Governor's Select Committee On Health Care
Summary of Presentations by
University of Utah
And
University of South Dakota
August 20, 2008
Boise, Idaho

Attending Committee Members: Stephen Weeg, Robin Dodson, Michele Sherrer, Leslie Clement, Joyce McRoberts, Adjoa Amin-Appiah, Karl Watts, Jeff Sayer, Joan Krosch, Jill Blanton

University of Utah Medical School – Visitors joined the meeting: Dr. David Bjorkman (University of Utah), Dr. DeVon C. Hale (University of Utah), Sue Philo (State Board of Education), Mike Killworth (State Board of Education), Milford Terrell (State Board of Education), Matt Freeman (Legislative Services Office), Senator Bob Geddes (Idaho State Senate). Stephen welcomed everyone to our meeting and explained the origins of the GSCOHC and our goals and objectives.

Dr. David Bjorkman and Dr. DeVon C. Hale, of the University of Utah, made a presentation on the U of U Medical School, what their relationship has been with Idaho, and what the future might hold. Dr. Hale distributed a report submitted to the Idaho Board of Education last year and discussed the relationship between U of U Medical School and Idaho students. Beginning in 1953, an agreement through WICHE allowed student from Idaho to attend U of U Medical School. In 1978, a direct contract between Idaho and U of U was made. Over the contract period to date, about 208 students have been sponsored by Idaho at U of U. U of U is in the process of finalizing the contract for the next four years; currently have eight students, could possibly increase to twelve; placing Idaho physicians on the selection committee for the student selection process. Mr. Terrell asked how increasing Idaho seats would affect total number of seats; U of U would add seats to accommodate additional students. Also asked about relationship between U of U and ISU; no relationship – ISU acts as the certifying body for Idaho is all. Asked about WICHE relationship with U of U; again, there is no relationship. Mr. Terrell asked if WICHE has a relationship with the state of Idaho? Robin offered to provide clarification: Idaho got in to WICHE to provide education for Idaho students who did not have access to programs in Idaho (students could attend medical school in another state and that school would be reimbursed by the state of Idaho). WWAMI and U of U now provide education for Idaho students through contracts with the State of Idaho, so Idaho backed out of medical education with WICHE. Idaho could still access medical school programs in other states through the WICHE program if needed, but not with WWAMI or U of U. Dr. Bjorkman presented data on the number of physicians in Idaho (49th) and Utah (44th); both states have severe physician workforce shortages. In primary care, Idaho is 48 and Utah is 49. U of U has taken steps to increased programs as much as possible in an effort to alleviate these shortages; have requested funding from Utah State Legislature to expand the school. At this time, they are at their limit and cannot accept any more students without additional funding to expand. Discussed options the legislature could take and what affect that might have on seats allocated for Idaho students (might be able to offer up to twelve seats instead of eight, dependant on funding). Leslie asked about expansion plans. Dr. Bjorkman advised they are

transforming their curriculum regardless of whether or not classes expand. Have no plans at this time to move to a rural-based medical school. Senator Geddes asked about the statistics presented previously and about the presence of Idaho students at U of U; what affect would it have it Idaho students were not going to U of U. Dr. Bjorkman replied if they were not there, it would be devastating to their programs. But the focus is on residencies to increase workforce; you have to increase residencies in Idaho to increase workforce. Mr Terrell asked a follow-up about seats (adding four more students). At this time, U of U is not in a position to accept any more Idaho students unless the legislature approves and funds expansion of classes at the school. Bottom line, legislature would have to providing the funding as well as the flexibility to add Idaho seats from the increased number of "at-large" students. Mr. Terrell asked about only minimal expansion of students in the history of the school – why has it been such a slow process? Lack of funding and physical facilities – Dr. Bjorkman presented the history of the expansions at the Medical School through the years, as well as the decrease in need for physicians in the '90's at the prediction of a surplus and now the need for more medical schools on the prediction of a physician shortage by the year 2020. Dr. Watts asked about residency programs – is it necessary to have an in-state medical school to increase residencies? There are some free-standing residency programs. Some states have no medical schools but do have residency programs, although most states do have a medical school. Senator Geddes asked if there is a premium being paid to U of Utah by Idaho for those seats? No, it's more about the relationship between U of Utah and the state of Idaho. Idaho does pay Utah, Idaho has not been compensating U of U at the same rate of what the education costs, but it isn't about the money – it is about the relationship. U of U values the relationship with Idaho and is pleased with the quality of students they get from Idaho. Leslie asked about states adding/expanding medical schools – what is the underlying financing and has it changed with the economic downturn? Financing is different for every school - depends on whether public or private medical school. Some schools (private) increase tuition, some states are providing the funding for new schools or expansion of existing schools; some schools are using donations to expanse. Robin pointed out that Idaho doesn't have a teaching hospital and asked if we want to increase residencies, how would we go about this without a medical school or teaching hospital? Dr. Bjorkman advised states are doing residencies without teaching hospitals. Need resources - physicians support, infrastructure, etc. - to startup a residency program. Costs differ around the country – no one knows for certain, but estimate the average is about $80K per year. Mr. Terrell asked about population of state of Utah (2.25 million), and Chair Weeg to collect statistics on population demographics and send out to everyone. Sue asked about workforce task force – Dr. Bjorkman explained process that has been established to accommodate (Utah Medical Education Council). MEC received commitment from state to help with increase in residency expansions and allowed MEC to choose where those funds should be directed. Have maxed out all funding that they currently have; it is a precarious funding situation. Any conversation to ask private sector to help pay for this is immediately squashed. Medicaid funding may be eliminated. Hospitals will sometimes provide funding for specialties that they specifically need in their facility. U of U has expanded some areas of study – pediatrics, ob/gyn, psychiatry, internal medicine, anesthesiology, pediatrics psych program. Dr. Hale talked about Idaho students and what happens thru the course of their education (Page 27 in report). Not certain, but it appears about 30% of Idaho students in Utah return to Idaho to practice. About 39% of U of U students from Utah come back to Utah to practice. Majority of students go elsewhere for residency. Leslie asked about experience with med school students – are fewer selecting primary medicine? Yes, Utah does a better job than some schools, but yes, that is happening; it

seems to be driven by economics and lifestyle (medical school debt along is about $125,000 which can drive students to specialized medicine). What is the future relationship with U of U? Whatever Idaho decides to do, U of Utah will be morally supportive of Idaho's decisions. Joyce asked about loan repayments – Utah does periodically provide those programs. Senator Geddes asked Dr. Hale's opinion about whether or not Idaho should have a medical school; Dr. Hale commented that Idaho is further along now in planning than in 1965, and we need to make plans for that, but we have to be very aware of the start-up costs. Dr. Bjorkman advised Idaho should first look at expanding residency programs, and then consider what all the options are. We have to have the political will from all sectors, and a unified vision before we can even start. Begin with residencies, build political will and settle any disputes between stakeholders, start looking at costs, get unified vision, then look for the right model. Sen. Geddes asked about increased income to Idaho with medical school and about academic medicine (teaching). Dr. Bjorkman responded that having a medical school will not necessarily generate increased revenue, you may have a few more specialists. What drives revenue is specialists. U of Utah is seeing patients being referred from Idaho due to complication of case. Mr. Terrell asked about a medical school diverting funding from established universities? In Utah, the School of Medicine receives a separate appropriation from the Legislature so it does not affect budgets for other universities. The medical school is viewed as a separate entity.

University of South Dakota Medical School - Those participating on the conference call are: Tim Ridgway, Gastroenterologist, Dean of Clinical Faculty; Janet Lindemann, Family Physician, Dean of Medical Student Education; Ron Lindahl, Executive Dean of Medical School and Dean of Basic Sciences; Julie Kriech, Director of Finance; Stephen Weeg, Chair of GSCOHC; Leslie Clement, DHW; Michele Sherrer, Gem Co; Robin Dodson, ISU; Joyce McRoberts, Governor's Office; Jill Blanton, DHW; Jeff Sayer, Karl Watts, Family Physician; Adjoa Amin-Appiah, Intern, Governor's Office; Matt Freeman, Legislative Services Office; Bob Geddes, Idaho State Senate.

Dr. Ridgway discussed the history of South Dakota School of Medicine. SD is 100 years old, and at first was a two year school; became four year school in the late 1960's. Dr. Ridgway strongly suggested Idaho not begin a medical school unless we are certain that adequate financial resources are in place. SD does not have a hospital associated with their medical school; they utilize hospitals throughout the state. Consider themselves a community-based medical school with four different campuses. Each campus has a slightly different experience for students and various tracks each year. They have approximately 30 – 65 students. About 45% of SD medical school students come back to South Dakota to practice. Retention rate goes up to 80% for students who do their residency in SD after medical school. All students must be SD residents or have SD ties (trying to "grow their own" physicians) I order to attend medical school there. They feel this is very important to retention rates. Stephen asked about population and how many seats they have; population is about 750,000 and have 50 students per year plus 4 MD PhD students; have prepared a proposal to go to 65 students per year and 4 MD PhD but will not do that unless they receive additional funding.

Stephen asked SD to expound on resources. Dr. Ridgway advised they have ample hospital facilities that are very engaged; very important to have support of physicians and hospitals. They have about 1600 practicing physicians, and 50% are teaching physicians. Students have ongoing relationships with their patients, particularly in their third year. Shortage of financial resources is of great concern. It is very important to

have enough funding to carry the program through at least third/fourth year. When SD converted to a four year school, there was no planning to financially support the 4th year. Initially it was covered by the fact that they had a practice plan in the school; the state, however, did not want to take responsibility for facilities for practice, no practice for physicians, overhead, etc. SD got into a position where there were issues with overhead. Physician educators are part-time and you must make sure they are reimbursed for time spent teaching. Over the past few years, the environment changed – phased out practice plan and now contract the teaching and have pay scale set up. There has been no visible difference in quality of students. SD has tremendous volunteer physician educators who are paid, but not nearly paid enough to offset for the time they invest. Need to ensure physicians have protected time for research, etc. Julie Kriech reviewed the pay scale of physician educators paid through contractual services. Created rate of pay for various activities such as per hour, per lecture, etc; $3.2 million is utilized for contracts to deliver services by these physicians. Robin asked about administration of campuses – there is a campus dean at each location; teaching hospitals in each community with support staff; for each clinical discipline there is a physician leader who interacts with the department chair and dean of student education. They try to make sure students are not isolated. Stephen asked about using telemedicine video conferencing – is SD's campus actual physical locations, academic setting, or more of a virtual set-up? Have both depending on location and purpose of the campus, and video conferencing is essential – both for students and for staff meetings. Technological investment is substantial – spent about $50-75,000 on last teleconferencing upgrades. Robin asked about campus deans – report to dean of Medical School? Yes, that relationship is very important; should be active in practice as adds credibility for students and staff. Have PA, PT, NP, etc., programs?? Yes, very important to the education and students are used to the concept. Joyce asked about first steps (besides financial), and how long it took to get accredited? It probably took SD two to three years for accreditation (go to accreditation website for the steps necessary to open a new medical school). Stephen asked about retention – what is it about SD or method of education that makes a difference? Student selection is very important; they look at how they select students, consider volunteerism, rural background, broad-based education. Ensure adequate resources for student support (scholarships, etc.); debt load may impact ability to go into primary care. Tuition & fees is about $20,000, plus allotments for housing, etc. (first year SD resident student). Tuition and fees is only about 8% of total health affairs operating budget of $40 million. Receive about 32% through general funds, 8% tuition & fees, 45% supported through research activities, about 12% self-generating revenue activities (public service). Robin asked about the economic benefits on investment for the state? Tim advised this is very hard to estimate; it is costing a minimum of $200,000 per recruitment (for hospitals to recruit). Have heard it estimated that there are about 8 new jobs created for every physician who opens practice in the community. Stephen asked about clinical practice revenues? SD used to, but just closed practice this June; clinical practice revenues supported about 25-30% of their total operating until recent years. When they had an active plan, it was very difficult to interact with the physicians.

Stephen discussed geographical demographics of Idaho and asked for additional input on establishing a medical school with these issues in mind. Makes it difficult to have conferences, impacts faculty meeting attendance; budgets need to include travel costs, which makes tuition more expensive; distributive campuses will drive up the cost of medical education, but it is also a great benefit to students and physicians – it keeps all the physician of the state involved in education. Robin asked about travel expenses for

students; they pay own expenses to move to campus of study, but the medical school pays if students are called back to Sioux Falls for a meeting, etc. Robin asked about what it actually costs to educate a medical student who is a resident of South Dakota? It starts at about $70,000 per student per year, and up to around $120,000. Hospitals provide facilities for students', but the school pays rent for this space. Have to have a structure of some kind to give credibility to your presence. Stephen asked about bonding/alignment of students throughout years of study considering multi-campus format? Students are all at Vermillion for the first year; they do begin bonding by campus during the second year and on through the third and fourth years. Michele asked about the opportunity cost of having or not having medical school, for the state. Feel SD would have a medical disaster without the medical school in their state. Students graduating here tend to be leaders in their communities, their hospitals, etc. Data clearly shows our most competitive students end up in medical school. Stephen asked about the competition, percentage of students applying versus those selected. SD received about total 600-700 applications, about 140 SD resident applicants, and about another 25 or so applications from people with strong ties to SD; interview about 160 students to fill 50 seats. SD has higher per capita application rate than most states. Robin asked about loan repayment program for students settling in rural areas? SD has had that in the past but it was not very consistent or successful. State leadership would support at times, and then drop support. Currently, the state department of health has a loan forgiveness program available for people going into the frontier areas of the state. This is outside of the medical school. Their affiliation hospitals have been considering a loan forgiveness program but it hasn't panned out very well. With the current shortage of physicians nationwide, some hospitals are more than willing to "buy-out" loan forgiveness plans to obtain a good physician so those programs are not very effective right now. Robin asked about affiliated teaching hospitals network? The institution has a residency corporation - programs operating through the residency corporation; funding is through the hospital. Leadership is in the medical school, the residency corporation is established with hospitals, and the finance committee has financial leadership. The recruitment committee is involved in finding the best residents for the program possible; looking for better class of U.S. trained graduates. Stephen asked for advice in terms of moving forward. Have to decide what kind of model would work best in our state, clarify your goals (research income, opportunity for students, etc.); look at several educational models; visit a medical school (or a couple of schools) that most closely mimics the educational model Idaho has selected. Karl asked, given all factors in place today, would SD begin a medical school? SD responded you pretty much have to, because you're not going to be able to recruit and retain physicians in your state. If there is one theme heard hear, it is state support and hospital support are critical. For human capital, you need the physicians in your state. If you have support in those three areas, it is definitely worth pursuing. Karl also asked what kind of relationship exists currently between the universities and colleges in SD and the Medical school. Medical school is housed at the U of SD, always has been. The University is proud to have medical school. Would like to see the medical school be able to bridge relationships between the various universities and colleges throughout the state. The model of medical sciences center separate from universities is intriguing, but current relationship with the universities is very good. Have to make sure resources dedicated to medical school actually go to the medical school and are not taken in to the general university funds – preserve the integrity of the financials. Do residency programs receive state appropriated funds? About 1% of family medicine dollars come from state appropriations, with matching funds from Medicaid. Medicare and IME funds are also added. SD recommended Idaho could look at CMS for new funding in cities that have never had residency before. Robin

asked how the board of regents has interacted with the medical school faculty, etc. Situation is good, considering very few people truly understand medical/residency education. Often find it a challenge to get the message to the right people, but having health education leadership have access directly to the board of regents would be beneficial.

Stephen thanked SD for their time and advised we may be calling on their expertise again in the future. SD recommended we visit American Association of Medical Colleges (AAMC) website and also the LCME (accreditation agency) to download more information.