Governor's Select Committee on Health Care

Report to
Governor C. L. "Butch" Otter

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Vision of the Committee

Every Idahoan will have access to healthcare that is provided in a coordinated system built upon a primary care medical home. This system will operate with quality, transparency, and a sufficient workforce. The focus will be on prevention and individuals taking personal responsibility for making good lifestyle choices and maintaining their health.

Executive Summary

In August 2007, Governor Otter convened the Idaho Health Care Summit to evaluate Idaho's current health care system and recommend ways to make health care more affordable and accessible to Idahoans. One month later, Governor Otter established the Governor's Select Committee on Health Care to evaluate the summit's recommendations, gather additional data, and provide additional recommendations based on its findings. The committee held public meetings and consulted state and national health care experts to deepen its understanding of the issues and identify potential strategies. The committee found that quality health care is available in Idaho but that Idahoans have difficulty accessing it because of an inadequate delivery system, the high cost of coverage, and a shortage of health care professionals. In addition, Idaho's population is growing at twice the national average, the baby boomers are adding new stresses due to their long-term care and chronic disease management needs, and health care providers cannot keep up with the access demand. To find ways to address these issues, the committee developed the "Target for a Healthy Idaho" model. This model stresses the importance of the individual and the patient-centered medical home and illustrates the vision and standard of what an ideal health system should be. The committee used the following principles to develop this model and to make a number of recommendations for improving Idaho's current health care system:

- Basic health care should be available and accessible to all Idahoans.
- Health care for the 50,000 uninsured children in Idaho should be an immediate priority.
- Every Idahoan needs a primary care medical home that provides prevention, primary care, continuity of care, positive outcomes, and quality.
- We all must take personal responsibility for our own health and proactively manage our health care costs.
- Improvements in health care access, cost, and quality must be built upon public and private partnerships and personal responsibility.
- Many Idahoans cannot achieve good health without a partnership between government, business, and Idaho's health care community to equip them with the tools and services they need to stay healthy.
- Reforms must be financially viable, sustainable, and measurable.
- In developing strategies to cover Idaho's uninsured residents, Idaho should leverage funds currently available in the existing system, including federal, state, county, and employer contributions to healthcare benefits.
- Health care reform must be developed collaboratively and include all key stakeholders, including consumers.

The above principles guided the committee in making the following recommendations for improving Idaho's health care system:

- **Cover Idaho's children:** Over 50,000 children are uninsured; of those, 27,000 are already eligible for Medicaid or SCHIP. The goal is to have all eligible children enrolled within five years.

- **Expand insurance coverage for adults:** Close to 200,000 adults lack coverage. Most work, but coverage is not affordable. Public and private solutions must be created to make coverage more affordable.

- **Expand residency opportunities:** Idaho desperately needs family physicians. In-state residency programs have the greatest potential to graduate physicians who will stay and practice in Idaho. The current residencies in Pocatello and Boise do not graduate enough family medicine residents to meet demand. In addition, Idaho has no full residency programs in other primary care specialties (i.e. internal medicine, pediatrics, OB/GYN, psychiatry).

- **Address undergraduate medical education:** Idaho students have limited access to medical education. The number of seats in the cooperative medical education program for Washington, Wyoming, Alaska, Montana, Idaho (WWAMI), and the University of Utah has not grown to meet the population growth of Idaho and the needs of Idaho residents. Undergraduate education increases should be directly tied to growth in primary care residencies to maximize the number of students who would stay in Idaho.

- **Address the health professions workforce shortage in Idaho:** According to the Idaho Department of Labor, Idaho faces a severe shortage in all health professions occupations in the near future. In addition to nursing, shortages in such fields as pharmacy, dentistry, allied health professions, and mental health professions will be acute. To address this, Idaho should create a health professions education council similar to Utah or other state models.

- **Develop primary care medical homes for all Idahoans:** Primary care and specialty physicians, community health centers, Medicare, Medicaid, employers, and insurance companies see the value of primary care medical homes as a means of improving care and managing costs. Two essential features of a medical home are increased care coordination and quality improvement.

- **Encourage prevention and personal responsibility for health:** Lifestyle has a critical impact on health. Obesity, smoking, alcohol and substance abuse all have a significant impact on health and health care costs. Consumers need more and better information on the cost and quality of care. Social marketing efforts similar to the Idaho Meth Project should be developed to encourage personal control of health. Health plans should incorporate appropriate incentives that encourage good health choices and should consider disincentives that discourage poor choices.

- **Continue to improve Idaho's behavioral health system:** Idaho has received an "F" from the National Alliance for the Mentally Ill regarding mental health care, ranks in the top 10 for suicides, and ranks close to last in public funding for mental health services. The legislature has begun to address this problem by increasing funding for behavioral health and commissioning a study of the public behavioral health system. Key stakeholders must continue to work collaboratively and Idaho should develop a plan to correct problems and build a coordinated mental health system.

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Background

Then Congressman C.L. "Butch" Otter said during his campaign for Governor that he does not believe it is the Government's job to provide health care coverage to everyone. He stated, "It is government's role to provide an economic, regulatory, and legal climate in which individuals and employers can afford to provide themselves, their families, and their employees the healthcare coverage they need." This means providing reimbursement rates and incentives that encourage providers to meet the needs of our rural communities. It also means working closely with providers and insurers to make sure limited resources are focused where they are needed most. The Governor views this approach as an investment in longer-term savings so government can provide temporary help to those who truly cannot afford healthcare coverage – especially children. Failing to address healthcare needs early in a person's life because of lack of coverage can lead to more serious medical problems, more costly emergency room visits, and a failure to find employment later in life. Good health is important for all of us.

The challenge is to identify and set priorities for making health care more affordable and accessible in Idaho. The Governor said he would call on a broad spectrum of providers, insurers, policy makers, and other stakeholders throughout the state to join him in an Idaho Health Care Summit.

Summit

The Idaho Health Care Summit was convened by Governor Otter on August 21-22, 2007. The summit's 45 participants were representatives of providers, insurers, hospitals, legislators, businesses, and other stakeholders. The purpose of the summit was to make recommendations for affordable and accessible health care for Idahoans. The Governor asked the summit participants to focus on achievable goals (it should not be a single payer), to focus on public and private sector partnerships, and to look at the feasibility of an Idaho medical school.

The summit participants presented the Governor with recommendations in five basic areas; workforce, comprehensive private/public health care coverage, prevention and self-responsibility, innovative service delivery models, and behavioral health (mental health and substance abuse).

Select Committee on Health Care

In order to continue and evaluate the recommendations of the Idaho Health Care Summit, Governor C. L. "Butch" Otter, by Executive Order NO 2007-13, established the Governor's Select Committee on Health Care to serve at the pleasure of the Governor from September 28, 2007, through December 31, 2010.

The Governor asked the Select Committee on Health Care to:

- Review and evaluate the recommendations of the Idaho Health Care Summit and periodically report its findings to the Governor.
- Provide additional recommendations to the Governor, beyond those proposed in the summit, for addressing Idaho's health care issues.
- Gather, review, and evaluate health care data and information from state agencies, within the limits of state and federal law, and report its findings and analysis to the Governor.
- Conduct meetings in each region of the state and gather public comments and perspectives.

- Propose ways to further encourage public and private sector partnerships for providing health care services in Idaho.
- Work closely with the Governor and legislature to evaluate existing state laws, policies, and procedures concerning health care in Idaho.

Scope of Research, Public Hearings, and Expert Testimony

The Governor's Select Committee on Health Care conducted 11 public hearings throughout the state from October 24, 2007, to April 2, 2008. Hearings were held in Pocatello, Montpelier, Emmett, Caldwell, Boise (2), Idaho Falls, Rupert, Twin Falls, Lewiston, and Coeur d' Alene.

In addition to the public hearings, the committee received testimony from local, state, and national experts. The committee heard from insurers, hospital CEOs, the Idaho Medical Association, the Idaho Hospital Association, the Idaho Primary Care Association, the Office of Performance Evaluation, providers (doctors, nurses, physician assistants, etc.), business leaders, small business owners, educators, the Idaho Employer Health Coalition, the YMCA, and others. The committee heard testimony from over 400 local citizens.

The National Governor's Association came to Boise to meet with the committee on three separate occasions to provide updates from other states and to provide technical support and assistance. The committee also heard from Dr. Stephen C. Schoenbaum from the Commonwealth Fund's Commission on a High Performance Health System; and Dr. Jonathan R. Sugarman, President and CEO of Qualis on the Medical Home Model of Care. The committee members were able to participate in a number of national workshops on such topics as medical homes, state reform initiatives, creative benefit packages, and Section 125 Plans. The committee visited with representatives from the University of Utah Medical School and South Dakota's Medical School.

The committee is working collaboratively with the Legislative Health Care Task Force, the Legislative Interim Committee on Medical Education, and the Idaho State Board of Education to develop sets of recommendations to improve health care and the health care workforce in Idaho.

Dominant Themes

As the committee pursued its work, a number of themes continued to recur. These ideas were heard from participants in the summit, from participants in the statewide public hearings, from state and national experts who presented to the committee, from other state initiatives, and from a review of the literature regarding health care reform. Those themes are:

- **Be bold.** This comment was heard at almost all statewide hearings, from all types of participants. They encouraged the committee to be creative and look at changes that would both increase access and change the model of care delivery.

- **Be achievable.** Idaho must start its reform efforts based upon what will work in Idaho. There was concern about a dramatic, large-scale change in a short time period. The emphasis was to chart a significant change, but build it carefully and phase it over time so that it can be successful and be done in a fiscally responsible manner.

- **Address access, cost, and quality.** Increasing access to care in a delivery model that is the most expensive in the world and that has great variability in quality is doomed to fail. The cost of care and access to care were the two strongest messages that the committee

heard during the public hearings. Individuals and employers are struggling with the cost of care. Idaho has almost a quarter of a million persons without any health coverage. Those persons live sicker and die younger than insured persons.

- **The status quo is not acceptable.** The continuing rise in health care costs is not sustainable. Current projections indicate that family insurance premiums will cost $21,000 and individual premiums will cost $7,600 by the year 2012.[1] Medicaid costs have grown by 152 percent over the past decade[2]. In 1999, Medicaid paid $486 per member, per month. In 2008, Medicaid paid $572 per member, per month, an increase of 17.69 percent. There are 225,000 Idahoans who have no health insurance coverage. There is great variability in the quality of coverage. A recent Rand study indicated that a person receives clinically indicated care only 50 percent of the time[3]. Price Waterhouse Cooper estimates $1.2 trillion in waste in the system, looking at individual behavior (obesity, smoking, alcohol abuse, and treatment compliance), clinical performance, and operational inefficiencies[4].

- **Build patient centered primary care medical homes.** The committee heard from numerous sources about the value of primary care. There is substantial data that shows the value of primary care in both improving the quality of care and reducing the cost of care[5]. The model of a patient-centered primary care home is seen as having great potential to change the way care is delivered, to improve the health care experience for patients, and to reduce the cost of care to individuals and employers. Major supporters of this concept are the American Academies of Family Physicians, the American Academy of Pediatricians, the American College of Physicians, the American Osteopathic Association, and the Patient Centered Primary Care Collaborative, a multi-stakeholder group of large employers, physicians, insurers, and state government.

- **Address physician workforce issues.** Idaho ranks 49th out of 50 in physicians per capita and has the 6th oldest physician workforce in the country[6]. Idaho also ranks 49th out of 50 in the number of resident physicians per 100,000 people[7]. Idaho relies on the cooperative medical education program for Washington, Wyoming, Alaska, Montana, and Idaho (WWAMI) and the University of Utah for undergraduate medical education, and has two family medicine residencies. At the summit and at public hearings, the committee heard strong encouragement to support strategies to greatly expand residencies in primary care (family medicine, pediatrics, internal medicine, general surgery, OB/GYN, and psychiatry) and to expand undergraduate medical education for Idaho students.

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[1] Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS) data, http://www.meps.ahrq.gov)

[2] Idaho Medicaid MMIS

[3] McGlynn, E. et al. "The Quality of Health Care Delivered to Adults in the United States." New England Journal of Medicine, 2003 June 26; 348(26):2635-45

[4] The Price of Excess: Identifying Waste in Healthcare Spending. PricewaterhouseCoopers' Health Research Institute, 2008

[5] Ginsburg, J. et al. Achieving a High-Performance Health Care System with Universal Access: What the United States Can Learn from Other Countries. Annals of Internal Medicine. 2008:148:55-75, Steinwald, Bruce. Primary Care Professionals: Recent Supply Trends, Projections, and Valuation of Services. Testimony before the Committee on Health, Education, Labor, and Pensions, U.S. Senate, 2008

[6] Medical Education Study Final Report, MGT of America, Nov. 1, 2007

[7] JAMA September 10, 2008

- **Change is a mutually shared responsibility.** Change will require public and private partnerships. No one at any meeting wanted a government only response to health care reform. All participants indicated that change will require participation from all sources; large and small employers, insurers, individuals, and government. Government can act as a catalyst for reform and alter its regulatory and funding mechanisms to support reform efforts, but change must happen at all levels. Individuals must take charge of their health and lifestyles as a key element of increasing health status and controlling cost.

- **Reform will require strong leadership and substantial stakeholder support.** In all states in which substantial change has been initiated, there has been strong leadership at both the gubernatorial and legislative levels and involvement of key stakeholders. Transforming the current delivery model to control the rate of cost growth, improve quality, and increase access requires efforts at all levels.

Status of Idaho's Current Health Care System

Quality health care is available in Idaho. Dedicated health professionals and educators work daily to improve the health of Idaho residents. Idaho citizens are healthier in many respects than the nation at large. Idaho health care costs are low compared to national data. However, based upon testimony from our citizens and health professionals, and reviews of the literature, it is clear that significant change must occur. Many of the experts and citizens argue that we don't have a health care system. Instead, we have a loose network of entities, industries, and groups functioning independently.

The current health care delivery system has several inherent shortcomings that need to be addressed in a comprehensive solution. Among them are:

- Critical health information is not easily shared.
- Negotiating care for patients with complex health problems is difficult.
- Continually rising costs are straining individuals, employers, and government.
- There is poor or no access to care due to uninsurance or underinsurance.
- A focus on illness and disease rather than prevention and personal responsibility drives costs up and quality down.
- There are significant variations in quality.

The Commonwealth Fund has been a leader in reviewing the status of health care and recommending changes to create high performing health systems that would improve quality and control cost increases. It has developed state score cards for adults (2007) and children (2008) to identify the strengths and challenges in each state. Idaho's results affirm that we are a relatively healthy state with low overall costs, but need to address issues of quality, access, and equity.

Table 1. Commonwealth Fund State Rankings for Idaho

Categories	Children	Adults
Overall Rank	33	30
Potential to Lead Healthy Lives	13	12
Access	33	43
Quality	48	39
Costs	7	-
Equity	45	45
Costs and Avoidable Hospital Use	-	3

Coverage
In its desire to address the issue of health care, the Idaho Legislature commissioned a series of reports to deepen its understanding and to identify potential strategies. Mathematica Policy Research, Inc. developed one of the reports, "Health Insurance Coverage in Idaho: A Profile of the Uninsured and Those with Coverage" and presented the report in July 2007. The report presents a comprehensive analysis of the topic. Some of the key findings are summarized below.

Idaho has about 1.5 million residents. Our population is growning at twice the national rate. Most recent estimates from the US Census Bureau are that Idaho has 225,000 uninsured residents. Twenty-two percent of non-elderly adults (175,000) and 10 percent of children (50,000) live without health insurance. Uninsured Idahoans are a diverse group, but they do have some common characteristics. For example, uninsured Idahoans generally have lower incomes. In fact, about 47,000 uninsured Idahoans live at or below 100 percent of the federal poverty level (FPL) and an additional 70,000 uninsured Idahoans live between 100 and 200 percent of the FPL. Generally, uninsured Idahoans:

- Are members of working families.
- Are between 18 and 35 years of age.
- Are high school graduates.
- Have been uninsured for more than one year.
- Vary substantially by county and their urban or rural location.

For the covered Idaho population (approximately 1.2 million people), coverage varies. Employers cover 61 percent of Idaho residents under age 65. That coverage is best for persons in higher wage jobs or working for large employers. Only 26 percent of small employers (10 or less employees) offer coverage, and the manufacturing industry offers coverage at twice the rate of service industries. Only 40 percent of Idaho employers offer some form of coverage. Individual insurance is selected by eight percent of the non-elderly population, but cost is a significant barrier.

Accessing coverage in the non-group market is expensive and difficult. The administrative costs related to these plans are high. The individual insurance market presents challenges for families seeking coverage due to high premiums and the difficulty of gaining coverage when individuals have pre-existing health problems. Finally, 13 percent of non-elderly Idahoans rely on public coverage (Medicaid), most of whom are children on Medicaid or SCHIP.

Cost
Many of the participants in the public meetings held by the committee commented on the cost of health care and the difficulties that ensued because of cost. Health care costs in Idaho and nationally have risen much more than the rate of inflation, with Idaho experiencing an increase of 7.1 percent a year. The committee was told many times that this level of cost increase is simply not sustainable.

Families USA just released (October 2008) a report, "Premiums versus Paychecks" that highlights the issue of cost.

- Health insurance premiums for families increased 121.6 percent from 2000 to 2007.
- The average family premium in that time rose from $5,160 to $11,432.
- The average individual premium from 2000 to 2007 rose from $2,961 to $3,791.

- In that same time, the median earnings of an Idaho worker rose from $19,004 to $24,798, a 30.5 percent increase.
- Health insurance premiums rose four times faster than median earnings.
- Benefits have also changed due to cost pressures, resulting in higher deductibles, more copayments, and fewer benefits.

Workforce
A sufficient workforce is necessary if Idaho is to address its health care needs. Key issues of workforce are:

- Idaho ranks 50th among states in primary care physicians for every 100,000 people.
- Idaho has the 6th oldest physician workforce among 50 states.
- Idaho ranks 49th in the number of resident physicians in training per capita.
- The entire state, with the exception of Boise, Sun Valley, McCall, and Idaho Falls is a health professions shortage area.
- There are shortages in nursing, pharmacy, and almost all other health professions.
- Beyond these statewide statistics is the reality that these same challenges are exaggerated in the rural areas of the state. Recruiting and retaining physicians, nurses, dentists, and other medical professionals in the rural areas is one of the state's biggest and increasing challenges.

Idaho shares many of the same challenges our nation faces but does not have enough medical professionals. Shortages of nurses and shortages of physicians are, and will continue to be, a burden on the state's health care system.

What Healthcare Consumers Want

The Commonwealth Fund commissioned a survey of Americans in early 2008 to determine what they wanted in a health care system. The results validated much of the input the committee received in its work over the past year.

- Eighty-two percent believe that the health care system needs fundamental change or complete rebuilding.
- Three of four adults have difficulty getting timely access to their doctor.
- Forty-seven percent report problems with care coordination among providers.
- Thirty-two percent experienced duplicative or unnecessary care.
- Over 90 percent support the key elements of a primary care medical home (access, coordination, single point of care, emphasis on quality)
- Over 85 percent support the use of information technology to improve patient care
- Eighty-eight percent believe it is important for doctors to work in teams with nurses, behavioral health professionals, and health educators to improve care.

What will happen if Idaho does nothing?
If Idaho does not create new programs to cover its uninsured residents, and improve current programs, the following will occur:

- An increasing number of Idahoans will be uninsured.
- Fewer employers will offer coverage.
- Coverage will become more expensive.
- People in poor health will continue to be rejected for individual coverage.
- The cost of providing care to the uninsured will continue to be shifted to those with coverage.

- We will have an increasingly unhealthy workforce.

Idaho's Healthcare Expenditures

In 2004, total public and private health care spending in Idaho was $5.6 billion, accounting for 13 percent of the gross state product. Private funds accounted for 58.4 percent of all health care spending in Idaho, or $3.2 billion. The balance of health care spending in Idaho, 41.7 percent or $2.3 billion, came from public (government) funds.

Hospital care accounted for the largest component of spending with 35.6 percent of all health care spending, followed by physician, clinical, and other professional services, which collectively accounted for 27.5 percent. Combined hospital and physician services accounted for 63.1 percent of all health care spending in Idaho in 2004[1].

About one in six non-elderly Idaho residents were uninsured in 2005, with a higher rate of uninsured among non-elderly adults than children. Among non-elderly adults, disproportionately high uninsurance rates were observed among young adults (ages 18 to 24), low-income adults (annual incomes below $25,000), and the unemployed. Idaho's uninsurance rates also vary substantially by counties' urban or rural locations[2].

Children make up the bulk (86 percent) of non-elderly, non-disabled enrollees with public health insurance coverage. They are eligible for the state's programs through age 19 and at an income of up to 185 percent of the FPL. Idaho has one of the most generous federal match rates in the country for its public programs, receiving slightly less than 70 percent of the cost of traditional Medicaid programs and approximately 79 percent for SCHIP[2].

Target for Healthy Idaho

The "Target for Healthy Idaho" (see Appendices) is the model that illustrates a vision and standard of what an ideal health system could be. The model identifies key stakeholders, how they would work together, and the key attributes that describe the relationship between the different groups. The darker rings represent the various groups and the respective professionals and services within each group. The lighter rings between the groups represent the attributes that would characterize or be included in an ideal relationship between the various groups.

Two key statements are illustrated in the model:

- The various groups are displayed in a strategic way to outline the ideal relationship between groups and how they are coordinated together.

- The model also illustrates how a patient can access the ideal health care system and the optimum approach for ideal care.

[1] Commonwealth Fund (2007). Moving the US and Idaho to High Performance Health System.
[2] Mathematica Policy Research, Inc. for Office of Performance Evaluations Idaho Legislature (July 2007). Health Insurance Coverage in Idaho: A Profile of the Uninsured and Those with Coverage.

The Individual

The starting point for any optimized health care system is the individual. For an ideal health care system to be successful, each individual must be responsible for making appropriate, healthy lifestyle decisions and must be accountable for those choices.
Promoting wellness, creating incentives for personal accountability, and focusing on prevention will all combine to have a significant effect on our state's overall health and reduce our cost of care.

Family and Community

To support and enable individuals to be personally responsible for their own health, communities and state services need to provide a basic infrastructure of support and service to sustain and promote healthy behavior.

Services such as school health programs, immunizations, accessible and meaningful education, health oriented parks and recreation areas, and general public health services are all services required to sustain an individual in their quest for better health.

Patient Centered Medical Home

In order for a health care system to be effective, individuals must have an easy and straight forward way to access their care.

The medical home, described later in the report, is the entry point for patients to receive optimized care. Here a medical professional becomes a "health coach", physician, and the advocate for helping a patient who needs access to more specialized and advanced care.

Specialized Medical Care and Payers

The two outer rings represent our current health care system. These are the parties who currently provide and pay for the majority of our health care.

The primary difference in the target's approach is that it focuses on the person's health and life choices and in anchoring health care delivery in a patient-centered primary care medical home. Necessary specialty care is an important component, but not the starting point of care. Enabling the medical home to address many health care issues prior to more expensive specialized care could have a significant impact in lowering overall costs for our state.

Summit Recommendations: Findings

One of the Governor's charges to the Select Committee on Health Care was to evaluate the recommendations developed at the Idaho Health Care Summit. In the following sections, the committee presents its findings on those recommendations and presents its own recommendations based upon those findings.

Workforce

Idaho, like the rest of the country, is now facing increasing numbers of senior citizens with various health care needs; the baby boomers are adding new stresses due to their long-term care and chronic disease management needs, Idaho's health professional workforce is quickly aging with many anticipating retirement, health care providers in Idaho cannot keep up with the access

demand, there are a limited number of graduate medical education programs in Idaho, and the issues of recruiting and retaining health care professionals has resulted in Idaho facing a serious crisis in the health professional workforce.

Summit Recommendation 1: Increase the number of graduate medical education training programs in Idaho to help increase the physician workforce in our state. Expand residency programs in family medicine, internal medicine, obstetrics/gynecology, pediatrics, and general surgery throughout the state.

Committee Findings:

- Idaho ranks 8th when one considers the percent of active physicians who completed a graduate medical education (GME) program in the state. Of the 257 active physicians who completed their GME in Idaho, 142 (55.3%) stayed in the state. This is evidence for the importance of having GME programs in the state and the ability to recruit and retain primary care physicians.
- The American Medical Association's Physician Masterfile (2007) shows that Idaho is 48th out of 50 states for active physicians who have completed an accredited GME program or fellowship in the state.
- Idaho ranks 49th out of 50 states for physicians who are in an accredited GME program per 100,000 people.[1]
- Idaho ranks 49th out of 50 states for active physicians for every 100,000 people[1].
- Idaho ranks 48th out of 50 states for active primary care physicians for every 100,000 people.[1]
- The 2007 State Physician Workforce Data Book (Association of American Medical Colleges) notes that Idaho has 2645 active physicians (14.2 per 100,000 people) compared to the US rate of 15.8 for every 100,000 people.

Summit Recommendation 2: Expand Access to Medical School Education including short-term and long-term solutions.

Committee Findings:

- The State Board of Education's 2007 Medical Education Study by MGT of America, Inc. pointed out that access by Idaho's citizens to undergraduate medical education ranks extremely low.
- Highly qualified Idaho students are applying to medical schools in greater numbers than can be served by the two out-of-state programs[2].
- Idaho currently spends $5.5 million on the two state supported programs for a total of 106 Idaho students in FY 2008 ($3.7 million for 74 students at the University of Washington School of Medicine (UWSM) and $1.8 million for 32 students at the University of Utah School of Medicine (UUSM)). These dollars do not include the tuition and fees the students pay ($19,000 per student at UWSM, and $22,300 per student at UUSM). The total per seat in FY 2008 at UWSM is $64,500 and $56,300 per seat at UUSM.
- Twenty eight seats are available for Idaho citizens (20 UWSM and 8 UUSM). The remaining Idaho applicants (30-50) attend other medical school programs in other states.
- Idaho is the largest state in the country without a medical education program[2].

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[1] AMA Masterfile 2007
[2] MGT Study 2007

Summit Recommendation 3: Expand nursing education opportunities to meet Idaho's future workforce needs by doubling the number of nursing seats at Idaho's colleges and universities, recruiting and retaining nursing faculty, giving access to a doctoral nursing education program, and exploring nursing scholarship and loan forgiveness programs.

Committee Findings:

- Idaho's health care workforce beyond nursing issues; all professional health care workers are aging and approaching retirement in the next decade.
- The Idaho Department of Labor's (September, 2008) top 10 "hot job" list indicates the number one job is registered nurses, number two is pharmacists, and number four is dental hygienists. In addition, the department noted the need for dental assistants, medical and health service managers, licensed practical nurses, physicians, and surgeons.
- The U.S. Department of Labor's occupational data base for Idaho notes that there is a significant need for all of the health professions including mental health counselors, dietetics/nutritionists, and clinical laboratory scientists (to note only a few) over the next decade.

Comprehensive Public and Private Health Care Coverage

Idaho has over 50,000 uninsured children, 27,000 are eligible for either CHIP or Medicaid. The Select Committee on Health Care supports outreach to and enrollment of uninsured children. In August 2007, Idaho Health Care Summit participants made the following recommendation for achieving comprehensive health care coverage.

Summit Recommendation: Make available to all Idahoans a defined-benefit insurance product that includes at least first-dollar coverage for preventive, primary, and catastrophic care; that is individually purchased and administered through a public or private entity; that is funded by a combination of federal, state, employee, and employer contributions; and is actuarially priced based on pooled risk.

The recommendation includes a proposal that incentives should be provided to small employers and employees who participate through contributions. Benefits of the recommended approach include coverage that is more affordable and portable, reduced cost shifting, a reduction in serious illness, future cost savings, and more competitive provider reimbursement. The recommendation also includes an individual mandate with available subsidies for those individuals who have difficulty purchasing coverage. The public/private solution would need to take full advantage of all federal matching opportunities while recognizing the challenges associated with some federal regulations.

Health Insurance Coverage in Idaho

The only coverage option for Idaho residents who do not have access to employer-based coverage and who are ineligible for public programs is the commercial non-group insurance market. Over 100,000 residents, eight percent of the non-elderly population, purchased individual or non-group coverage in 2005. Like many other small states, Idaho's individual health insurance market is concentrated among a few carriers. As in the small group market, the

largest carriers are Blue Cross of Idaho followed by Regence Blue Shield. These two carriers are estimated to insure 80 percent of all non-group lives in Idaho[1].

Accessing coverage in the non-group market can be expensive and difficult. The diseconomies of marketing and administering plans for small groups are exacerbated in the individual market. More importantly, because non-group coverage is not subsidized by employers, each insured individual pays the full premium[1].

National data suggests that consumers respond to the higher prices in the non-group market by purchasing policies with lower actuarial values (that is, fewer benefits or higher cost sharing). The increasing prevalence of high deductible health plans (HDHPs), those with deductibles of more than $1000 for single coverage, may be contributing in a modest way to lower actuarial values. Researchers estimate that these plans still represent just three percent of the privately insured market nationally, with more than half being purchased in the non-group market (GAO 2006). Besides cost, another barrier to obtaining individual coverage may be pre-existing health conditions[1].

The committee reviewed data on Idaho's uninsured population. While there are some variations depending upon data source, the committee found that almost 19 percent of adults in Idaho have no insurance coverage. Children's coverage is somewhat better. Close to 90 percent of Idaho children have health insurance coverage. Much of that success is due to the State Children's Health Insurance Program (SCHIP), which helps cover children in families whose income is higher than Medicaid limits but still low enough that private coverage is unaffordable for them. Idahoans know this program by the name of CHIP. Of the approximately 50,000 children who are uninsured, the data shows that almost half are currently eligible for public health coverage through CHIP, as well as Medicaid. A study conducted by Mathematica Policy Research, Inc., commissioned by Idaho's legislature, suggests that if the income parameters were adjusted to 200 percent, an additional 4,000 children could be covered. Most states that have been successful in improving rates of health coverage for their citizens have leveraged federal funds through Medicaid and CHIP as part of their overall solution.

Health Coverage Options

In an effort to expand the options for health coverage and reduce the number of uninsured, a majority of states have established high risk health insurance pools. These programs target individuals who cannot obtain or afford health insurance in the private market.

High Risk Pools

Many states also use their high risk pools to comply with the portability and guaranteed availability provisions of the Health Insurance Portability and Accountability Act of 1996[1]. For eligible individuals moving from the group to a non-group market, HIPAA requires state-licensed health insurers to make coverage available to such individuals, and prohibits exclusion of coverage for pre-existing conditions.

High risk pools fill a niche in the health insurance system - a patchwork system of private markets and public programs designed to meet the needs of different types of health care

[1] Mathematica Policy Research, Inc. for Office of Performance Evaluations Idaho Legislature (July 2007). Health Insurance Coverage in Idaho: A Profile of the Uninsured and Those with Coverage.)

consumers. High risk pools were designed to help individuals who, because of their health conditions, have very few options for private health coverage.

Idaho Individual High Risk Reinsurance Pool
In 2000, in an effort to bring about a more competitive market, and based on recommendations of members of the National Association of State Comprehensive Health Insurance Plans, Idaho adopted the current high-risk reinsurance pool. This pool receives funding from reinsurance premiums paid by carriers ceding risks to the pool, a portion of the state's premium tax revenue and, if necessary, carrier assessments.

The pool plans include Basic, Standard, Catastrophic A, Catastrophic B, and HSA Compatible Benefit Plans. These vary primarily by deductible, co-payment, and out-of-pocket maximum benefits. Individuals are eligible for the high-risk reinsurance plans if they are a HIPAA eligible individual, are eligible based on the Health Care Tax Credit (HCTC), if the carrier is unwilling to offer the individual coverage under a "street" product based on underwriting requirements, or if the individual carrier offers substantially similar coverage at a premium rate greater than the high risk pool rate.

The benefits and the premiums of the High Risk Pool plan are the same for all individual carriers. All pool plans issued must be reinsured through the pool.

Insurance Premium Assistance Programs
Many states offer premium assistance as a method for expanding coverage to uninsured individuals. By contributing to the cost of the premium, premium assistance programs enable individuals to purchase employer-sponsored insurance that they would otherwise be unable to afford. A portion of the premium is paid by the state, while an affordable amount is paid by the employee. States have managed their premium assistance programs through Medicaid and SCHIP programs, providing premium assistance to individuals at the higher end of the programs' eligibility levels. This provides states the opportunity to leverage federal funds.

Children's Access Card
The Children's Access Card helps families buy health insurance for qualified children. The Children's Access Card is a premium assistance program administered in partnership with Idaho insurance carriers.

An eligible child qualifies for up to $100 a month in premium assistance. Families with three or more eligible children can receive up to $300 a month. Children in families whose income is between 133 percent and 185 percent of federal poverty guidelines may be eligible. Parents are responsible for premium payments, co-pays, and deductibles.

Access to Health Insurance
Access to Health Insurance (AHI) helps employees of small businesses and their families enroll in employer–sponsored insurance. Small business is defined as having between two and fifty employees.

The employer, the employee, and the employee's spouse and children can receive up to $100 a month for each person with a maximum of $500 a month for each family. The employer must agree to participate in the program and pay 50 percent of the employee's premium.

Prevention and Personal Responsibility

Summit Recommendations: Reduce instances of chronic disease and obesity in Idaho through prevention and personal responsibility. Provide incentives for wellness behaviors and penalties for unhealthy behaviors. Implement transparency for cost and quality to increase consumer choice and control of care.

Committee Findings:

- Idaho's obesity trend among adults for 2006 was between 20 and 24 percent. This percentage has continued to increase each year and has more than doubled since 1986[1].
- Sixty-three percent of Idaho males between the ages of 18 and 34 are overweight and 25 percent are obese. Seventy percent of females in the same age group are overweight and 24 percent are obese[2].
- Fifty-four percent of Idaho females between the ages of 34 and 54 are overweight and 28 percent are obese. Fifty-six percent of males in that same age group are overweight and 26 percent are obese[2].
- Sixty-eight percent of Idaho males 55 years or older are overweight and 28 percent are obese. Sixty-seven percent of females in the same age group are overweight and 26 percent are obese[2].
- Nineteen percent of Idaho females and 20 percent of Idaho males between the ages of 18 and 34 do not participate in leisure time physical activity[2].
- Twenty percent of Idaho males and 14 percent of Idaho females between the ages of 35 and 54 do not participate in any leisure time physical activities[2].
- Twenty-seven percent of Idaho males and 19 percent of Idaho females 55 years plus do not participate in any leisure time physical activities[2].
- Idaho adults who smoked cigarettes were 1.6 times more likely to report fair or poor health than non-smoking adults[2].
- Idaho adults who smoked cigarettes were 2.2 times more likely than non-smoking adults to not have health coverage[2].
- Idaho adults who smoked cigarettes were 1.6 times more likely than non-smoking adults to participate in leisure time physical activity[2].
- Thirty-two percent of Idaho males and 33 percent of Idaho females between the ages of 18 and 34 did not visit a dentist in the past 12 months.
- Thirty-two percent of Idaho males and 35 percent of Idaho females between the ages of 35 and 54 did not visit a dentist in the past 12 months.
- Thirty-one percent of Idaho males and females age 55 years plus did not see a dentist in the past 12 months[1].
- Thirty-two percent of Idaho females and 25 percent of Idaho males between the ages of 18 and 34 did not wear a seat belt[1].

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[1] YMCA Activate America, 2006
[2] BRFSS, 2008

- Seventeen percent of Idaho males and 30 percent of Idaho females between the ages of 35 and 54 years of age did not wear a seat belt[1].
- Nineteen percent of Idaho females and 25 percent of Idaho males age 55 years plus did not wear a seat belt[1].
- Twelve percent of Idaho's adult population (both male and female) 18-34 years of age have high cholesterol levels and 8.3 percent have high blood pressure[1].
- Thirty-five percent of Idaho's adult population (both male and female) 35-54 years of age have high cholesterol levels and 22 percent have high blood pressure[1].
- Fifty-three percent of Idaho's adult population (both male and female) 55 years plus have high cholesterol levels and 50 percent have high blood pressure[1].
- Between 1994 and 2006, the rate of Idahoans with diabetes has gone from 4.2 percent to 6.8 percent, which represents a 61 percent increase. In 2008, eight percent of Idaho adults were diagnosed as being pre-diabetic[1].
- In 2001, the percent of Idaho adults with diabetes who were overweight was 86 and 58 percent were obese[1].

Innovative Service Delivery Models

Summit Recommendations: Take measures to ensure all Idaho citizens have a primary care medical home - a primary health care setting where individuals and families receive appropriate preventive and primary care services. The Governor should support and expedite the pending pilot project through the Quality Planning Commission (Health Data Exchange).

Of all the proposed models for health care reform, none are generating the optimism among health care professionals, payers, employers, and patients like the patient-centered medical home (PCMH) model. This concept is not new; it was originally developed by the American Academy of Pediatrics in 1967 with the aim of improving health care for children with special needs. Over the years, the model has been expanded by the American Academy of Pediatrics, the World Health Organization, the Institute of Medicine, the American Academy of Family Practice, and others, placing more emphasis on adults with chronic disease. In 2007, the American Academy of Pediatrics, the American Academy of Family Practice, the American College of Physicians, and the American Osteopathic Association issued principles defining their vision of a patient-centered medical home. The core features include a physician-directed medical practice; a personal doctor for every patient; the capacity to coordinate high quality, accessible care; and payments that recognize a medical home's added value for patients. The Patient-Centered Primary Care Collaborative, whose membership includes a number of large national employers, most of the major primary care physician associations, health benefits companies, trade associations, profession/affinity groups, academic centers, and health care quality improvement associations, was created in late 2006 in order to facilitate improvements in patient-provider relations and create a more effective and efficient model of health care delivery. To achieve these goals, the Patient-Centered Primary Care Collaborative has become one of the major developers and advocates of the PCMH model in America.

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[1] BRFSS, 2008

The Patient-Centered Primary Care Collaborative developed seven principles of the PCMH that have been jointly endorsed by the American Academy of Pediatrics, the American Academy of Faily Practice,the American College of Physicians, and the American Osteopathic Association:

- Personal physician – each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- Physician directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- Whole person orientation – a personal physician takes responsibility for directly providing or appropriately arranging for all the patient's health care needs in all stages of life including acute care, chronic care, preventive care, and end of life issues.
- Care is coordinated and integrated – across all elements of the complex health care system and the patient's community. Integration is complex, time-consuming work and improving primary care's performance in this area will require investment in information technology and disease management.
- Quality and safety – are hallmarks of the medical home. Information technology will be needed to implement evidence-based medicine and clinical decision-support tools; maintain registries of patients and their conditions to measure outcomes of treatment; support optimal patient care, performance measurement, patient education, and enhanced communication.
- Enhanced access – care is available through systems such as open scheduling, expanded hours, and new options for communication between patients, physicians, and staff.
- Payment – appropriately recognizes the added value to patients who have a PCMH. Reforms in financing are highly important, however, solutions have been rather elusive in our complex reimbursement system.

The PCMH is producing such optimism because it potentially can make improvements in the benchmark indicators used to evaluate health system performance; access, quality, cost, equity, efficiency, positive outcomes, and healthy lives. Unfortunately, the U.S. receives low marks in surveys of patients, health care professionals, and policy makers. Even more dramatic are the low marks received when comparisons are made with other industrialized nations. Many studies have addressed each of these items and discuss how the U.S. lags behind most industrialized nations.

- Of 13 countries in a recent comparison, the U.S. ranks on average 12th (second from the bottom) for 16 available health indicators. Japan was first, followed by Sweden, Canada, France, Australia, Spain, Finland, the Netherlands, the United Kingdom, Denmark, Belgium, the U.S., and Germany.

- In a compilation of three surveys by the Commonwealth Fund on patient satisfaction in Australia, Canada, Germany, New Zealand, the United Kingdom, and the US; the US placed last in access, efficiency, equity, and healthy lives, and 5th in quality care. The United Kingdom was first, followed by Germany, Australia and New Zealand (tie), Canada, and the U.S.

- In the 2007 Commonwealth Fund State Scorecard on Health System Performance, Idaho ranked 30th in the U.S. overall; 43rd for access, 39th for quality, 45th for equity, and 12th for healthy lives.

In studies that compare the U.S. with other industrialized nations with better quality, a number of differences immerge; universal coverage, half the cost, better outcomes, and emphasis on primary care. There is evidence that the PCMH can improve our health care system in these areas. Studies have shown that when the per capita number of primary care physicians increases, the quality of health care increases[1]. Also, as quality increases, spending decreases. Thus, we can conclude (and studies have found true) that as the per capita number of primary care physicians increases, spending decreases. The Commonwealth Fund has shown that patients in a PCMH are more likely to get preventive care reminders, receive preventive care screening, receive care when needed, and check their blood pressure regularly. There is also evidence of reduced costs.

Health Care Expenditures and Mortality five year follow up: United States 1987-1992: Adults (age 25 and older) with a primary care physician rather than a specialist as their personal physician had 33 percent lower cost of care, were 19 percent less likely to die (after controlling for age, gender, income, insurance, smoking, perceived health and 11 major health conditions)[2].

Many other studies done within countries, both industrial and developing, show that areas with better primary care have better health outcomes, including total mortality rates, heart disease, mortality rates, infant mortality, and earlier detection of cancers such as colorectal cancer, breast cancer, uterine/cervical cancer, and melanoma. The opposite is the case for higher specialist supply, which is associated with worse outcomes.

An example of a high performance patient-centered primary care system is Denmark, which has the highest public satisfaction among European countries. Highlights of the program include:

- Blended primary care payment system – fee for service and medical home monthly fee per patient.
- Organized off-hours service with evening and weekend clinics and physician staffed phone banks with computerized access to patient information.
- Health information technology and information exchange – ninety-eight percent of primary care physicians have totally electronic health records; e-prescribing and payment for e-mail consultation; all prescriptions, lab and imaging tests, specialist consult reports, and hospital discharge summaries flow through a single electronic portal accessible to patients, physicians, and home health nurses[2].

Behavioral Health (Mental Health and Substance Abuse)

Summit Recommendations: In addressing health coverage expansion, behavioral health benefits (including mental health and substance abuse) should be included in benefit plan design.

Idaho has a failing mental health and substance abuse delivery system. This was reinforced to the committee through testimony at the public hearings and the WICHE study. Cited below are the recommendations from the WICHE study and key comments heard at the public hearings.

[1] Health Affairs, April 2004
[2] Commonwealth Fund (2007). Moving the US and Idaho to High performance Health System

WICHE Mental Health Program Idaho Behavioral Health System Redesign 2008
The Legislative Health Care Task Force sponsored Concurrent Resolution No. 108 in 2007. This resolution commissioned the WICHE Mental Health Program to conduct a review of the state's behavioral health status. That report contained several observations and recommendations. The major points that the report covered are:

- Idaho's mental health and substance abuse systems are severely fragmented (this includes child and adult systems, Medicaid and non-Medicaid eligibles, mental health and substance abuse systems, and the executive branch agencies).
- The WICHE Report recommends the following:
    - Transforming the executive branch structure, including the roles of the Division of Behavioral Health, with a focus on quality of care at the point of care.
    - Creating regional authorities and districts for planning, administering, and delivering services to children and adults.
    - Identifying gaps in the mental health and substance abuse programs within the respective criminal and juvenile justice systems to ensure integration across agencies.
    - Increase the access to care through a review of eligibility criteria (both clinical and fiscal) and the use of waivers.
    - Enhance the efficiency of Idaho's hospital capacity in caring for the mentally ill and substance abuse cases.
    - Increase accountability via information and a statewide data system.
    - Enhance the mental health and substance abuse workforce capacity and create a "Workforce Collaborative", increase educational and training programs in the professional settings, and create incentives for the recruiting and retaining behavioral health providers and best practice interventions.

Summary of Public Hearing Comments

- There is a relationship between morbidity and behavioral and mental health.
- Behavioral and mental illnesses have distinct challenges, yet insurance benefits favor physical conditions and do not reflect these challenges.
- Mental and behavioral health issues have a huge impact on hospital emergency services.
- The need for more educational and training programs for behavioral and mental health providers is pressing (physicians, mid-level, nurses, and technicians).
- Behavioral and mental health issues have significant challenges for families, including the distribution of communications about services available.
- Small communities have major challenges.
- The relationship between behavioral/mental health and law enforcement/corrections, including the fiscal impact.
- Insurance benefits for behavioral and mental health services have huge deductibles.
- There is a stigma about mental and behavioral illnesses and a need for a cultural change.
- The political issues in Idaho have resulted in the access to care being fragmented, the need for collaboration and cooperation between agencies, and the need to integrate care across agencies.
- Prevention, access, intervention, and follow up care are a major issue for Idaho.
- The cost of pharmaceutical drugs for treating behavioral and mental illnesses is a challenge.

Select Committee Recommendations

Principles for Health Care Reform

The committee has identified a number of principles on which to build reform efforts. These principles can guide the selection and prioritization of efforts to make a true difference in health care for all Idaho residents. These principles have guided the committee in analyzing and developing recommendations. The principles are:

- Basic health care should be available and accessible to all Idahoans.
- Health care for the 50,000 uninsured children in Idaho should be an immediate priority.
- Every Idahoan needs a primary care medical home that provides prevention, primary care, continuity of care, positive outcomes, and quality.
- We all must take personal responsibility for our own health and proactively manage our health care costs.
- Improvements in health care access, cost, and quality must be built upon public and private partnerships and personal responsibility.
- Many Idahoans cannot achieve good health without a partnership between government, business, and Idaho's health care community to equip them with the tools and services they need to stay healthy.
- Reforms must be financially viable, sustainable, and measurable.
- In developing strategies to cover Idaho's uninsured residents, Idaho should leverage funds currently available in the existing system, including federal, state, county, and employer contributions to healthcare benefits.
- Health care reform must be developed collaboratively and include all key stakeholders, including consumers.

Action Steps to a Healthy Idaho

Committee Recommendations: The committee has identified a number of action steps to begin the reform process. Each step is a building block to further action. All are necessary but not sufficient to accomplish significant reform, but all are achievable and will create a solid starting point for Idaho's efforts to increase access, control costs, and increase quality. These strategies are:

- **Cover Idaho's children:** Over 50,000 children are uninsured; of those, 27,000 are already eligible for Medicaid or SCHIP. The goal is to have all eligible children enrolled as soon as feasible. Steps that could be taken include:
    - Enhance outreach efforts to enroll children who are currently eligible but not enrolled, targeting a 10 percent increase in enrollment.
    - Establish resources for community partners to assist in outreach efforts.

- Begin working to expand coverage to children at or below 200 percent of the Federal Poverty Level, currently projected to be less than 5,000 children.
- Expand the use of the Access Card to enroll children who are SCHIP eligible by simplifying the application process and program requirements.
- Consider the use of the high risk pool or reinsurance to create affordable child only insurance products for children above SCHIP eligibility. These products must cover wellness and connection with a medical home.
- Continue to work with private insurers to develop affordable child health policies.

- **Expand insurance coverage for adults:** Close to 200,000 adults lack coverage. Most work, but coverage is not affordable. Public and private solutions must be created to make coverage more affordable. These solutions include:
  - Expanding the use of the Access Card to increase coverage for low-income adults.
  - Creating low premium, low deductible insurance packages with preventive first dollar coverage.
  - Marketing newly created, affordable insurance products that emphasize wellness and preventive care and are targeted for those Idaho citizens who are 25-40 years of age.
  - Exploring opportunities to better utilize county funds and other potential resources to expand coverage for adults.
  - Continuing to evaluate health care reform initiatives in other states to determine which might be most suitable for Idaho.

- **Expand residency opportunities:** Idaho desperately needs family physicians. In-state residencies have the greatest potential to graduate physicians who will stay and practice medicine in Idaho. The current residencies in Pocatello and Boise do not graduate enough family medicine residents to meet demand. Idaho is sorely lacking other primary care residencies. Idaho can address this issue by:
  - Increasing by 50 percent the number of residents at the Family Medicine Residency of Idaho and the ISU Family Medicine Residency, with a focus on rural practice.
  - Creating a residency program in northern Idaho to address the needs of northern Idaho communities.
  - Exploring opportunities for other primary care residencies (internal medicine, OB/GYN, pediatrics, general surgery, psychiatry) with other key health stakeholders.
  - Creating a sponsoring institution(s) network to develope new GME programs including public and private partnerships such as community health clinics; a teaching hospital network with public institutions; and in the future, Idaho's own undergraduate medical education program as a sponsoring agent for GME residencies and fellowships.

- **Address undergraduate medical education:** Idaho students have limited access to medical education. The number of seats at WWAMI and the University of Utah has not grown to meet the population growth of Idaho and the needs of Idaho residents. However, any increase in undergraduate education must be directly tied to growth in primary care residencies to maximize the number of students who would stay in Idaho. Idaho must:
  - Commit to the planning process required by the Liaison Committee for Medical Education (LCME), to evaluate the potential for an Idaho medical school.

- Consider expanding the number of medical seats purchased at WWAMI or other medical schools.
- Support the efforts of the State Office of Rural Health to recruit and retain health professionals for rural Idaho.

- **Address the health professions workforce shortage in Idaho:** According to the Idaho Department of Labor, Idaho faces a severe shortage in all health professions occupations in the near future. In addition to nursing, shortages in such fields as pharmacy, dentistry, allied health professions, and mental health professions will be acute. To address this, Idaho should create a health professions education council similar to Utah or other state models.

- **Develop primary care medical homes for all Idahoans:** Major physician groups, Medicare, Medicaid, employers, and insurance companies see the value of primary care medical homes as a means of improving care and managing costs. Two essential features of a medical home are increased care coordination and quality improvement. To achieve these, Idaho should:
  - Work with key stakeholders to align the vision and key elements of a primary care medical home.
  - Consider developing a multi-payer pilot to test the efficacy of a medical home.
  - Tie Medicaid reimbursement increases in primary care to implementing core elements of the medical home (e.g., participation in the Idaho Health Data Exchange, electronic medical record, documented care coordination, NCQA standards).
  - Support the implementation of the Idaho Health Data Exchange to improve care coordination and quality.
  - Provide matching grants and/or zero interest loans to rural and safety net providers to upgrade health information technology.
  - Continue funding the Community Health Center Grant Program to increase access to care for uninsured residents.

- **Encourage prevention and personal responsibility for health.** Lifestyle has a critical impact on health. Obesity, smoking, alcohol and substance abuse all have a significant impact on health and health costs. 2008 marked the third year that methamphetamine was the primary drug of choice for adults, increasing from 44% in SFY 2007 to 46% in FSY 2008. Social marketing efforts similar to the Idaho Meth Project can be used to encourage personal control of health. Idaho should create a coalition to implement the Target For A Healthy Idaho that will:
  - Develop and implement strategies to increase the immunization rates for Idaho's children.
  - Work with the Employers Health Coalition of Idaho, insurers, and other stakeholders to spread effective workplace wellness programs statewide. For example, the State Employee Wellness Program.
  - Work with key stakeholders to spread coverage models with an emphasis on prevention and wellness (e. g., reduced premiums and incentives for wellness).
  - Work with schools regarding wellness initiatives, healthy menus and snacks, and replacing sodas and sweets in vending machines.
  - Work with community groups on wellness and personal responsibility.
  - Work with restaurants to encourage healthy menu items.

- Work with the Health Quality Planning Commission to develop transparency regarding quality of health care providers.
- Work with health promotion organizations, both public and private, to increase consumer knowledge of health.
- Encourage the development of personal health records.

- **Continue to improve Idaho's behavioral health system.** Idaho has received an "F" from the National Alliance for the Mentally Ill regarding mental health care, ranks in the top 10 for suicides, and ranks close to last in public funding for mental health services. The legislature has begun to address this problem by increasing funding for behavioral health and commissioning a study of the public behavioral health system. Idaho should:
  - Encourage efforts to improve the behavioral health system.
  - Continue the Community Collaboration Grant program.
  - Respond to the findings of the WICHE study with a plan to improve Idaho's behavioral health system.
  - Work with private partners to implement equality in all coverage.

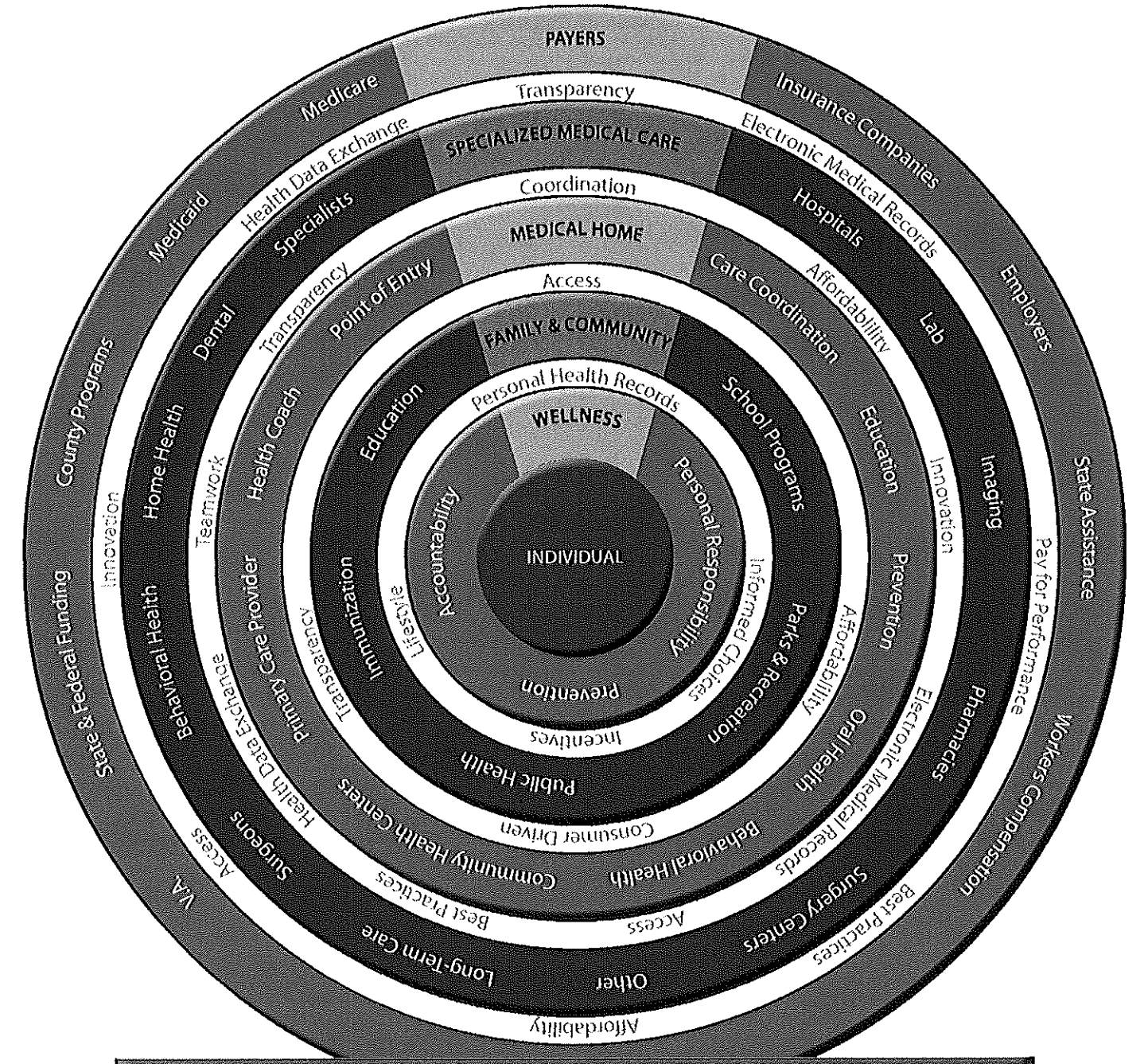
Although this report provides a fairly comprehensive picture of Idaho's current health care system, the committee has identified oral health care, senior services (long-term care options), end of life care and costs, and financing as four additional areas that are important and need to be addressed in the future.

Glossary

AAFP	American Academy of Family Practice
AAMC	Association of American Medical Colleges
AAP	American Academy of Pediatrics
ACP	American College of Physicians
AHI	Access to Health Insurance
AMA	American Medical Association
AOA	American Osteopathic Association
BMI	Body Mass Index
BRFSS	Behavioral Risk Factor Surveillance System
CHIP	Children's Health Insurance Plan
FPL	Federal Poverty Level – determines eligibility for services; changes annually
GME	Graduate Medical Education
HCTC	Health Care Tax Credit
HDHP	High Deductible Health Plans
HIPAA	Health Insurance Portability and Accountability Act 1996
HRP	High Rate Pool
IHA	Idaho Hospital Association
IMA	Idaho Medical Association
IOM	Institute of Medicine
JAMA	Journal America Medical Association
LCME	Liaison Committee for Medical Education
MEPS	Medical Expenditure Panel Survey
NASCUIP	National Association of State Comprehensive Health Insurance Plans
PCMH	Patient Centered Medical Home
PCPCC	Patient-Centered Primary Care Collaborative
SCHIP	State Children's Health Insurance Programs
UUSM	University of Utah School of Medicine
UWSM	University of Washington School of Medicine
WICHE	Western Interstate Commission for Higher Education
WWAMI	Washington, Wyoming, Alaska, Montana, Idaho (Medical education program at the University of Washington School of Medicine, Seattle, WA)
YMCA	Young Men's Christian Association

Appendices

Target for a Healthy Idaho



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Governor's Select Committee on Health Care

Designed by Spencer Michael

Governor's Health Care Summit Recommendations

August 21-22, 2007

RECOMMENDATIONS	BARRIERS	SOLUTIONS
WORKFORCE		
1. Increase the number of graduate medical education training programs in Idaho to help increase the physician workforce in our State. We recommend expansion of residency programs in family medicine, internal medicine, obstetrics/gynecology, pediatrics, psychiatry and general surgery throughout the State. • Increase the total number of family medicine residents to at least sixty, which will allow expanded rural family medicine training in our State. • Increase the Internal Medicine Primary Care Track residents to at least twenty and the Psychiatry Advanced Clinician Track residents to at least twelve. We recommend striving to have at least twelve pediatric residents, sixteen obstetrics/gynecology residents and twenty general surgery residents.	Funding Attitude within the health care community toward participating in residency education Having a champion in each residency location to lead the program	Potential funding sources for these programs are: • Federal government/Medicare • All hospitals in the State; • Clinical revenue from each residency program; • Medicaid/Upper Payment Limit funds • Grants/contracts • State funding
2. Expand Access to Medical School Education: Short term solutions: • Expand the number of seats with the current programs with WWAMI and University of Utah. • Explore the possibility of additional first year sites within the State through the existing WWAMI program. • Explore options of buying seats at other medical schools such as Oregon or Nevada. • Explore options with the newly created osteopathic medical school in Yakima or other osteopathic medical schools.	Funding Infrastructure	Long term options include creating a 4-year medical school program through expansion of current in-state medical education programs or the development of an independent state medical school. The timeline for the development of a 4-year medical school program or independent State medical school is 5-15 years.
3. Expand Nursing Education opportunities to meet Idaho's future workforce needs. • Double the number of nursing student seats at Idaho's colleges and universities in order to produce the 5,000 additional nurses the by the year 2020. • Nursing faculty salaries must be raised to be competitive with hospital wages. To create adequate numbers of nurses qualified to teach, we further recommend an increase in the number of masters and doctoral nursing programs delivered through distance education technology.	Lack of nursing faculty willing to work for lower salaries	

• Due to the immediate need for BSN prepared nurses in the state, as evidenced by the open nursing positions at Idaho's hospitals, we recommend tripling the number of fast-track nursing seats at ISU • We also recommend increasing nursing scholarship and loan forgiveness programs to encourage out of state nurses to move to Idaho.		
COMPREHENSIVE PUBLIC/PRIVATE HEALTH CARE COVERAGE		
4. Make available to all Idahoans a defined-benefit insurance product that includes at least first-dollar coverage for preventive and primary care and catastrophic care, that is individually purchased and administered through a public/private entity, and which is funded by a combination of federal, state, employee and employer contributions, and is actuarially priced based on pooled risk . Incentives should be provided to small employers & employees who participate through contributions. Benefits: • More affordable & portable for all • Reduce cost shifting • End the need for subsidized catastrophic care • Reduce serious illness • $ savings down the road • Reimbursement is competitive [NOTE: Recommendation #4 may be paired with Recommendation #5 to offer a standard limited-benefit insurance product on the market funded through public/private partnerships, and require individuals to carry health insurance with sliding-scale subsidies. For purposes of this document they are separated for consideration of each idea on its merits.]	The State's ability to match federal contributions Stakeholder acceptance of a mandate solution will require; good marketing, grassroots advocacy & education, and continual mindfulness of stakeholder needs & concerns. Initially this may not be budget neutral Administrative challenges to manage Outreach to the public will be needed This requires a shift to a new way of doing insurance - individual vs. employer Provider reimbursement fears	Good public outreach & education Be mindful of stakeholder needs & concerns Explore funding through sales or cigarette tax increase Tax credits could motivate participation In order to provide a comprehensive public/private health care coverage program, funding should take full advantage of all federal matching opportunities (e.g. Medicaid, SCHIP, etc.) and be implemented immediately in accordance with federal guidelines.
5. Idaho should take full advantage of public/private partnerships to design and implement a requirement that individuals carry health care coverage (individual mandate). Subsidies should be provided on a sliding scale basis to those individuals who have difficulty purchasing coverage.	Some of same barriers as #4	Some of same solutions as #4

PREVENTION AND PERSONAL RESPONSIBILITY		
6. Reduce instances of chronic disease & obesity in Idaho through prevention and personal responsibility. • Utilize school programs/policies to: o Provide educational materials on healthy lifestyles and wellness activities (short term solution) o Publish best practices through school organizations (short term solution) o Replace all candy and pop vending machines with health snacks (short term solution) o Support schools providing healthy foods (short term solution) o Require additional physical activity as part of the curriculum and/or through extra curricular activities (long term solution) o Set performance measures for determining the level of healthy lifestyles and wellness activities at the school level (long term solution) • Utilize existing community programs to: o Share their existing wellness programs and curriculum with smaller towns and schools who do not have the resources to develop materials (short term solution) o Publish community best practices such as recreation districts, local college programs etc. (short term solution) o Encourage community planning around making environment pedestrian friendly (bike lanes, walking paths, community parks etc.) (long term solution)	Adding physical activities and wellness curriculum is a challenge due to the length of school day and the existing educational requirements Local school boards control school agendas Lost school revenue (vending machines) Lack of planning coordination for pedestrian and environmental friendly infrastructure Local jurisdictions/turf issues between community programs	Sharing ideas and programs will reduce costs and increase likelihood of success Providing healthily food and teaching children at a young age to have healthy behaviors decreases the chances of obesity Community planning around health lifestyle increases the chances of long term success
7. Provide incentives for wellness behaviors and penalties for unhealthy behaviors Benefits: • Motivation to change behaviors • Health care providers are the paid the same for preventative care resulting in increased wellness services	There would be a cost to pay incentives and administration of the program Unsure how to target the population that would have the best outcomes. Unsure how to enforce penalties or provide incentives How do you reward those who are already healthy?	**Short term:** Private/public insurers/provide information on the benefits of wellness behaviors & activities to consumers **Long Term:** Provide rebates or a reduction in premium costs to employers whose employees reduce their medical costs and/or participate and succeed in wellness programs such as

	Large corporation & government regulations could inhibit implementation Society's resistance to consequences Little evidence that incentives and/or penalties really work	smoking cessation, weight loss etc. Public/private insurers provide rebates or a reduction in premiums to individuals who reduce their medical costs and/or participate and succeed in wellness programs such as smoking cessation, weight loss etc. Increase reimbursement to health care providers for prevention related counseling
8. Implement cost/quality transparency to increase consumer choice and control of care	Stakeholder resistance to share information Definition of quality indicators that providers must report (or need for clear definition of what is reported so comparisons are "apples to apples")	Long Term: Require system-wide participation from all players Create a neutral entity to be the data source for consumers
INNOVATIVE SERVICE DELIVERY MODELS		
9. Measures should be taken to ensure that all Idaho citizens have a primary care "medical home" – a primary health care setting where individuals and families receive appropriate preventive and primary care services and avoid costly crisis care in hospital emergency rooms. The medical home provider(s) would manage the patient's health throughout the life cycle and refer them to other medical and non-medical services as appropriate.	Idaho first must have an adequate primary care provider workforce before everyone could be required to have a primary care medical home County commissioners resistant to using indigent funds in a different model (this was explored in the past couple years)	Focus efforts on expanding pipeline of primary care physicians into Idaho Community Health Centers can help to provide a medical home for low income Idahoans Utilize county indigent funds differently to provide preventive/primary care (leveraging federal match) Expand Healthy Connections to all Medicaid eligible participants
10. The Governor should support and/or expedite the pending pilot project through the Health Quality Planning Commission (authorized by the Legislature).	Funding: Some physicians, particularly primary care, have difficulty implementing electronic health	Incentives and information technology support could be offered to physicians to assist them in implementing electronic health

Data collection and analysis are critical to improving quality processes – a statewide health database on quality indicators should be implemented to ensure high quality health care and to enable statewide health planning. There should be a long-term goal of providing coordinated, high-quality care between hospitals and providers on a common electronic platform (requires interoperability of systems).	records in their offices due to the high cost Funding may be necessary for statewide infrastructure to administer a health database Proprietary information that providers may be hesitant to share No work has yet been done on use of data for health planning Who will manage/administer data	records Explore innovative funding sources (sin taxes, Rental car tax) Process already underway; Governor's support may help expedite process
BEHAVIORAL HEALTH (MENTAL HEALTH AND SUBSTANCE ABUSE)		
11. In addressing health coverage expansion, Behavioral Health (including mental health and substance abuse) benefits should be included in benefit plan design. Additional focus should be placed on education, early identification and intervention.	Lack of quality providers/ Current supply of providers insufficient System support to expand capacity Limited health resource people in K-12 system	Role of primary care "medical home" in coordinating behavioral health care (referral to resources, follow-up, etc.) should be explored Increase opportunities for specialized provider education about behavioral health issues Investigate treatment capacity options (secure mental health facility vs. other options, etc.) Extend teen counselor program for at-risk children to elementary school level

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Gary Babble (Member of the Summit) Small Business issues

Dr. David McClusky (Member of the Summit) Medical care for the Uninsured

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