Utah Primary Care Summit, November 3rd-4th

DAY 1: (Attended by ALL coalition members)

8:00 – 8:30	*Breakfast*
8:30 – 9:00	Welcome Message – Dr. Mike Magill
9:00 – 9:45	The National State of Primary Care – Dr. David Sundwall
9:45 – 9:55	*Break*
10:00 – 11:00	Current & Future Realities of Utah's Primary Care Workforce – Dr. Sarah Woolsey
11:00 – 12:00	Moderated Discussion
12:00 – 1:00	Lunch & Introduce AHEC (*30 mins AHEC*) - Izzi Alder
1:00 -2:30	Pipeline Discussion: Breakout Groups
2:30 - 3:00	Presentation of Group Resolutions
3:00 – 4:30	Policy Discussion: Priorities for Upcoming Legislative Session
4:30 – 5:00	Closing Message – Dr. Mike Magill

DAY 2: (1/2 Day, Attended by EXECUTIVE coalition members) (Led by Mike)

8:00 – 8:30	Breakfast & Debrief
8:30 – 9:30	Review Identified Top Challenges, Pipeline Resolutions, and Policy Priorities
9:30 – 10:30	Draft Strategic Plan to Address Utah's Primary Care Workforce Challenges
10:30 – 11:00	Outline Next Steps

Following the summit, all participants will receive a copy of the comprehensive strategic plan developed over the course of the two days. We will also develop and distribute a post-summit evaluation tool to send out to all participants. The results and feedback received will guide planning for future events.

SPEAKERS AND MODERATORS

Michael K Magill, MD, is a board-certified physician specializing in family medicine. He currently serves as Chairman of the Department of Family and Preventive Medicine at the University of Utah's School of Medicine and the Executive Director of Utah AHEC. Dr. Magill graduated from Duke Medical School and completed the Duke-Watts Family Medicine Residency Program, Durham, North Carolina. His many professional achievements include serving as Executive Medical Director of the University of Utah Hospitals and Clinics/Community Physician Group, in which he helped develop the University of Utah's model of the Patient Centered Medical Home – known as Care by Design™ (CBD). He also served as Executive Medical Director of the University of Utah Health Plans from 2012 to June 2015, leading implementation of PCMH payment for care for University employees and Medicaid patients. Dr. Magill is dedicated to health care reform and educating future physicians.

David N. Sundwall, MD, is a board-certified physician in Internal Medicine and Family Practice. He received his medical degree from the University of Utah – School of Medicine and further training in the Harvard Family Medicine Residency Program. Dr. Sundwall has considerable experience in health policy and administration at both the state and national level. He has served as Administrator in the Health Resources and Services Administration, Vice President and Medical Director of American Healthcare Systems, Assistant Surgeon General in the Commissioned Corps of the U.S. Public Health Service, and Executive Director of the Utah Department of Health. In addition to his extensive government service, Dr. Sundwall has always maintained his medical license and volunteered in public health clinics, providing primary care to medically underserved populations. He currently serves as a Professor in the University of Utah Division of Public Health.

Ric Campbell, MS, is the Executive Director of the Utah Medical Education Council. The Council has the mission to conduct health care workforce research, to advise on Utah's health care training needs, and to influence graduate medical education (GME) financing policies. UMEC also serves as the Nursing Workforce Information Center for the state and facilitates rural residency training opportunities. Before joining UMEC, Ric served two terms on the Utah Public Service Commission regulating public utilities. Early in Ric's public service in state government he led health care reform efforts for Governor Michael Leavitt and was the Executive Director of the Utah Health Policy Commission.

Isabella Alder, MPH, is the Associate Director for Utah AHEC. She recently completed her graduate degree in Public Health from the University of Utah, and has a keen interest in healthcare education and training. Isabella has sought out academic and professional experiences focused on connecting populations to appropriate health resources, both locally and globally. She is excited to carry-out Utah AHEC's mission to "help current and future health professionals acquire knowledge, skills, and attitudes needed to practice in a transformed health system for medically underserved rural and urban communities".

Senator Stephen H. Urquhart, JD, is Global Ambassador for the University of Utah. Steve was a member of the Utah House of Representatives from 2001 to 2008, serving as Majority Whip and Rules Chair. In 2009, he joined the Utah Senate, serving as Senate chair of the Higher Education Sub-Appropriations Committee until 2016. Steve was born and raised in Houston, Texas. He received his education at Williams College (biology) and BYU Law School (law review, honors). Steve is a founder of the Partnering Institute of Africa and director for Red Butte Garden, Equality Utah, and the Salt Lake Area Restaurant Association. For successfully championing difficult causes, Steve has been honored by the ACLU (Torch of Freedom), Equality Utah (Abraham Lincoln Award), and the Utah Pride Festival (Pete Suazo Political Action Award). He is married to Sara Stanley. They have 4 children.

Mark R. Greenwood, MD, grew up in the small rural Utah town of Richfield as the son of a country doctor. Family Medicine and Primary Care were in his blood, and his goal was always to become a doctor and join his father in practice. Following college at Brigham Young University (B.S. 1996), Medical School at The George Washington University (M.D. 2000), and Residency at the University of Utah, that dream became a reality. In 2003 he joined the Intermountain Medical Group and has practiced full spectrum Family Practice in Richfield including outpatient, inpatient, ER, and obstetrics. In 2012 he become the Medical Group Rural Region Medical Director. More recently, in August of 2016 he became the Medical Director of the Intermountain Healthcare Primary Care Clinical Program. In this new role he hopes to elevate the role and importance of primary care in population health management, chronic disease management, and most especially healthy lifestyle and disease prevention.

Jennifer L. Dailey-Provost, MBA, is the Executive Director of the Utah Academy of Family Physicians. She is also a registered lobbyist in the state of Utah. Jennifer focuses her lobbying efforts on advocating for healthcare reform, particularly related to family practice and primary care. Jennifer is passionate about improving health for all Utahans through working with family physicians and other health professionals to achieve the Quadruple Aim. In addition to holding B.S. in Business from the University of Utah and her M.B.A. from Westminster College, she is currently pursuing her Masters of Public Health at the University of Utah. This exciting endeavor gives her the opportunity to work on research focused on transforming how health care (particularly primary care) is delivered in the health system.

UTAH'S PHYSICIAN WORKFORCE

Utah Primary Care Summit
November 3, 2016

Utah Medical Education Council

- Created in 1997 by H.B.141

- Primary Purposes:

1. conduct health care workforce research
2. advise on Utah's health care training needs
3. influence graduate medical education (GME) financing policies
4. facilitate rural residency training opportunities
5. serve as the Nursing Workforce Information Center

2015 Physician Survey

- 9,990 licensed physicians in Utah
- 4,622 surveys returned – overall 47% response rate
- 32 questions
- 6,035 physicians practicing in the state

Physician to Population Ratios

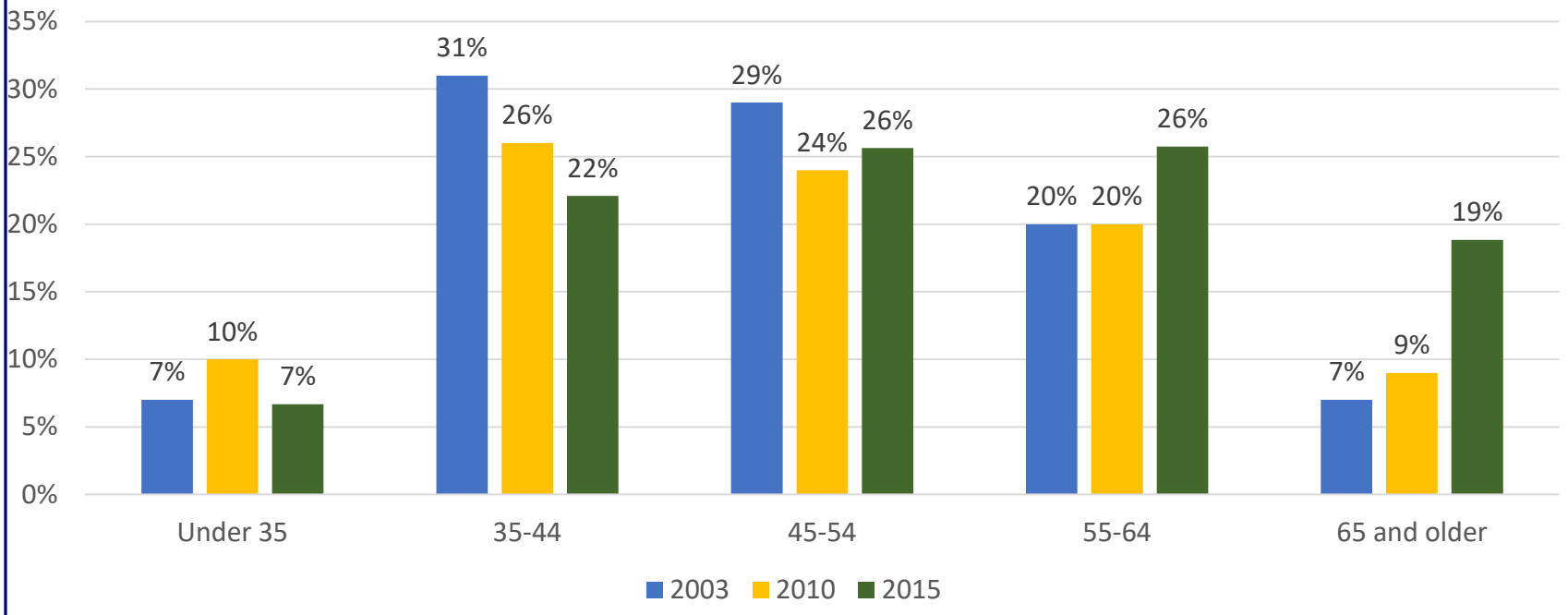
	Primary Care	Specialty	Overall
Count	2,078	3,801	6,035
Percent	34.4%	63.0%	100%
Utah Physicians per 100,000 Population (UMEC)	68	125	198
Utah Physicians per 100,000 Population (AMA 2015)	65	_	207.5
U. S. Physicians per 100,000 Population (AMA 2015)	91	_	265.5

Active Patient Care Primary Care Physicians Per 100,000 Population

State	Rank	#
Vermont	1	119.2
Maine	2	117.1
Massachusetts	3	115.5
Nevada	48	63.5
Utah	49	61.6
Mississippi	50	60.1

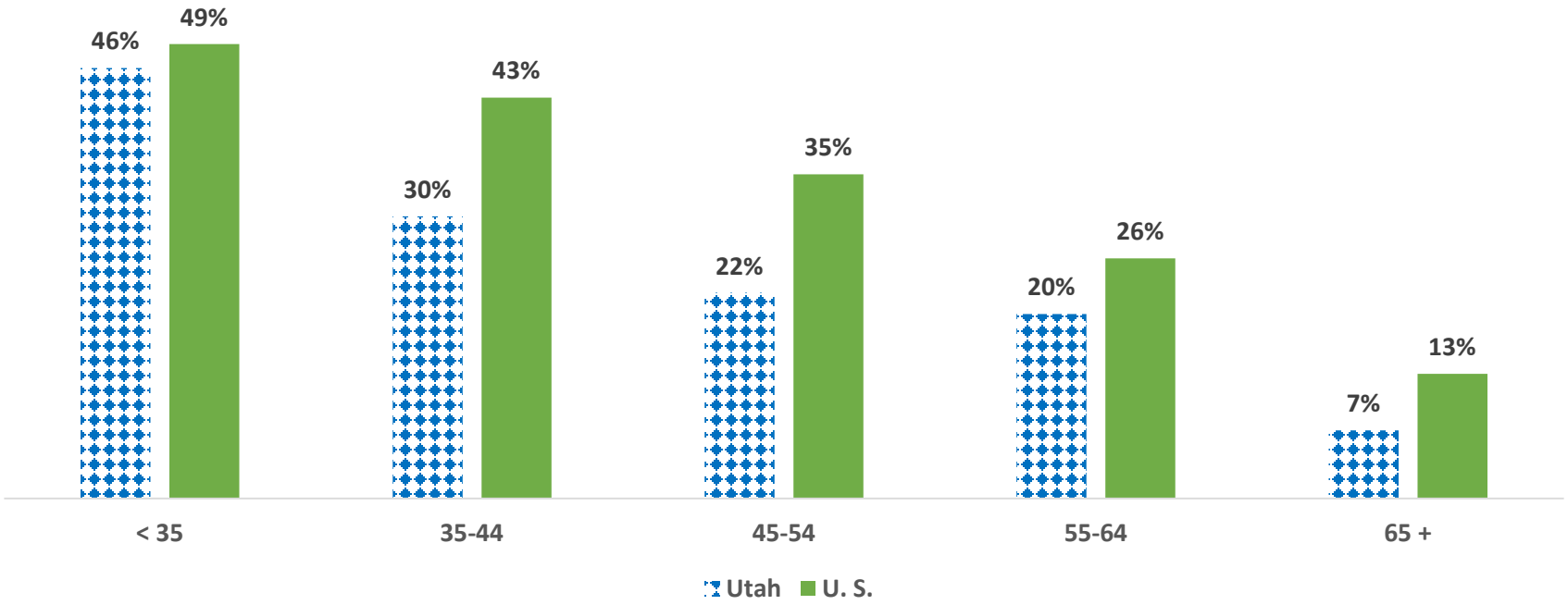
Source: AAMC 2015 State Physician Workforce Data Book

Demographic Data: Age



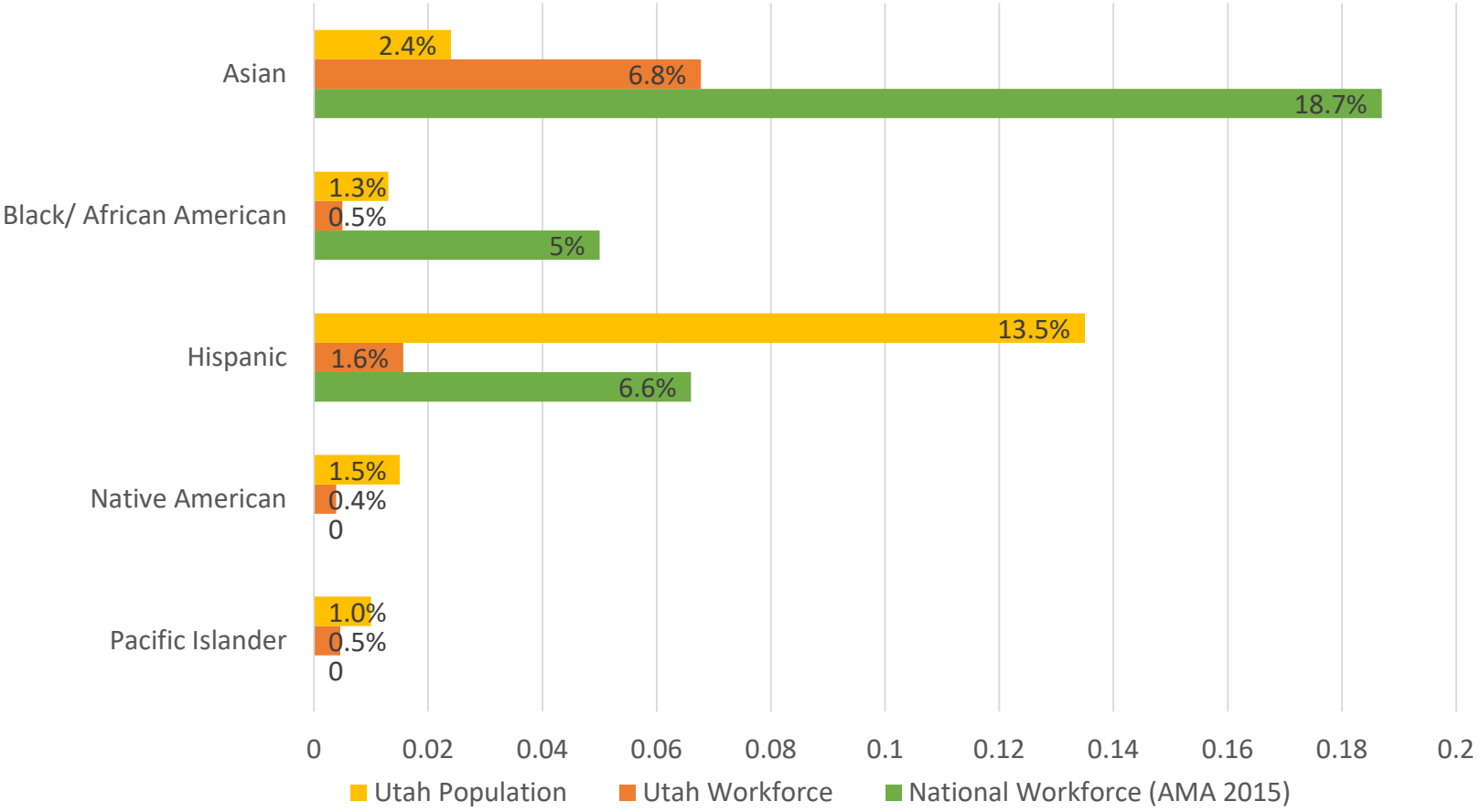
	Median Age	SD
2010	48.7 Years	11.7 years
2015	53 Years	12.3 Years

Demographic Data: Gender- Percent Female



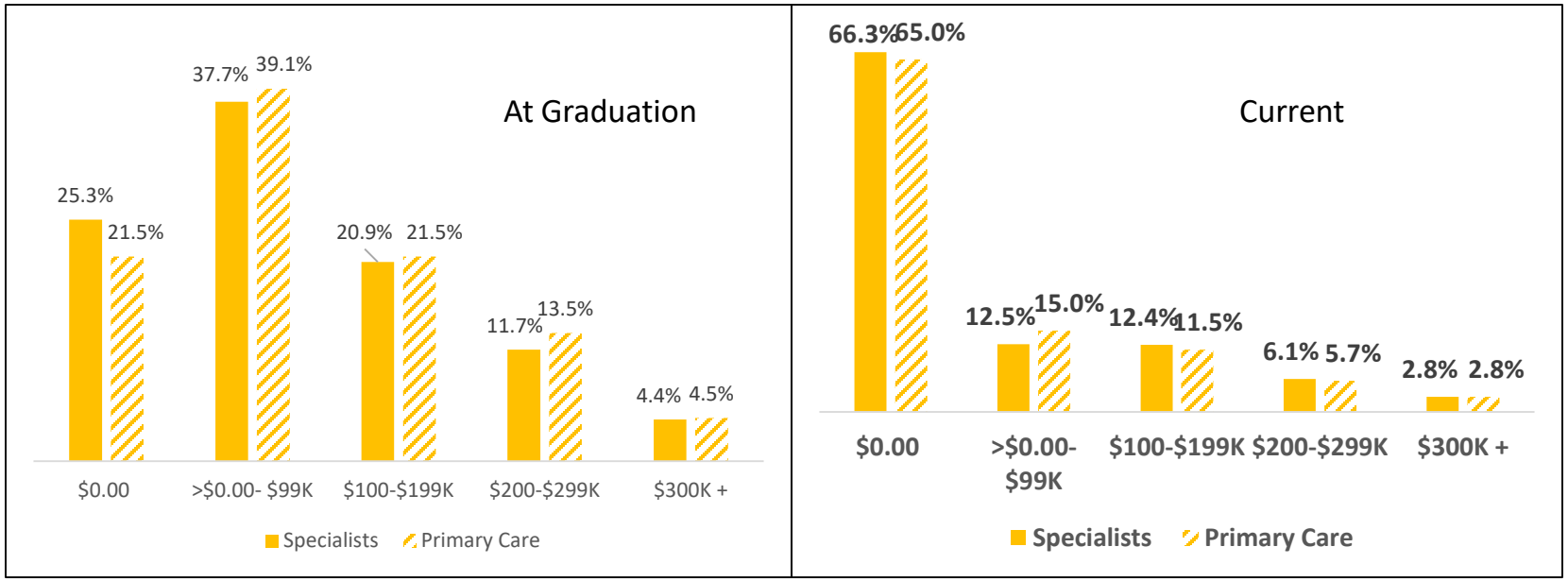
Overall, 22% of the Utah physician workforce is female, compared to 32% nationally.

Demographic Data: Race & Ethnicity



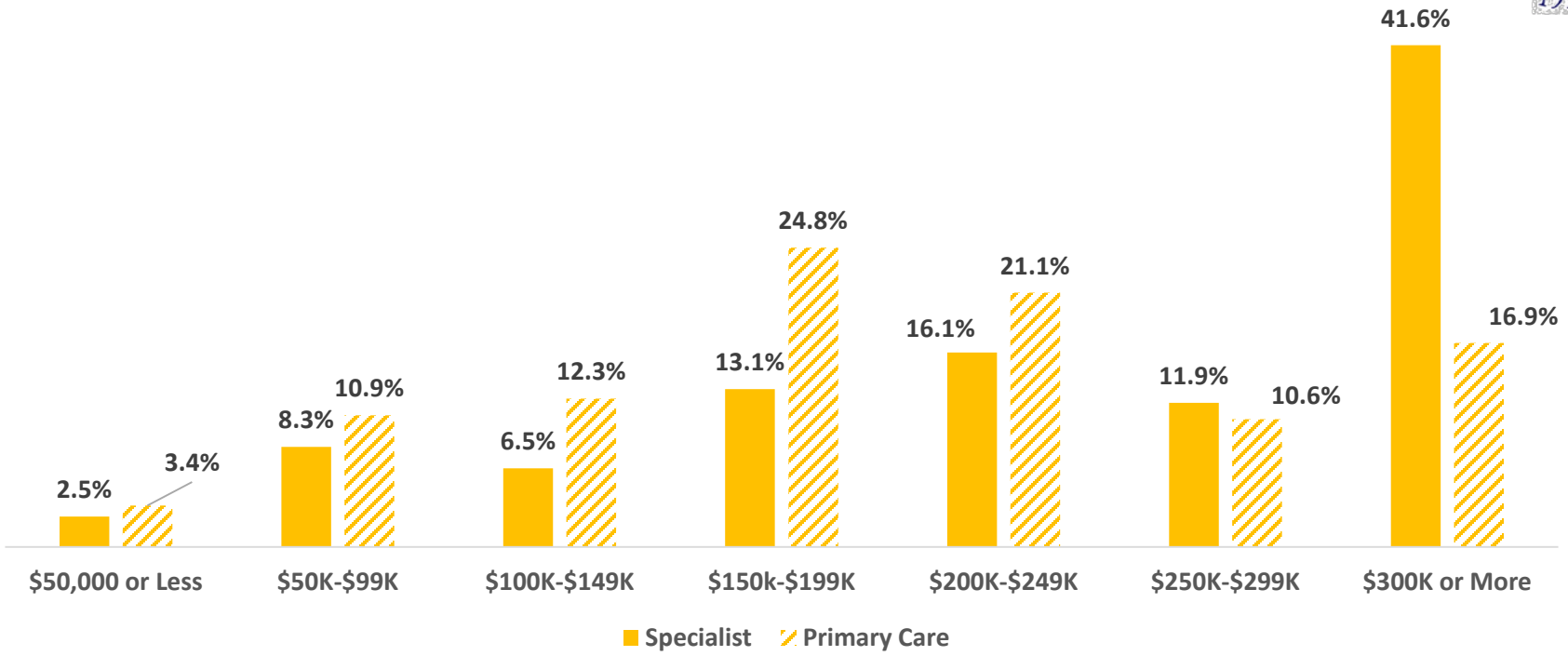
Hispanics are grossly underrepresented in the state's physician workforce in comparison to their percentage share of the state's population.

Educational Debt



	0% Debt at Graduation	Average Debt
Utah (UMEC)	7.5% (≤ 5yrs exp.)	$178,000 (≤ 5yrs exp.)
National (AAMC)	19% (2015)	$183,000 (2015)

Income

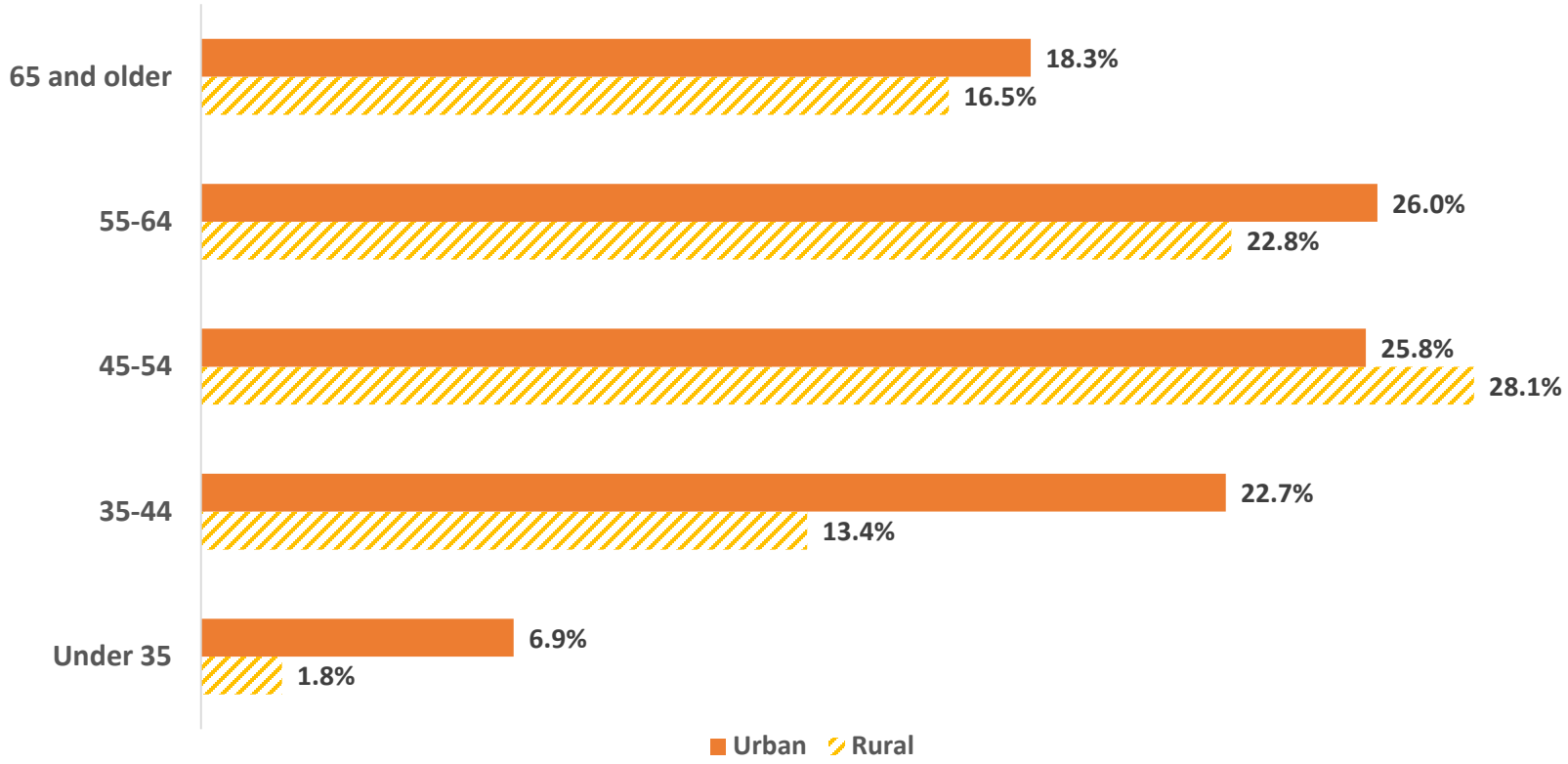


	Utah	MGMA National	MGMA Western Region
Primary Care	$196,750	$263,207	$261,536
Specialist	$264,431	$360,367	$376,837

Practice Location

	Population	Primary Care	Specialty Care	All Physicians
Urban	84.6%	87.8%	94.6%	84.7%
Rural	15.4%	12.2%	5.4%	7.9%

Practice Location and Age



<u>55 years of age or older</u>

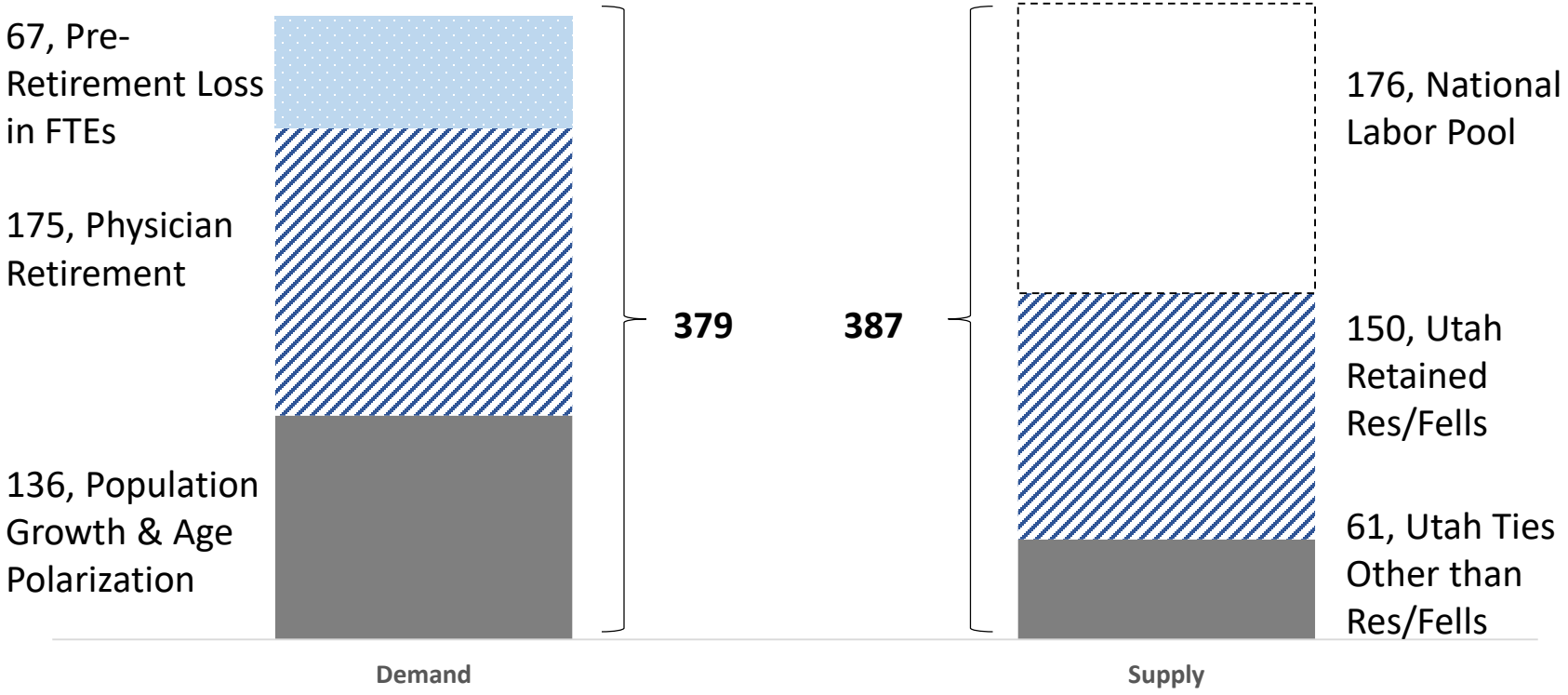
39.3% (188) of the State's Rural Physicians

44.3% (2,266) of the State's Urban Physicians

Utah Ties

- 54% of physicians practicing in Utah report having done a residency or fellowship in Utah.
- 48% of physicians practicing in Utah report having a Utah upbringing.
- 33% of physicians practicing in Utah report having attended medical school in Utah.

Projection Model 2015-2030



Annual Population Growth Rate	1.75%	Physician-to-Population Ratios					Annual Projected Needs				Annual Training Capacity, Retention, and Recruitment						
Primary Practice Specialty	Physician (FTEs)	Ratio for 100k Pop.	Target Ratio (Average)*	Ratio minus Target	Current Physician (Shortage) or Surplus	2010 Physician (Shortage) or Surplus	Retire Rate next 10 yrs	Retirees	Popul. Growth	Need (a)	Residency/ Fellowship Graduates^	Average Retention Rate	New Licensees Trained Out-of-State$	Entering Utah Workforce (b)	Annual (Shortfall) or Surplus (b - a)	Current Overall (Shortage) or Surplus	2010 Overal (Shortage) or Surplus
Primary Care																	
Family Medicine	789.7	26.0	28.3	(2.3)	(71)	40	3.5%	27	14	41	31	60.0%	20.0	39	(3)	(74)	50
Internal Medicine (General)	353.5	11.6	21.5	(9.9)	(301)	(191)	5.1%	18	6	24	32.2	58.4%	2.9	22	(3)	(303)	(179)
Pediatrics (General)	360.1	11.8	11.8	0.0	1	66	3.2%	12	6	18	21.8	70.6%	7.1	23	5	6	79
Pediatrics Subspecialties	120.7	4.0	1.4	2.6	78	68	3.8%	5	2	7	17.4	50.0%	5.0	14	7	85	71
Obstetrics/Gynecology	250.8	8.2	9.6	0.3	8	22	3.5%	9	4	13	6.4	75.0%	12.1	17	4	14	24
Ob/Gyn Subspecialties	49.7	1.6	combined with OB/Gyn				5.6%	3	1	4	2.6	84.6%	2.9	5	1		
Medical																	
Allergy and Immunology	26.1	0.9	1.2	(0.3)	(10)	(6)	4.6%	1	0	2	0		1.4	1	(0)	(11)	(6)
Cardiology	68.1	2.2	4.0	(1.8)	(54)	(35)	6.6%	4	1	6	12.4	35.0%	2.9	7	2	(52)	(32)
Critical Care Medicine	22.1	0.7	1.2	-0.5	(14)	(4)	7.9%	2	0	2	3.3	44.4%	0.7	2	0	(14)	(3)
Dermatology	101.0	3.3	2.3	1.0	31	42	2.0%	2	2	4	3.2	68.8%	2.1	4	1	32	44
Endocrinology and Metabolism	24.1	0.8	0.8	0.0	0	(2)	2.2%	1	0	1	1.2	16.7%	2.1	2	1	1	(2)
Gastroenterology	54.9	1.8	2.4	(0.6)	(18)	(16)	3.9%	2	1	3	2.6	53.8%	2.1	4	0	(18)	(18)
Geriatrics	26.4	0.9					3.7%	1	0	1	1.8	88.9%	0.0	2	0		
Hematology/Oncology	40.8	1.3	1.8	(0.5)	(14)	9	6.9%	3	1	4	4.2	61.9%	1.4	4	0	(13)	9
Infectious Diseases	31.4	1.0	0.6	0.4	13	8	5.3%	2	1	2	3.2	43.8%	3.6	5	3	16	8
Nephrology	20.9	0.7	1.0	(0.3)	(10)	5	3.7%	1	0	1	2.6	53.8%	1.4	3	2	(8)	8
Pulmonary Disease/CCM	40.1	1.3	1.5	(0.2)	(5)	1	4.9%	2	1	3	3.8	68.4%	2.1	5	2	(3)	4
Rheumatology	14.7	0.5	0.9	(0.4)	(13)	(7)	6.5%	1	0	1	1.4	28.6%	0.0	0	(1)	(13)	(8)
Surgical																	
Surgery (General)	152.7	5.0	6.6	(1.6)	(48)	(30)	4.9%	8	3	10	8	47.5%	5.0	9	(1)	(49)	(27)
Cardio-Thoracic Surgery	32.1	1.1	1.2	(0.1)	(4)	(3)	5.8%	2	1	2	1.6	37.5%	1.4	2	(0)	(5)	(3)
Ophthalmology	168.4	5.5	4.0	1.5	47	28	4.2%	7	3	10	3	66.7%	4.3	6	(4)	43	33
Orthopedic Surgery	175.8	5.8	5.6	0.2	5	65	4.1%	7	3	10	18.8	24.5%	7.8	12	2	8	66
Otolaryngology	75.7	2.5	2.6	(0.1)	(3)	11	3.9%	3	1	4	3.4	38.8%	2.1	3	(1)	(4)	10
Plastic Surgery	77.9	2.6	1.2	1.4	41	45	4.3%	3	1	5	2.2	12.5%	1.4	2	(3)	38	44
Urology	67.2	2.2	2.7	(0.5)	(15)	(6)	5.7%	4	1	5	2.2	27.3%	0.7	1	(4)	(19)	(6)
Surgery Subspecialties	70.9	2.3	3.0	(0.7)	(20)	9	4.4%	3	1	4	3	41.7%	5.0	6	2	(18)	13
Hospital																	
Anesthesiology	353.3	11.6	6.8	5.3	161	179	4.1%	14	6	21	13.4	72.5%	8.6	18.3	(2)	161	188
Anesthesiology-Pain Mgmt	15.0	0.5	combined with Anesthesiology				0.0%	0	0	0	3.4	41.2%	0.7	2.1	2		
Emergency Medicine	243.3	8.0	6.0	2.0	61	140	3.1%	8	4	12	8.2	65.9%	14.3	19.7	8	69	150
Pathology	77.6	2.5	2.4	0.1	5	63	3.3%	3	1	4	15	54.4%	3.6	11.7	8	12	68
Radiology (Diagnostic)	124.0	4.1	8.4	(3.2)	(98)	(37)	3.3%	4	2	6	8.4	47.6%	7.1	11.1	5	(90)	(27)
Radiology (Therapeutic)	34.0	1.1	combined with Radiology (Diagnostic)				1.7%	1	1	1	3	80.0%	1.4	3.8	3		
Other																	
Hospice and Palliative Medicine	10.7	0.4					6.6%	1	0	1	0	0.0%	0.7	0.7	(0)		
Neurology	81.6	2.7	2.3	0.4	12	11	2.8%	2	1	4	10	64.0%	5.7	12.1	8	20	15
Physical Medicine and Rehab	86.2	2.8	1.0	1.8	56	53	3.5%	3	2	5	5.2	50.0%	4.3	6.9	2	58	54
Preventive/ Occupational/ Public	37.2	1.2	1.5	(0.3)	(8)	5	4.7%	2	1	2	3.2	43.8%	0.7	2.1	(0)	(9)	6
Psychiatry	154.1	5.1	5.5	(0.4)	(13)	19	3.8%	6	3	9	7.6	71.1%	5.0	10.4	2	(11)	18
Psychiatry-Child and Adolescent	68.8	2.3					3.1%	2	1	3	2	90.0%	1.4	3.2	(0)		
Other Specialty	44.8	1.5					2.9%	1	1	2	2.5	46.8%	3.6	4.7	5		

Physician FTE total does not include physicians who are practicing in Utah but whose primary practice location is out-of-state
As a result, specialties that do not require the physician to be in the same location as the patient (e.g. radiology) may show shortages where there are none (since a portion of the Utah population is being served by out-of-state physicians).

^5 year average
$3 year average
± U.S. Census Bureau Population Estimate for the State of Utah as of December 2015

*** Target ratios are an average of several published physician-to-population ratios, including:**
Lohkamp & Simmons 1995 (Longshore & Simmons base rates)
Goodman et al. 1996 (national rates based on AMA Masterfile)
Hart et al. 1997 (HMO)
Solucient 2003 (national consulting company estimates)
Weiner 2004 (average of several large prepaid group practices)
Simmons & Harris 2004 (documented several of the above ratios)

Contact Information

Ric Campbell

rcampbell@utah.gov

801-526-4553

Utah Primary Care Summit

QUESTIONAIRE

Michael Magill, MD
Chairman of the Department of Family and Preventive Medicine
Executive Director Utah AHEC

Question 1:

Who do you define as being in the Primary Care Workforce?

Question 1:

Who do you define as being in the Primary Care Workforce?

GROUP CONSENSUS:

The Primary Care Workforce in comprised of TEAMS!

(*family medicine physician, internal medicine physician, pediatricians, OB/GYN, nurse practitioners, physician assistants, community health workers, public health, mental health providers, dentists, pharmacists, etc.*)

Question 2:

How well does this workforce meet the current primary care needs of the State of Utah?

Question 2:

How well does this workforce meet the current primary care needs of the State of Utah?

GROUP CONSENSUS:

Not Well.

(*barriers include inter-professional conflict, insufficient number of providers for the demand, inefficient system, etc.)*

Question 3:

What are the biggest opportunities for improving primary healthcare in Utah?

Question 3:

What are the biggest opportunities for improving primary healthcare in Utah?

GROUP CONSENSUS:

- **Transformation Efforts** *(lowered costs, enhanced quality, improved population health outcomes, and improved satisfaction of healthcare professionals)*
- **Improved supply and distribution of Workforce**
- **Improved Communication/Coordination among Stakeholders**
- **Payment reform** *(Medicaid expansion, value based payments, health maintenance incentives, re-designed reimbursement)*

Question 4:

Who is in a position to address these opportunities?

Question 4:

Who is in a position to address these opportunities?

GROUP CONSENSUS:

The stakeholders invited to today's event

(legislature, physicians, business community, healthcare associations, schools of medicine, primary care workforce, public health, educational centers, etc.)

Question 5:

What is the biggest challenge for access to Primary Healthcare in Utah?

Question 5:

What is the biggest challenge for access to Primary Healthcare in Utah?

GROUP CONSENSUS:

Cost $$

Number of Providers

Distribution of Providers

How primary care is delivered *(uncoordinated, physician centric, etc.)*

Workforce Burnout

Question 6:

What are the priority actions our developing coalition can take to address these opportunities and challenges?

Question 6:

What are the priority actions our developing coalition can take to address these opportunities and challenges?

GROUP CONSENSUS:

Very little consensus.

We are all approaching solutions from different angles.

What the heck is **Utah AHEC?**

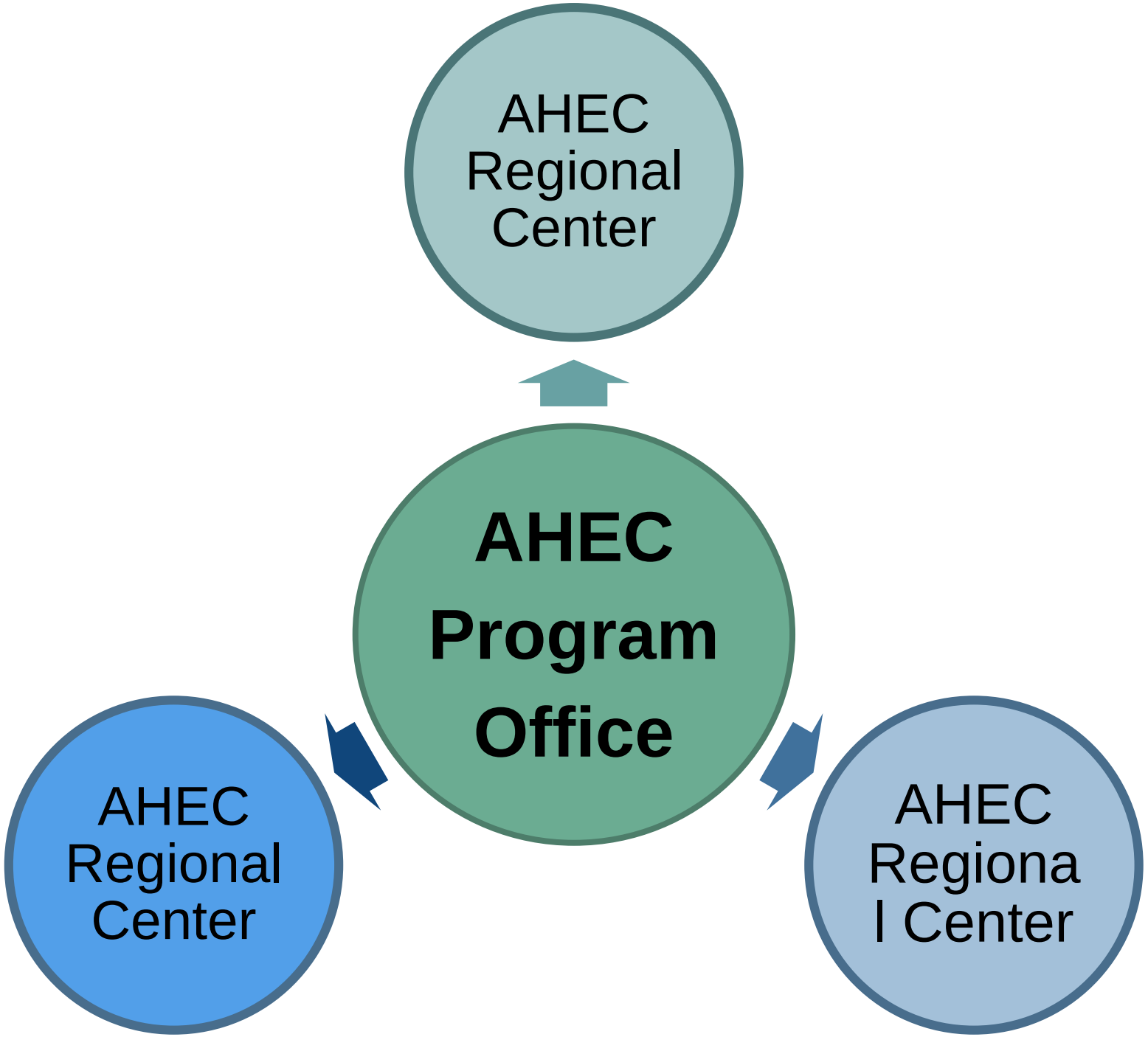
Isabella Alder, Associate Director Utah AHEC

OBJECTIVES:

- ✓ Why AHEC?
- ✓ Two Decades of AHEC in Utah
- ✓ The Numbers Are In:
  2015-2016 Accomplishments
- ✓ What's Next?

WHY AHEC?

The AHEC Program


AHEC Regional Center
AHEC Program Office
AHEC Regional Center
AHEC Regiona l Center

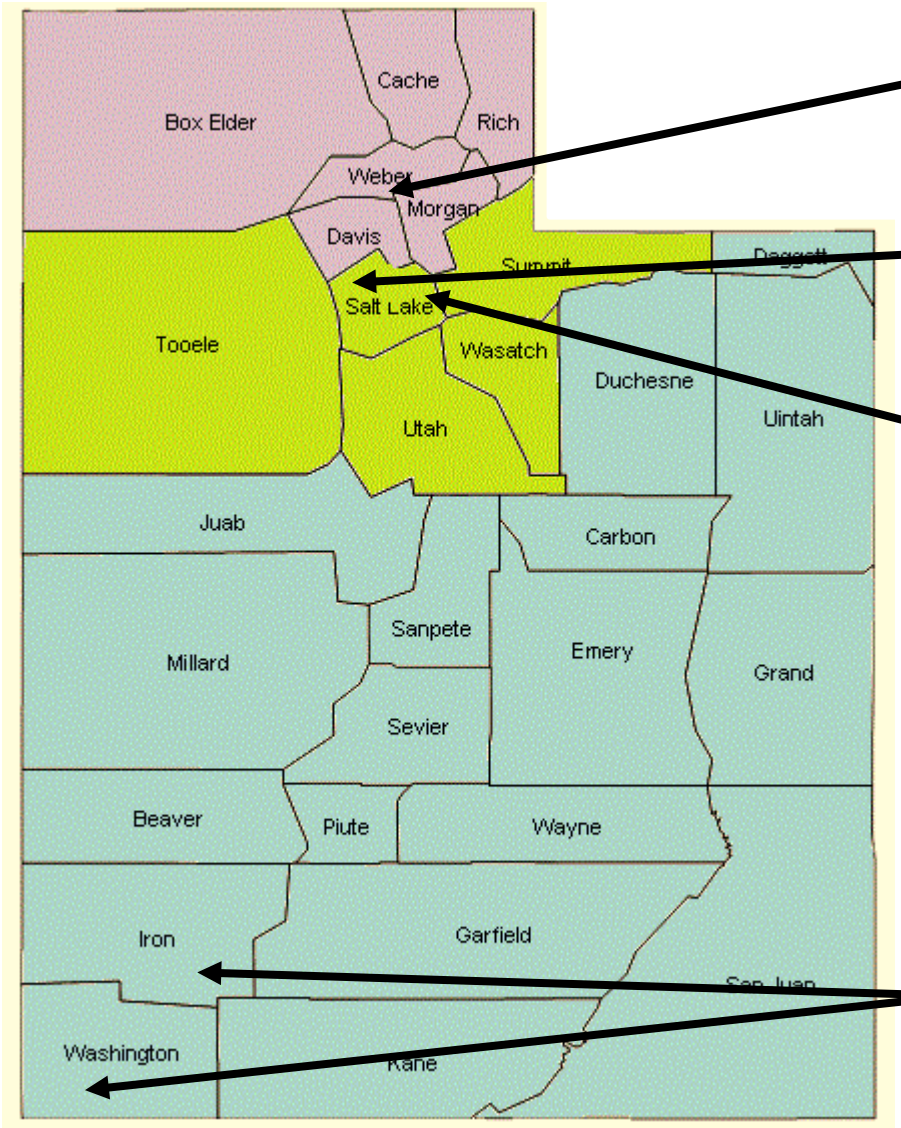
IN THE U.S. TODAY…

- ✓ **56** AHEC Programs
- ✓ Over **235** Centers
- ✓ AHEC program in **almost every** state and the District of Columbia
- ✓ AHEC collaboration with **~120** medical schools and **~600** nursing and allied health schools

Two Decades of AHEC in Utah

INITIAL GOALS OF UTAH AHEC

- ✓**Encourage** young people from rural and urban underserved communities to select health careers
- ✓**Provide** training in underserved communities for health professions students
- ✓**Support** existing providers through continuing education
- ✓**Listen** to communities



Northern Utah AHEC, hosted at Weber State University

Crossroads Utah AHEC, hosted at Salt Lake Community College

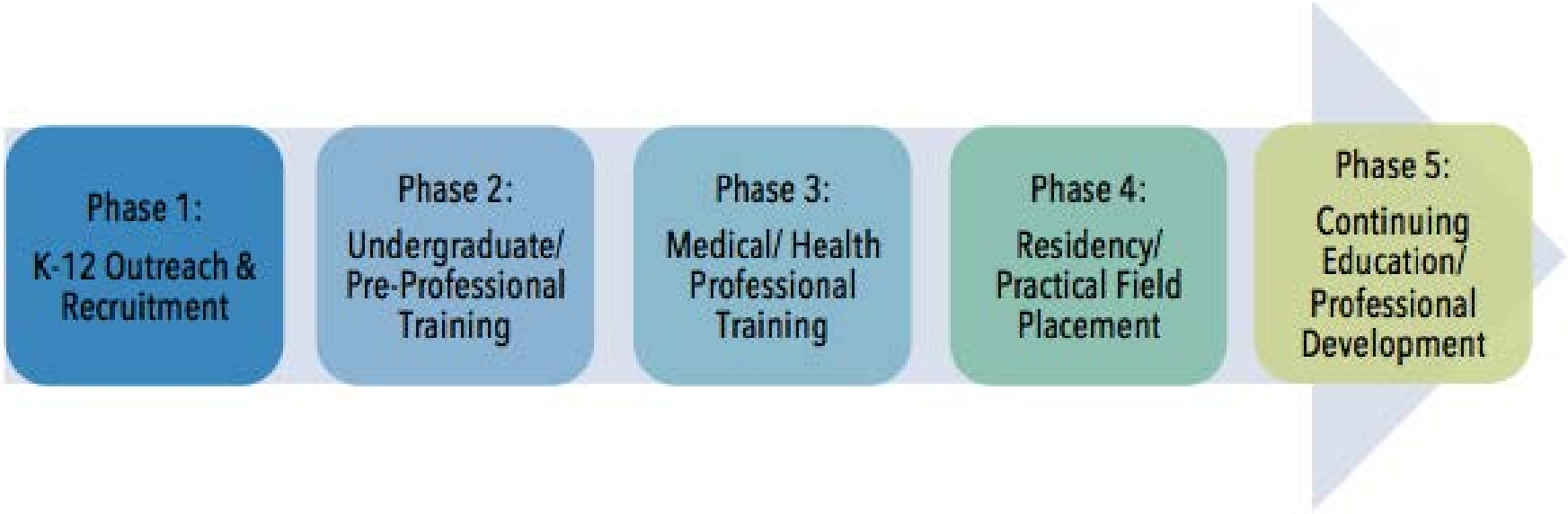
Utah AHEC Program Office, hosted at University of Utah

Southern Utah AHEC, hosted at Southern Utah University – with an office at Dixie State University

“Utah AHEC helps current and future health professionals acquire knowledge, skills, and attitudes needed to practice in a transformed health system for medically underserved rural and urban communities.”

UTAH AHEC
Area Health Education Centers

THE HEALTH PROFESSIONS PIPELINE



THE NUMBERS ARE IN:
2015–2016 ACTIVITIES

Utah AHEC Program

AHEC Stands for Jobs
NATIONAL AHEC ORGANIZATION

2015-2016 Annual Report Highlights

23,561
participants*

Enhancing access to quality healthcare, particularly primary and preventive care, by improving the supply and distribution of healthcare professionals through community/academic educational partnerships.

Pipeline programs expose students to health careers and develop intent to pursue post-secondary education in primary healthcare professions.

22,125
grades 7-16 participants
(many more participated at the K-6 level)

9,249
curriculum-based pipeline program participants

from disadvantaged backgrounds

from rural backgrounds

underrepresented minorities

Clinical training improves readiness, willingness, and ability of health professions trainees to serve in primary care, and rural and underserved community settings.

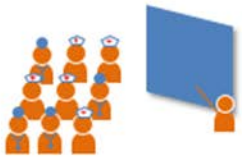
facilitated
189
unique student rotations

189
total health professions students placed in rural and underserved locations
(includes students in multiple rotations)

- 93 medical students
- 96 associated health professions students

Training sites used include:

- 51 primary care setting
- 58 located in a medically underserved community
- 51 located in a rural area



Continuing education programs address key issues in health professional shortage areas by providing health professionals with access to resources that support practice, reduce professional isolation, disseminate best practices, and improve quality of healthcare for medically underserved communities and health disparities populations.

1,388
continuing education participants

employed in medically underserved communities

National AHEC Organization Conference, Washington DC

June 2016

REDESIGNED PRIORITIES FOR AHEC

1

1. Diversity of Health Professionals

2

3

Distribution of Health Professionals

1. Practice Transformation

WHAT'S NEXT?

- ✓ Expand successful programs
- ✓ Partner with Shriners Hospitals for Children – SLC
- ✓ Continue in HPV Vaccination Training
- ✓ Take action on opportunities discussed today

THANK–YOU!

Medical Education “Pipeline”

A brief “SOAP” Note

Mark R. Greenwood, M.D.
Medical Director
Intermountain Healthcare
Primary Care Clinical Program

Subjective: “I want to be a doctor when I grow up”

Patient #1: “Sarah”

- Symptoms:
  - Grew up in Paiute County
  - Worked as a trucker
  - Went back to college and then medical school (D.O.)
  - Years of school: 4+4+3=11
  - Student Loan Debt: $400,000
  - Annual salary: $350,000
  - Loan repayment: none
  - Started practice age 40
  - 1 year practice in Monticello
  - 2 years practice in Richfield
  - Worked 80-100 hours per week (days, nights, weekends)
  - Practically and financially non viable—moved to Alaska

Patient #2: “James”

- Symptoms:
  - Grew up in Sanpete County
  - Married a girl from Richfield
  - Worked as XR tech in Richfield x 4 years
  - Went back to PA school at UofU
  - Years of school: 4+2=6
  - Entering practice at age 33
  - Just started practice in Richfield as FP PA
  - Student loan debt: $70,000
  - Annual salary $100,000
  - Loan repayment: none
  - Working 40-60 hours per week (no nights, no call, occasional evening or Sat)
  - Practically and financially viable long term

Patient #3: “Paul”

- Symptoms:
  - Grew up in Richfield, UT
  - Son of Rural FP
  - College at BYU
  - Stated goal and desire: Rural Family Practice
  - However, denied acceptance at University of Utah
  - Attended George Washington University (M.D.)
  - Years of School=4+4+3=11
  - Student Loan Debt: $230,000
  - Loan Repayment: $25,000 (taxable) x 2 years from State of Utah
  - Practiced Full Spectrum Family Medicine 2003-2016
  - Worked 70-80 hours per week (days, nights, weekends, call)
  - Moved to Urban administrative position 2016 (no nights, weekends, or call)

Objective

- Vital Signs:
  - 10.2 % of most recent graduating class chose Family Practice
  - 15.5% of D.O. graduates chose FP
  - 8.7% of M.D. graduates chose FP
  - Primary care retirees exceed new entrants
  - Medical Schools are not producing enough primary care physicians
  - PA/NP more likely to choose primary care, including rural
  - West of Mississippi higher rate of going into FP than East
  - ***Most graduates practice within 100 miles of residency program***
  - Most residency programs are in fairly urban areas
  - Tuition costs skyrocketing
  - Salaries fairly flat

Assessment/Diagnosis

- Medicine still a noble and desired profession
- Primary care has some pathology (CHF? CFS? Dementia? Psychosis?)
- Medical School admissions biased against rural applicants
- Medical School education biased against primary care
- PA's/NP's more likely to choose primary care, including rural
- PA/NP may be the smarter choice right now
- Only 50% of PC physicians recruited to rural region last 5 years
- **Rural providers with local ties more likely to stay long term**
- Loan Repayment inconsistent, short term, and aimed at recruitment
- A provider retained is better than a provider recruited

Plan/Treatment

- Educate/motive kids to primary care careers (MD/ DO *and* NP, PA)
- Involvement in college pre-med/pre-professional clubs
- Medical School positions geographically allocated
- Eliminate out of state slots at University of Utah
- Dedicated Primary Care Medical School slots with up-front commitment to primary care (FP, Outpt IM, Peds, ?OBGYN?) with lower tuition
- Expanded primary care and rural rotations in medical school and residency
- New residency programs vs. increased slots
- Loan repayment that addresses recruitment ***and*** retention
- Increased compensation for primary care, especially rural (money talks)

The Health Professions Pipeline Breakout Sessions