AD to MS Program. If someone has an associate degree in nursing (after 1995), they are admitted into the ISU program and can complete a baccalaureate in one semester. This person would be concurrently admitted to the master's program. ISU also has post masters certificates available and is actively working with the State Board of Nursing to make those available to nurses with masters degrees in Public Health so they can become nursing faculty.

Dr. Ashton said that two years ago, ISU developed a regional collaborative with Oregon Health Sciences University (OHSU) to offer a PhD. She noted there is currently one student enrolled in this but there could be eight if ISU had been able to help with tuition. OHSU is the sixth-ranked doctoral program in the country and this was an unprecedented opportunity. She suggested developing a program similar to WICHE or WWAMI to begin to be able to incentivize nurses in Idaho to be able to access doctoral education. She noted that ISU has a doctoral program on the State Board of Education's eight year plan but that does not take care of beginning to have higher degree-prepared faculty at this point. The minimum is five years for a nursing doctorate.

Dr. Ashton reiterated that ISU is actively looking at renovating space, simulations and grant sources to help alleviate physical space limitations. She added that there are still major limitations in Idaho for technological infrastructure. Many communities are without the necessary infrastructure to support contemporary and state-of-the-art delivery of distance education and there is a need for that. **Dr. Ashton** said that ISU has partnerships and has had clinical agencies actually support a full-time salary for faculty. She stated that these clinical agency margins are also decreasing and, in her opinion, this support will probably not continue to the extent that it has in the past.

Dr. Ashton said that in addition to the need for faculty salary equity, there is no statewide plan in Idaho to examine health professions education. There are program proliferations without documentation of needs and without forecasting and modeling in terms of what is needed. She said this is within the realm of government and there is desperate need for this.

Sharon Stoffels, President, Idaho Nurses Association, was the next speaker. She explained that the American Nurses Association represents 2.9 million nurses nationwide and the Idaho Nurses Association was initiated in 1909. **Ms. Stoffels** stated that the nursing shortage is a threat to the health of all Idahoans, noting that studies have documented that the lack of quality nursing care leads to adverse outcomes. According to a 2002 report by the Joint Commission on Accreditation of Healthcare Organizations, inadequate nurse staffing has been a factor in 24% of the 1,609 cases involving patient death, injury or permanent loss of function reported since 1997. She distributed a handout that lists workplace issues that affect retention of experienced nurses and includes national recommendations on what to do to solve the nursing shortage issues. **Ms. Stoffels** commented that unless the work environment is addressed, any strategies proposed to increase the supply of nurses will not be successful. **Ms. Stoffels** noted that Kootenai Medical Center and St. Lukes Regional Medical Center are both magnet hospitals for Idaho and others are applying. Magnet hospital programs have been successful in retaining nurses nationwide.

Senator Corder asked what is it about the work environment that is causing nurses to leave. **Ms. Stoffels** answered that studies done nationwide show that the workplace environment needs to improve flexible scheduling, nurses want more say in control of patient care and the decision making process, and mandatory overtime causes burnout.

Senator Compton asked why nurses want to work at magnet hospitals as opposed to other hospitals. **Ms. Stoffels** said this is due to the fact that a hospital has a to take many steps in order to qualify as a magnet. They are more nurse-focused and nurse-friendly. She noted that the differences between magnets and nonmagnets are very great.

Sandy Evans, Executive Director, Idaho Board of Nursing, was the final panel member to speak. She distributed a fact sheet that included the purpose of the Board, its powers and duties, the number of licensees, and board-approved nursing programs. She explained that the standards for licensure are regulated by the Board as are standards for educational programs that prepare nurses for licensure and continued practice in the state. She noted that there are criteria in place to guard against the tendency, in times of a shortage, to reduce standards.

Senator Compton stated he serves on a commission where he is learning that hospitals are rapidly moving to information technology to increase productivity but it is difficult due to the expense and the fact that the skills required to use the technology are lacking. He asked whether school curriculum is teaching nurses to use the latest technologies. **Dr. Buettner** said that CSI has a computer literacy graduation requirement. She noted that this entry of information into the technology might be the responsibility of the medical assistants. CSI has garnered a $3 million grant at Magic Valley Regional Medical Center that allows electronic medical records in the doctors' offices that CSI has access to as an educational tool. **Dr. Ashton** added that, in her opinion, the nurse is probably not the most appropriate person to do this type of entry. She said the nurse needs to know how to use decision support systems that are available for facilitating quality of care. She said it does take opportunities to be able to access real data systems for people to learn how to use such systems.

Senator Kelly asked how the Governor's request for $37 million to expand health care facilities fits in with the Nursing Task Force's recommendations. **Mr. Ellsworth** clarified that the Governor's recommendation went beyond the Nursing Task Force's recommendations. The request is for two specific facilities: Lewis-Clark State College for a $16 million health sciences building, and a $21.1 million health sciences facility at CSI intended to house the nursing education programs at those schools. **Senator Cameron** noted that it was his understanding that the Governor is also endorsing the recommendations of the Nursing Task Force.

Senator Cameron commented that the focus of the Health Care Task Force has been health care costs and he would like to know how the nursing shortage affects that and how it affects health care service.

Robert Vande Merwe, Executive Director, Idaho Health Care Association, was introduced to discuss the nursing shortage and how it affects long term care. His complete presentation is available at the Legislative Services Office. **Mr. Vande Merwe** explained that vacancy rates are different than unemployment rates. He said there is probably a mechanism that would deal with a vacancy in the Legislature or in a school district. He said with regard to nursing, there is no such mechanism. A licensed nurse has to replace a licensed nurse. He said a zero vacancy rate is the magic number and he would love to have two qualified applicants for each opening but there are more openings than applicants so quality is lowered.

Mr. Vande Merwe noted that there are four or five agencies in the Treasure Valley that hire staff RNs at a higher wage than they would be paid by working at a hospital or long term care facility. These RNs pick and choose the shifts they want to work and at which facilities. This causes staff RNs to leave thereby creating more openings and increasing the cost of health care. **Mr. Vande Merwe** discussed a slide showing that the demand for nurses over the next twenty years in hospitals and nursing homes will increase but the most dramatic increase will be in home health care. Home health care is one-on-one care and will require more nurses.

Mr. Vande Merwe said that Idaho law requires a certain number of staffing hours per patient day. All facilities exceed that in order to provide high quality care. The national average is around 3.5 and he said Idaho is similar to that. A national commission has reported to Congress that it should be 5 hours per patient per day. Translating that into bodies at a 100 bed nursing facility, which if full would currently have about 40 FTEs, would increase it to 60 FTEs. **Mr. Vande Merwe** said that all facilities would like to have more staff but that would require about 250,000 more bodies at a cost of several billion dollars. His last slide showed that the ratio of elderly people to caregivers in the year 2000 was fine: There were more caregivers than elderly. With baby boomers aging, by the year 2020, that ratio will be reversed.

Bob Seehusen, Idaho Medical Association (IMA), and **Dr. Suzanne Allen, WWAMI Clinical Medical Education Coordinator for Idaho**, were introduced to discuss the physician shortage in Idaho. **Mr. Seehusen** said he agrees with all of the earlier comments about the nursing shortage and stated that there is also a shortage of physicians in Idaho. There are approximately 4,000 licensees in Idaho and about 2,600 actually practice in the state. He said that is a shortage

in numbers as well as in distribution and in primary care doctors and some specialties. Idaho ranks about 49th per capita of doctors and the most acute need is for family practitioners.

Mr. Seehusen said if they could hire every doctor, the state could use 100 family doctors and 175 general internists. He said that internists are very hard to find and this leaves family doctors having to handle these problems. He noted that there needs to be a psychiatry residency developed in Idaho. Idaho could hire 40 psychiatrists today. According to **Mr. Seehusen,** every community in Idaho that can support a doctor is searching for one.

Mr. Seehusen said that it is becoming more difficult to find family doctors for many reasons. The main reason is strictly economic. Costs, including medical education costs, are increasing. Young people in medical school might want to do family practice but with the amount of debt incurred, they become a specialist with a higher income level. He said that another reason for the shortage is due to older doctors cutting back on the amount of time they spend in their practice.

Mr. Seehusen added that primary care doctors see many Medicare and Medicaid patients. He noted that Idaho provides a reasonable reimbursement increase in Medicaid every year. Medicare, according to **Mr. Seehusen,** is where the real problems is as the population ages. More people will be needing care and the care will be more costly. He said that as reimbursements go down, more physicians are saying they will have to cut back on the number of Medicare patient slots. He said this is a very large problem. **Mr. Seehusen** said that there is not much being done nationally to alleviate this problem. There is work going on for Congress to totally revamp the reimbursement system to physicians. It needs to be changed so that people will be motivated to go into the primary care field.

Mr. Seehusen said that the IMA was grateful to the Legislature for supporting medical school seats. Idaho does not have a medical school but we are able to buy seats at both the University of Washington and the University of Utah. He added that the IMA is very supportive of the Board of Education's budget request for two more seats at the University of Washington, but said that the University of Utah should not have been left out of this request. Utah's program is a very cost-effective program because they supplement what Idaho pays per student.

Mr. Seehusen said medical education and training is a great investment. People from all over the country come to Idaho's residency programs to train here for three years. The residency here is the largest provider of Medicaid services in the state and allows young doctors to gain experience with the uninsured and Medicaid patients. These programs not only train young doctors but they help take care of an unmet need in communities. He also noted that Idaho enacted excellent tort reform legislation and that has become a large recruitment tool. Average premiums in Idaho are about the fourth lowest in the nation. High risk specialties on the East Coast are paying $200,000 to $250,000 per year for $1 million-$3 million in coverage. In Idaho, for the same amount, they pay $36,000 to $42,000.

Mr. Seehusen concluded by stating that a shortage of physicians does not affect the quality of health care. In his opinion, patients will always get the best quality care that a physician has to

offer. He said it can affect health care costs due to access issues.

Dr. Suzanne Allen reiterated **Mr. Seehusen's** comments. Her presentation is also available at the Legislative Services Office. The presentation included slides showing the number of family physicians, general internists, pediatricians, OB-GYNs and general surgeons in Idaho per 10,000. She commented that many parts of Idaho qualify as Primary Health Care Professional Shortage Areas. If all of the family physicians were removed from Idaho, nearly the entire state would be a Health Profession Shortage Area.

Dr. Allen discussed the following changes in medical students and residents:

- more than 50% of today's students are female versus fewer than 10% in 1980
- more likely to choose specialty based upon lifestyle and salary
- more likely to work part-time
- more likely to be an employed physician
- work hour regulations for residents

She explained that several years ago the requirement was changed so that residents cannot work more than 80 hours in a week and they cannot work more than 30 hours at a time. She said she thinks this is an improvement. On the other hand, when residents have finished their training programs, they do not want to work seven days a week or work the day after being on-call overnight. This means there is a need for more physicians to replace those who are retiring.

Dr. Allen stated that the population is expected to increase by 29% by the year 2020 with a 117% increase in those aged over 65 years. She said the need for physicians increases as the population ages. She explained that as of the year 2000, the ages of 45-64 and 65-74 showed the largest increase in need for physicians in both primary care and for medical specialties. Another projection shows that if the graduation rate continues as it is, there will be a decrease in the number of non-primary care specialists compared to the population and that there is a need for a 20% increase in primary care physicians by the year 2020. **Dr. Allen** added that due to the rural nature of Idaho, the state will actually need a larger increase in primary care physicians compared to national projections. To alleviate some of the shortages, the American Association of Medical Colleges projected a 30% increase in medical student seats and a projected 12.5% increase in graduate medical education positions.

Dr. Allen said that for Idaho, using the 2005 data, there were 161 students who applied for medical school last year. Sixty-one percent of those applicants matriculated into a medical school in the United States. Sixteen percent went to an in-state school; either one of the 18 seats at the University of Washington or one of the eight at the University of Utah. This compares to the national average of 28.5% of applicants attending in-state schools. She noted that student who attend in-state schools are more likely to have a lower debt load so they are more likely to go to rural areas to practice. Idaho would need 46 students attending in-state medical schools to meet the national average for in-state medical students.

Dr. Allen explained the graduate medical education program in Idaho. For family medicine programs, Boise has eight residents per year; Caldwell, with the rural training track, has two

residents per year; and Pocatello has six residents per year. She noted that Caldwell and Pocatello each increased by one resident this past summer. There is also the internal medicine primary care track association with the University of Washington. These residents are here to do their second year of the residency education and there are ten here at any given time.

In response to a question from **Representative Henbest** regarding the number of family physicians in Idaho, **Dr. Allen** explained that the Idaho average is slightly higher than the national average due to the fact that rural states have more family physicians than urban states and noted that she would get the actual state number. **Dr. Allen** said it is important to compare this average to the health professional shortage areas that show if all family practitioners are taken out of Idaho, the entire state becomes a health professional shortage area.

Representative Henbest asked whether Congress is discussing funding graduate medical education. **Dr. Allen** explained that in 1997 the Balanced Budget Act froze funding for medical education. She said there is a push over next several years to unfreeze that funding. **Mr. Seehusen** commented that recent discussions in Washington, DC, show that very little is being done. He said there is an underlying concern that more doctors will lead to more utilization.

Representative Block asked how many of the 161 medical school applicants applied to Washington or Utah and how many were declined due to space. She also asked whether incentives are in place for graduates to practice in rural areas. **Dr. Allen** said all 161 applied to the University of Washington. Most usually try to apply to both schools. She noted that University of Utah has an additional requirement that the student have completed research. **Mr. Seehusen** said that University of Utah has about 30% fewer applicants due to that requirement. Regarding incentives, he explained that the Legislature established a pool that some of the money students pay goes into and if they go into rural practice, they can apply to get some of that money back. **Dr. Allen** said that 2003 was the first group to pay into that pool and they will be eligible for rebates in 2010.

Senator Compton questioned the statement that quality of care has not suffered. In his opinion, physicians will need to see more patients in order to make up differences paid by Medicare, causing them to spend less time with each patient. He asked whether there is anything in progress to help physicians use technology to increase their productivity. **Mr. Seehusen** said that electronic medical records will happen but will happen more slowly in rural states like Idaho. He stated that the cost is thought to be between $30,000-$40,000 per physician to put this into their office and there will also be a cost for ongoing maintenance. It is believed that electronic medical records will increase productivity, but he still believes that when a patient visits a physician, the physician gives the best care he can provide. The pressure on physicians is greater with increased paperwork.

Larry Dewey, M.D., VA Medical Center, gave a briefing on mental health needs in Idaho and a description of a Psychiatry Residency Proposal. He listed the following data:

- Every county in Idaho is now designated as a “Geographic Health Professional Shortage Area” by Health and Welfare. **Dr. Dewey** noted that Idaho is the only state he knows that

enjoys this “distinction.”

- According to the “2006 Health Care State Rankings” published by Morgan Quitno Press, Idaho ranks:
  - 4th in the nation in “percent of population reporting serious mental illness in 2003" at 10.5% while the national average is 8.8%.
  - 9th in the nation in “death by suicide in 2002" at 15.1% per 100,000. The national average is 11% per 100,000.
  - 50th in the nation for “rate of physicians in psychiatry in 2004" with five per 100,000. The national average is 14 per 100,000.
- National Alliance for the Mentally Ill (NAMI) rated all 50 states and the District of Columbia in 2006 based upon the adequacy and quality of their mental health services. Idaho is one of seven states to receive an “F.” Idaho was 51st in total mental health funding and 49th in funding per capita ($33.69/person). Two of the most urgent needs listed were “funding” and a “comprehensive plan to address the workforce shortage.”

Dr. Dewey explained that Idaho is establishing a graduate medical psychiatry residency that will follow the pattern successfully developed by the community of Spokane and the University of Washington. Residents spend their first two years in Seattle and their third and fourth years in Spokane. He stated that over 50% of the graduates of this program now practice in Spokane and the surrounding underserved areas.

Dr. Dewey said that Idaho has received $300,000 in annual costs of the residency from the VA. This funding will be ongoing for the life of the residency. He said they have been promised the rest of the support for the next four years from St. Lukes and St. Als. He noted that those hospitals are providing this support as an act of charity and receive no financial benefit for it.

Dr. Dewey commented that currently, none of the planned training for these residents will occur in state facilities. He said that to integrate training into state programs, Idaho would have to provide some funding for the residency. He noted that there is interest among clinicians working in Idaho to participate in the program. He asked whether Idaho would consider funding at least 10% of the cost of this residency. Some of the applicants being interviewed are from Idaho and the majority of those that come to the program will settle here. It is anticipated that the first residents will begin coming to Idaho for their third year residency in July of 2008.

Senator Cameron asked what 10% of the cost would be. **Dr. Dewey** said that it would be about $110,000. **Senator Cameron** asked if the request has been submitted through an agency budget. **Dr. Dewey** said he did not know. **Representative Garrett** said she has had some preliminary talks with the Board of Education as well as Legislative Services regarding this funding. **Senator Cameron** asked whether this residency program would adhere to the same qualification standards that require a person be trained at an approved medical school in the United States. **Dr. Dewey** said he was unsure how to answer that question. He said all of the candidates for the program graduated from a United States medical school except one.

Dr. Dewey stated that this program is a great opportunity and is a very inexpensive way to train

physicians with someone else bearing the cost of their medical education. Idaho would be getting them post-medical school. He said these are quality candidates due to the tight association with the University of Washington. **Senator Cameron** said he recognized that a residency program is a much less costly program than providing the actual medical education or medical schools.

Nancy Kerr, Director, Idaho State Board of Medicine, was introduced to discuss physician standards for licensure. She commented that the Idaho Board of Medicine is mandated to regulate physicians in Idaho. Public protection is part of that regulation to ensure that people who are qualified are licensed to practice in Idaho and also to regulate those who are licensed. The Board also licenses both M.D.s and D.O.s, Physician Assistants, Occupational Therapists, Occupational Therapist Assistants, Athletic Trainers, Dieticians, Respiratory Therapists and Polysomnographers. They also register both intern and extern medical residents.

Ms. Kerr said the licensure requirements are similar to those of other states' boards. She explained the following standards for general allopathic and osteopathic licensure:

- Graduation from a recognized school of medicine: Undergraduate, medical school and post graduate training is verified.
- Disclosure requirements: Previous license and discipline; mental, physical, substance disability; and license, hospital, school or association actions.
- The Board also does criminal background checks and checks with Hospital Affiliations, the National Practitioner Databank and Health Integrity Data Bases, Other State License Authorities, and the AMA and FSMB databases.

Training requirements for international graduates include:

- US/Canadian Graduate: Graduation from an acceptable school plus one year postgraduate training at an ACGME-approved program.
- International Graduate: Graduation from an acceptable school of medicine (1975); 3 years progressive American Council on Graduate Medical Education postgraduate and Education Commission on Foreign Medical Graduates certificate. Currently, 156 Idaho licensed physicians are graduates of a foreign medical school.

Graduates from unapproved schools must meet three of the following four requirements for licensure: (1) ECFMG certificate; (2) three years progressive postgraduate training at an ACGME-approved program; (3) ABMS Board Certification; and/or five years of unrestricted practice in another state.

The final category of licensure in Idaho is a volunteer license. To be a volunteer physician a person must have:

- Held a valid unrestricted license
- No disciplinary or other restrictions on license
- A non-compensated position
- CME required
- No fee for licensure or renewal

Ms. Kerr said that in order to maintain a license, physicians are required to have continuing medical education. She said there are currently only three boards that do not require this. Idaho requires disclosure on renewal of any actions that occurred since their last renewal and they are required to maintain a current, correct Idaho profile.

She noted that national and international trends include:

- Demonstration of continued competence (American Board of Medical Specialties and the Federation of State Medical Boards)
- IMARA- Internal medical regulatory groups. **Ms. Kerr** explained that IMARA is an international council of medical and regulatory agencies that allows states to obtain information on disciplinary actions on international medical graduates or international physicians.
- International licensing regulatory authority currently being formed

Ms. Kerr stated the follow current license count in Idaho:

- MD: 3692 Active, 204 Inactive
- DO: 295 Active, 13 Inactive
- Medical residents - 64
- Volunteer Physician - 4
- 123 Physician Applications in progress
- Physician Assistants: 410 Active, 10 Graduate
- 8 Physician assistant applications in progress

Ms. Kerr distributed pictures of a foreign medical school that recently opened in the Carribean that had been visited by a staff member. She explained that this is in a very desolate area with small temporary lodging facilities. There were no labs available and the staff member who was visiting was told that all of the books in the library had been checked out. She said this is why national organizations are being formed to evaluate foreign medical schools. On the other hand, she clarified that there are a large number of foreign medical schools that are approved.

Senator Cameron asked how long the statutory authority that the Board operates under has been in place. **Ms. Kerr** said since the 1970's. **Senator Cameron** asked whether the Board has considered changes in foreign-trained medical student requirements. **Ms. Kerr** said it has been discussed. She added that the changes that were made that allowed individuals from unapproved medical schools to be licensed opened a huge door for unauthorized/unqualified people to get licensure in Idaho. Public safety very important. **Senator Cameron** asked how, if a foreign-trained student can pass the test and meet all other qualifications except that the school is not approved/accredited, that endangers public safety. **Ms. Kerr** explained that the exam has recently added a clinical component because sometimes foreign-trained students have great knowledge but no actual clinical skills. Some foreign schools have indications that students are taught only to pass the test. **Senator Cameron** commented that in his opinion, an adequate residency program would help foreign graduates meet some of these skill requirements. **Ms. Kerr** clarified that Medicare controls the amount of residency slots available and currently 30% of those must be filled by foreign students because there are not enough U.S.-trained students

available.

Brian LaPray was the next speaker. He said that it is not uncommon for foreign medical school graduates to practice medicine in the U.S. He said he is from Idaho Falls but graduated from a foreign medical school. He explained that in the 1990's, testing requirements for foreign students were changed to include four tests. Step one, after the 1st year, is on the basic sciences; step two, after the 3rd year, is hands-on experience. He said the clinical test was at one time only given to foreign medical school students. This was done to see if they had clinical skills including language skills necessary to communicate. In 2005, all medical school graduates must take this clinical exam. The last exam can be taken at end of 4th year before starting residency or, in some states, it cannot be taken until after the first year of residency.

Mr. LaPray said, in his opinion, the public was being protected. If a student can pass the basic science part of the test that tells whether he can identify diseases and so on, the student should be able to continue his training. This test takes eight hours to complete. His school has residency students in 25 states and the District of Columbia but he cannot do his residency in Idaho. On the other hand, after he gets the training, he can practice in Idaho. He noted that the Board has been very cooperative in meeting to discuss this with him. In his opinion, after passing this test, he should be able to move on to clinical training.

In response to a question from **Senator Corder, Mr. LaPray** said he attends University of the Americas. He said there are many different foreign medical schools and admitted that there are some that are unscrupulous because they are only trying to make money. He said that at most of these schools, students realize they are not getting the necessary education and they leave and file complaints.

In response to a question from **Senator Cameron** regarding the fact that there is no U.S. accreditation process for a foreign medical school that came into existence after 1975, **Mr. LaPray** said it was his understanding that schools can apply to each state that they want to be accredited in but that Idaho does not approve new schools.

Representative Henbest clarified that he is saying there is a barrier for some foreign medical school graduates in possible residency positions; they are barred from getting residencies in Idaho for family practice. **Mr. LaPray** said that was correct. He added that certain graduates cannot receive any portion of their training in Idaho. He explained that in Idaho Code there are several different terms for medical students including resident (a person doing a residency), intern (used to be first year medical resident) and extern (someone like himself who wants to do third year medical rotations in Idaho).

Mr. LaPray explained that third year rotations include internal medicine, psychiatry, OB/GYN, family practice, pediatrics and surgery. Fourth year consists of electives. He said he can not do either in Idaho because under current Idaho law he is a graduate of a nonapproved school. He can only be licensed in Idaho once he has trained and passed all of the steps of licensure elsewhere. He must also be board certified. On the other hand, a graduate from a U.S-approved

medical school does not have to be board certified.

Representative Henbest commented that the Board of Medicine does not license medical school students and asked how this is controlled. **Mr. LaPray** explained that the rule is written for residents, interns and externs and all must apply to the Board of Medicine for residency in Idaho.

Rakesh Mohan and Ned Parish, Office of Performance Evaluations, gave an update of the Study of Idaho's Health Care Costs and Options to Improve Health Care Access for the Uninsured. They distributed a copy of the RFI that was issued October 27, 2006. Responses to the RFI are due on November 17, 2006 and OPE hopes to pick contractors and begin working in December. **Mr. Parish** said that it is probably not realistic to get all of this information to the Legislature by the end of March and instead OPE anticipates having some information by that time but the project will not be complete. The hope is to have everything ready to go by May or June, 2007.

Representative Henbest commented that she was disappointed that the time frame for the project had to be slowed down but she felt that the quality of information was more important than turnaround time.

Representative Garrett said that one of the first steps for this project was to define health. She said that some states include mental health and asked if that was done for the Idaho project. **Mr. Parish** answered that mental health and long-term care costs will both be captured in the project.

Mr. Mohan explained that the project was being delayed because most consultants said it would be almost impossible to do anything meaningful in that time frame. He said it is a very large project so in order to be meaningful, they feel the time frame needs to be extended.

Caralee Lambert, Legislative Services Office updated the Task Force on the meetings, presentations and general recommendations of the Mental Health and Substance Abuse Interim Committee. She noted that the Committee may meet one more time to finalize any recommendations and to review possible legislation.

Representative Henbest commented that one final recommendation of the Committee was to have an independent contractor study Idaho's system and make recommendations. She also noted that it was decided that the mental health subcommittee of this Task Force should be the oversight body for the study.

Representative Garrett said that the Mental Health Substance Abuse Interim Committee was given the specific task to look at whether mental health and substance abuse should have its own agency. She added that the Committee also wanted to look at a more regional mental health system that mirrors Idaho's public health system.

Representative Block said the Committee received a lot of information about how behavioral health has been restructured in the Department of Health and Welfare as well as information from the new drug czar on restructuring that will be beneficial.

Senator Corder said he would like to have a discussion of community resource boards at the next meeting.

Representative Garrett said she is a member of a mental health transformation work group and suggested that the group present its findings to the Task Force at a later date.

The meeting was adjourned at 2:30 p.m.