

Alaska Psychiatry Residency

**Second Update:
Feasibility Study & Business Plan**

Alaska Psychiatry Residency Steering Committee

**Prepared for the
Alaska Mental Health Trust Authority
University of Alaska**

March 1, 2012

Dr. Alexander von Hafften, Chair of the Alaska Psychiatry Residency Steering Committee, prepared this ***Second Update: Feasibility Study and Business Plan*** on behalf of the Alaska Psychiatry Residency Steering Committee.

Errors and omissions are Dr. von Hafften's not those of the Steering Committee or its members.

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On behalf of the Alaska Psychiatry Residency Steering Committee, Dr. von Hafften thanks Lisa Markgraf for her commitment to our efforts. Steering Committee alignment and articulation would not have been possible without her patience and persistence. She tirelessly coordinated coalition communications and meetings.

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List of Abbreviations

| | |
|--------|--|
| AADPRT | American Association of Directors of Psychiatry Residency Training |
| ACGME | Accreditation Council for Graduate Medical Education |
| ACMHS | Anchorage Community Mental Health Services, Inc. |
| AMHTA | Alaska Mental Health Trust Authority |
| APF | Alaska Psychiatric Foundation |
| API | Alaska Psychiatric Institute |
| APR | Alaska Psychiatry Residency |
| APRC | Alaska Psychiatry Residency Committee |
| ARH | Alaska Regional Hospital |
| ATA | American Telemedicine Association |
| AVAHS | Alaska Veterans Affairs Healthcare System |
| BRH | Bartlett Regional Hospital |
| CPH | Central Peninsula Hospital |
| DHSS | Alaska Department of health and Social Services |
| DME | Direct Graduate Medical Education (cost or reimbursement) |
| DOC | Alaska Department of Corrections |
| FMH | Fairbanks Memorial Hospital |
| GME | Graduate Medical Education |
| IME | Indirect Graduate Medical Education (cost or reimbursement) |
| IOM | Institute of Medicine |
| JBER | Joint Base Elmendorf Fort Richardson |
| LQ | LifeQuest |
| MRH | Mat-Su Regional Hospital |
| NSBH | North Star Behavioral Health System |
| OAA | Department of Veterans Affairs Office of Academic Affiliations |
| PGY | Post Graduate Year (or Resident Year) |
| PHSA | Providence Health & Services Alaska |
| PSVAHS | Puget Sound Veterans Affairs Healthcare System |
| SCF | Southcentral Foundation |
| SEARHC | Southeast Alaska Regional Health Corporation |
| TCC | Tanana Chiefs Conference |
| Trust | Alaska Mental Health Trust Authority |
| UA | University of Alaska |
| UAA | University of Alaska Anchorage |
| UAF | University of Alaska Fairbanks |
| USARC | US Arctic Research Commission |
| UW | University of Washington School of Medicine |
| UWSOM | University of Washington School of Medicine |
| VA | Department of Veterans Affairs |
| YKHC | Yukon Kuskokwim Health Corporation |

Executive Summary

The Alaska Psychiatry Residency Steering Committee is a coalition of federal and state agencies, hospitals and providers, and the University of Alaska united in the mission to address the critical shortage of psychiatrists in Alaska.

The shortage of psychiatrists in Alaska is not new. Historically, most psychiatrists came to Alaska with the US Military or US Public Health Service. The federal government used to assign psychiatrists and other health care professionals to serve in Alaska. From an Alaska perspective this was passive recruiting. Passive recruiting is unable to meet Alaska's current and future need for psychiatrists.

In 2006, the Alaska Physician Supply Task Force concluded that Alaska needed 28 more psychiatrists. In 2009, the Medical Development Specialists concluded that Alaska needed 24 more psychiatrists. In 2011, the Steering Committee surveyed 111 Alaska health care organizations. Respondents reported that they would hire 29 more full time equivalent (FTEs) psychiatrists if available. These estimates suggest a minimum shortage of 30%-40% compared to the current supply.

Alaska is not alone. There is a national shortage of psychiatrists. Between 2009 and 2010 Merritt Hawkins reported that demand for temporary psychiatrist increased more than for all other medical specialties.

There is also a national shortage of psychiatric training positions. During the past eight years the national vacancy rate for first year psychiatric training positions has averaged 3.6% with 1/3rd of positions being filled by international medical graduates (IMGs). Current efforts to increase psychiatric training positions will not meet the national need for psychiatrists. The national shortage will get worse. Recruiting psychiatrists to Alaska will become increasingly competitive.

Psychiatrists are integral to a comprehensive coordinated health care system. Psychiatrists are physicians who specialize in the prevention, diagnosis, and treatment of mental, addictive, and emotional disorders. Psychiatrists complete the most rigorous and intensive training of all mental health professionals. Psychiatrists provide direct patient care. Psychiatrists provide consultations for other health care workers, employers, and the court system. Psychiatrists frequently supervise other health care workers.

Several small and large Alaska health care organizations must contract for psychiatric services with out of state temporary workers. This is expensive and inefficient. In 2009, the Alaska Psychiatric Institute, Alaska Veterans Affairs Healthcare System, Anchorage Community Mental Health Services, and one Alaska Native health organization spent \$2.9 million for temporary psychiatrists. This was almost twice the cost of employed psychiatric FTEs. Additionally, temporary psychiatrists increase indirect costs because of lower productivity, loss of patient care continuity; and loss of community relationships, knowledge, and collaboration.

Competing political and economic priorities have fostered a fragmented and crisis driven mental health care system. Most Alaskans with mental illness, their families, and communities have few

viable options. Inadequate access and marginal quality of care have paved the way for a history of out of state placement and the Department of Corrections becoming the largest provider of mental health services in Alaska.

Mental health benchmarks during the past decade rank Alaska second in the nation for non-fatal suicide attempts requiring medical hospitalization, second in the nation for highest completed suicides, and second in the nation for illicit drug use. Community health benchmarks during the past decade rank Alaska first in the nation for sexual assault and first in the nation for substantiated child abuse and neglect. Alaska's prevalence of interpersonal violence ensures a cycle of mental illness.

Can Alaska reverse these trends? To do so requires improving access to and the quality of mental health care. Without change, Alaska will experience increasingly frequent mental and physical illness and disability.

Increasing the supply of psychiatrists is essential to any effort to improve health care and outcomes. Increasing the number of primary care physicians, nurse practitioners, nurses, psychologists, and therapists are all necessary but inadequate when it comes to mental health care.

Increasing access and the quality of mental health care are fundamental to health care reform including "patient-centered care" and "accountable care." Alaska is at a crossroads.

Alaska needs more psychiatrists and the best way to meet this need is to create an **Alaska Psychiatry Residency**. A residency has the highest probability of producing a consistent supply of new Alaska psychiatrists. A residency provides the best opportunity to design a curriculum specifically to train psychiatrists for work in Alaska. However, Alaska should not try to start a residency alone.

Alaska should partner with an international leader in medical education. The University of Washington School of Medicine (UW) is an ideal partner. UW is an international leader in psychiatry & primary care integration. UW pioneered patient-centered care 20 years ago. UW is an international leader of telehealth implementation to improve clinical outcomes, quality, and cost. UW is an excellent resident recruiting partner. Forty percent of all U.S. medical school graduates going into psychiatry apply to UW. Finally, UW has successfully partnered with consortiums in Spokane and Boise to create and operate psychiatry residencies to meet local needs.

The ideal **Alaska Psychiatry Residency** would focus on primary care integration (patient-centered medical homes), telepsychiatry, and rural/remote consultation. Residents would train at the UW in Seattle for the first two years and in Alaska for the last two years. Four of the 11 training positions would be at Veterans Affairs facilities.

In Alaska, residents would train at the Alaska Family Medicine Residency, Alaska Native Medical Center, Alaska Psychiatric Institute, Alaska Veterans Affairs Healthcare System, Anchorage Community Mental Health Services, Fairbanks Memorial Hospital, Joint Base Elmendorf Richardson, North Star Behavioral Health, Providence Alaska Medical Center, Southcentral Foundation, Southeast Alaska Regional Health Consortium, and Tanana Chiefs Conference. Psychiatrists and health care

providers in many disciplines would be instructors and supervisors. Providence Health & Services Alaska would be the administrative host.

The Alaska Federal Health Care Partnership, Alaska Mental Health Trust Authority, Alaska Psychiatric Foundation, Alaska Veterans Affairs Healthcare System, Anchorage Community Mental Health Services, Fairbanks Memorial Hospital, North Star Behavioral Health, Providence Health & Services Alaska, Southcentral Foundation, and the University of Washington have pledged financial support.

Partners have pledged \$4.73 million for the first six years (FY13 – FY18) and more than \$799,000 for ongoing annual operations beginning year six (FY18). The remaining balance for year one is \$150,000, year two is \$190,000, year three is \$410,000, year four is \$594,000, year five is \$661,000 and year six is \$1,050,000.

In summary, partners have pledged funding for 60% of the start up costs and 40% of annual costs. The estimated annual net cost per resident per year in year six (FY18) is \$100,000.

| Pledged Financial Support | | | | | | | |
|---------------------------|-------------------|-------------------|---------------------|---------------------|---------------------|---------------------|------------------------|
| Program Fiscal | <u>1</u> FY 13 | <u>2</u> FY 14 | <u>3</u> FY 15 | <u>4</u> FY 16 | <u>5</u> FY 17 | <u>6</u> FY18 | Total FY 13 - FY 18 |
| AFHCP | \$ 20,000 | \$ 45,000 | \$ 50,000 | \$ 50,000 | \$ 50,000 | \$ - | \$ 215,000 |
| AMHTA | \$ 26,000 | \$ 100,000 | \$ 320,000 | \$ 320,000 | \$ 320,000 | \$ - | \$ 1,086,000 |
| APF | \$ 10,000 | \$ 10,000 | \$ 10,000 | \$ 10,000 | \$ 10,000 | \$ - | \$ 50,000 |
| AVAHS | \$ - | \$ 64,000 | \$ 133,000 | \$ 208,000 | \$ 290,000 | \$ 295,000 | \$ 990,000 |
| ACMHS | \$ 10,000 | \$ 10,000 | \$ 10,000 | \$ 10,000 | \$ 10,000 | \$ 10,000 | \$ 60,000 |
| FMH | \$ 30,000 | \$ 50,000 | \$ 100,000 | \$ 100,000 | \$ 100,000 | \$ 100,000 | \$ 480,000 |
| NSBH | \$ 10,000 | \$ 10,000 | \$ 10,000 | \$ 10,000 | \$ 10,000 | \$ 10,000 | \$ 60,000 |
| PHSA | \$ 30,000 | \$ 50,000 | \$ 100,000 | \$ 100,000 | \$ 100,000 | \$ 120,000 | \$ 500,000 |
| SCF | \$ 30,000 | \$ 30,000 | \$ 50,000 | \$ 50,000 | \$ 50,000 | \$ 50,000 | \$ 260,000 |
| UWSOM | \$ - | \$ 198,000 | \$ 201,000 | \$ 206,000 | \$ 210,000 | \$ 214,000 | \$ 1,029,000 |
| Total-Partners | \$ 166,000 | \$ 567,000 | \$ 984,000 | \$ 1,064,000 | \$ 1,150,000 | \$ 799,000 | \$ 4,730,000 |
| Balance | \$ 150,000 | \$ 190,000 | \$ 410,000 | \$ 594,000 | \$ 661,000 | \$ 1,050,000 | \$ 3,055,000 |
| Total | \$ 316,000 | \$ 757,000 | \$ 1,394,000 | \$ 1,658,000 | \$ 1,811,000 | \$ 1,849,000 | \$ 7,785,000 |
| Recruiting | 4 | 3 | 3 | 3 | 3 | 3 | 19 |
| Training WA | 0 | 4 | 5 | 5 | 5 | 5 | 24 |
| Training AK | 0 | 0 | 2 | 5 | 6 | 6 | 19 |
| Graduating | 0 | 0 | 0 | 2 | 3 | 3 | 8 |

By year five (FY17), the targeted number of residents in training will be 11 and all recruiting and educational processes and costs will be operational. By the end of year six (FY18), 19 residents will have been recruited and eight residents will have graduated.

Indirect benefits include improving access and quality of mental health care, improving clinical outcomes, and reducing costs of temporary workers. The Alaska Psychiatry Residency would improve psychiatrist recruitment efficiency by appealing to psychiatrists seeking careers in an educational environment. Finally, Alaska would have the first psychiatry residency in the nation requiring significant telepsychiatry training.

Medical residency training is not self sustaining. This is especially true for psychiatry because psychiatry is relationship oriented rather than procedure oriented. Psychiatric work and training are time intensive.

Medicare is the largest public funder of graduate medical education (GME). In 2007, Medicare invested \$8.8 billion in GME. However, Alaska is basically ineligible for Medicare funding for a psychiatry residency. This is not likely to change. In 2010, the National Commission on Fiscal Responsibility and Reform recommended reducing Medicare GME funding by 50%. Current policy discussions include eliminating Indirect Medicare GME (IME) funding. This could reduce overall Medicare GME by 2/3rds.

State Medicaid programs are the second largest public funders of GME. In 2005, Medicaid invested \$3.2 billion in GME. The federal government does not require state Medicaid GME. Policy debates include limiting federal Medicaid GME. In 2007, the Centers for Medicare and Medicaid Services proposed eliminating federal Medicaid GME. This proposal was not acted upon. The expansion of Medicaid in 2014 to cover an estimated 15.9 million new enrollees will increase the fiscal pressures on federal and state Medicaid programs. These pressures will likely impact federal and state Medicaid GME.

The Department of Veterans Affairs trains approximately 10,300 full time residents. Thirty percent (37,000) of all US medical residents complete at least a portion of their training in a Veterans Affairs facility. In 2010, the Alaska Veterans Affairs Healthcare System successfully applied to the Veterans Affairs Office of Academic Affiliations (OAA) to become an Alaska Psychiatry Residency funding partner and training site. Four of the 11 Alaska Psychiatry Residency training positions would be at Veterans Affairs facilities.

Alaska should not require state service after completing training. No state requires service after training. Only the US Military and Public Health Service offer residency training for post-training service. These are national workforce programs and are not comparable with state workforce programs. But combining resident recruiting with post-training service and student loan reimbursement would benefit both resident recruitment and post-training retention.

The pathway to becoming a physician requires four years of college, then four years of medical school, and then at least one year of internship. Most medical school graduates complete at least three to seven years of post graduate medical education or residency (GME). The core of residency training is supervised patient care. Even though residents are in training, their patient care work adds value to the health care system. Residents receive an annual stipend. One of every seven actively-

practicing physician in the nation is a resident or fellow in an Accreditation Council for Graduate Medical Education (ACGME) accredited training program.

Compared to the educational pathways for other professions, the pathway to becoming a clinically working physician is much longer. Medical students entering residency usually have college and medical school debt. Average medical student loan debt is \$150,000 to \$175,000 depending on year. Medical student debt will increase in coming years.

Alaska should continue **Elective Rotations** until the residency is fully operational. The Alaska Mental Health Trust Authority has been funding elective rotations since 2008. Psychiatry residents from programs around the country are recruited to train in Alaska for one to three months. The objective is that these residents will return to Alaska after completing training. Elective rotations are flexible to meet the needs of Alaska's health care organizations and the educational objectives of residents. Elective training has occurred at the Alaska Department of Corrections, Alaska Native Tribal Health Consortium, Alaska Psychiatric Institute, Anchorage Community Mental Health Services, Bartlett Regional Hospital, North Star Behavioral Health, Providence Breakthrough, and Tanana Chiefs Conference. Residents have primarily been located in Anchorage, Fairbanks, and Juneau. Resident work has included travel to Bethel, Haines, Kodiak, Sitka, and St. Mary's.

Elective Rotations are a step in the right direction but insufficient to replace the projected loss of psychiatrist to retirement. More than 60% of Alaska's psychiatrists are at least 50 years of age and more than 80% are at least 45 years of age.

Elective Rotations will cost less than an Alaska Psychiatry Residency in the short term. However, an Alaska Psychiatry Residency will be more cost efficient in long term. Graduates of an Alaska Psychiatry Residency will be much more likely to remain in Alaska compared to residents only doing Elective Rotations in Alaska.

Recommendations:

1. Create an **Alaska Psychiatry Residency**. An Alaska Psychiatry Residency has the highest probability of creating a consistent supply of new Alaska psychiatrists. It provides the opportunity to train psychiatrists specifically for work in Alaska. Partners include all sectors of Alaska's health care system. Four of the 11 training positions would be in Veterans Affairs settings. Partners have pledged more than \$4.73 million in financial support. The remaining balance for year one is \$150,000. The annual remaining balance will gradually increase to \$1.05 million by year six. Alaska Medicaid may be able to leverage state funding to obtain federal matching funding.
2. Continue the **Elective Rotations** currently funded by the Alaska Mental Health Trust Authority. Seven to 12 months of resident training are funded in FY12 and FY13. Elective Rotations move Alaska in the right direction but are inadequate to meet the long term workforce need for psychiatrists.

Introduction

On October 1, 2008, the Alaska Psychiatry Residency Steering Committee (APRSC) submitted a proposal to the Alaska Mental Health Trust Authority (AMHTA). The proposal requested funding to complete a feasibility analysis and business plan for an Alaska Psychiatry Residency (APR). On December 1, 2009, an Interim Report was completed. On December 1, 2011, a Draft Update Report was distributed to the APRSC. This is a Second Update.

The APRSC has met monthly since September 2008. The APRSC is chaired by Dr. Alexander von Hafften. Steering Committee meetings are open and the Committee has invited any interested party. Teleconference has been available for anyone unable to meet in person. APRSC participants are listed in **Appendix I**.

The APRSC has been funded by the Alaska Federal Health Care Partnership (AFHCP), Alaska Mental Health Trust Authority (AMHTA), Alaska Psychiatric Foundation (APF), Anchorage Community Mental Health Services (ACMHS), Fairbanks Memorial Hospital (FMH), Providence Health & Services Alaska (PHSA), Southcentral Foundation (SCF), and the University of Alaska (UA). APRSC funding is included in **Appendix II**.

APRSC Meeting Agendas and Summaries from October 2008 to March 2012 are available upon request.

The APRSC came together because of the shared concern about the shortage of psychiatrists in Alaska. The APRSC believes this shortage is a public health crisis. The APRSC mission, values, and measures of success are included in **Appendix III**.

The APRSC mission is to increase the number of psychiatrists in Alaska. Psychiatry is the medical specialty focusing on the prevention, diagnosis, and treatment of mental, emotional, and addictive disorders. Time is of the essence. During the 2010 legislative session the shortage of psychiatrists was not a legislative priority. During the 2011 legislative session Governor Parnell and the Alaska Senate supported efforts to create APR. However, the Alaska House of Representatives did not support creation of APR.

Prior to the beginning of the 2012 legislative session the APRSC tried to respond to remaining questions about the need for psychiatrists and concerns about sustainable funding. Governor Parnell did not include APR as an FY13 funding priority. Consequently, APR may not have the support necessary to obtain the final funding necessary to begin operations during FY13.

The shortage of health care resources in Alaska is not new. This is part of Alaska's history. Monumental geography, circumpolar weather, limited organization infrastructure and connectivity have been factors. Alaska has only recently begun looking at graduate medical education; 30 to 100 years after most other states and the federal government initiated physician workforce efforts.

The Alaska health care system has a history of competing political and economic priorities. Alaskans have a history of being sent to the lower 48 for services not available here. During the first two thirds of the 20th century Alaskans were sent to Morningside Hospital in Portland, Oregon. During the later part of the 20th century and beginning of the 21st century Alaskan children and adolescents with emotional and behavioral difficulties have been sent to residential facilities outside. Alaska has had several “bring Alaskans home” initiatives. Yet, despite the best intentions and hard work of many the mental health system remains inadequate and fragmented. Mental illness, addictions, suicide, and interpersonal violence are long standing challenges for health planners, provider organizations, and public safety agencies.

Alaska has gone through several phases of deinstitutionalization. Closing Harborview Memorial Hospital and downsizing the Alaska Psychiatric Institute were done with an expectation of increasing community-based services. However, comprehensive community services for mental illness, developmental disorders, dementia disorders, traumatic brain injury, and addictions remained inadequate. Our mental health system is crisis-driven. Delays in transporting and evaluating involuntarily detained adults are a court issues again.

Successive Alaskan administrations and legislatures have sought solutions to these challenges while managing state resources. One of these efforts has been increasing the Alaska health care workforce. Historically, Alaskans left for education not available here. In essence, Alaska exported the future health care workforce to other states. During the past decade, the Department of Health and Social Services (DHSS), University of Alaska (UA), and AMHTA have coordinated efforts to increase the Alaska health care workforce. “Growing our own” is now a strategy in nursing, medicine, counseling, psychology, dental hygiene, pharmacy, and peer support. “Growing our own” is also a strategy to increase our supply of teachers, engineers, scientists, and business leaders.

The Alaska Family Medicine Residency is a “grow our own” success. The Alaska Family Medicine Residency began in 1997. Family Medicine Residency is a three year training program after medical school. Twelve residents graduate per year. Thirty-six percent (36%) of graduates practice in Anchorage and 79% practice in Alaska. Seventy-five percent (75%) of graduates practice in rural or underserved areas. Approximately 16% of all family practice physicians in Alaska are graduates of the Family Medicine Residency. Program Director, Dr. Harold Johnston, projects that within 10 years half of all family medicine physicians in Alaska will be graduates of the Alaska Family Medicine Residency.

The UA Nursing Program is another “grow our own” success. UA doubled the number of graduating nurses between 2000 and 2009. Ninety percent (90%) of graduating nurses begin their professional career in Alaska.

The Alaska Department of Labor (DOL) tracks population and labor trends. In 2003, the DOL reported that the health care industry was the fastest growing sector of Alaska’s economy. Two drivers have been the aging of the Alaskan population and that more Alaskan’s now receive care in Alaska rather than going to the lower 48. In 1990, only 4% Alaska’s wages and salaries were in health care. By 2010, this had increased to 9.3%. During the same period, national health care wages and salaries increased from 7% to 10.6%. In September 2011 the DOL reported that health care remains the

fastest-growing industry in Alaska. Health care in Alaska employs 32,000 people and has a payroll over \$1.5 billion.

Despite growth in the Alaska health care workforce, the U.S. Health Resources and Services Administration (HRSA) reports that Alaska has 51 mental health profession shortage areas. This coincides with 35% of the Alaska population. Primary care and dental care shortages exist as well.

HRSA health profession shortage data for Alaska:

- 51 mental health profession shortage areas (**250,000 Alaskans**, 35.2% of population)
- 72 primary care health profession shortage areas (110,000 Alaskans, 15.5% of population)
- 46 dental health profession shortage areas (75,000 Alaskans, 10.6% of population)
- 18 medically underserved areas

Alaska DHSS is facing increasing numbers of Alaskans without adequate health insurance and health plan barriers regarding the evaluation and treatment of mental illness and substance use disorders. DHSS is constantly challenged by how to address one problem without precipitating a new problem or complicating something somewhere else.

The Patient Protection and Affordable Care Act of 2010 (ACA) is trying to improve access and quality of care by making changes in how insurance is structured and how health care is delivered. ACA will expand Medicaid eligibility and may add 32,000 Alaskans to Medicaid in 2014, an increase of more than 20 percent. ACA will be unsuccessful without increasing mental health care access for people in primary care and improving the coordination of care within the public mental health system.

Defining the Problem

No Health without Mental Health

The World Health Organization (WHO) estimated that depression was the fourth leading cause of disability world-wide in 1990. The WHO projects that by 2020 depression will become the second leading cause of disability world-wide after heart disease. In the United States, mental illness and addictive disorders are leading causes of combined death and disability for men and women.

The prevalence of mental illness and addictive disorders in Alaska are well documented. The following reports summarize data of particular interest:

Alaska Scorecard (Alaska DHSS, 2010)¹

Alaska Scorecard (Alaska DHSS, 2008)²

Moving Forward-Comprehensive Integrated Mental Plan 2006-2011 (Alaska DHSS, 2006)³

In Step-The Plan: Comprehensive Integrated Mental Health Plan (Alaska DHSS, 2001)⁴

Selected specific mental health and public health challenges for Alaska include:

- 1st in the nation for rate of sexual assault.⁴
- 1st in the nation for rate of substantiated child abuse and neglect.⁴
- 2nd in the nation for rate of illicit drug use.²
- 2nd in the nation for non-fatal suicide attempts requiring medical hospitalization of at least 24 hours.²
- 2nd in the nation for rate of suicide.⁴
- Suicide rate almost twice the national rate.¹
- Non-fatal suicide attempt rate almost twice the national rate.¹
- 4th in the nation for rate of illicit drug use.¹
- Age-adjusted death rate by suicide almost twice the national rate (2001-2005).³
- One Alaska Native person completed suicide on average every nine days (2003).³
- Suicide attempts by Alaska males increased to the highest level in seven years (2006).²
- 6th in the nation for rate of substantiated child abuse and neglect.²
- 7th in the nation for rate of heavy drinking.¹
- 11th in the nation for rate of adult binge drinking.¹
- Alcohol-induced death rate consistently 2.5 times higher than national rate since 2000.²
- 14.2 years of productive life lost for each alcohol-related death (2005).²
- 11,900 Alaskans hospitalized for at least 24 hours because of traumatic brain injury (2007).¹

Ideally, Alaska would rank 50th on all of these measures.

To further highlight the fragmented and crisis driven nature of our mental health system:

- The Alaska Department of Corrections is the largest Alaskan provider of mental health services.²
- 42% of incarcerated adults are mentally ill or have a mental disability.¹
- Adults with mentally illness or mental disability have a 36.2% one year criminal recidivism rate.¹
- 58.1% of Alaska State Trooper arrests involving alcohol or substance abuse.¹

- Alaska has the highest growth rate for incarceration per capita in the nation.²

Adverse childhood experience is one of the most important causes of health and social problems. Growing up with abuse, neglect, domestic violence, alcohol or substance abuse, mental illness, parental discord, or crime are a common pathway to social, emotional, and cognitive impairment (Anda, 2006). Adverse childhood experience increases the future risk of unhealthy behavior, risk of violence and re-victimization, disease, disability, and premature mortality (Anda, 2006). This risk includes mental illness, alcohol and substance use disorders, suicide; and heart, lung and liver disease.

Community and public health efforts must include timely access to individualized and coordinated mental health care. This requires a properly trained and supervised workforce within a well organized health care system. Psychiatrists are essential for this workforce.

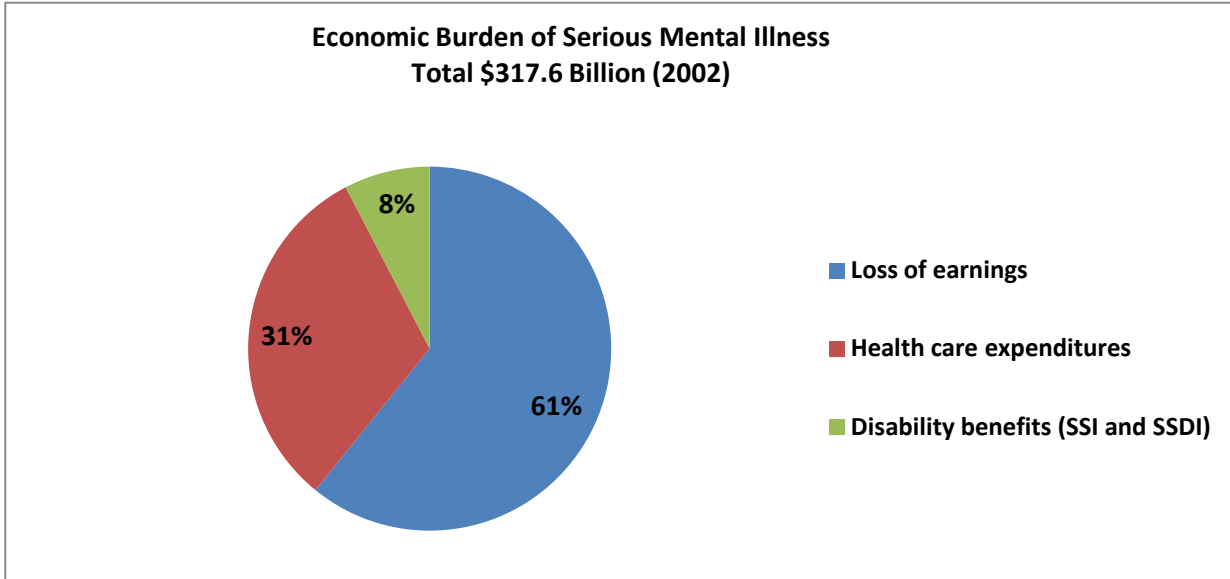
Hidden Costs of Untreated and Poorly Managed Mental Illness

Thomas Insel, MD, Director of the National Institute of Mental Health, called “health care costs one of the greatest challenges in US public policy.” Michael Hogan, PhD, chair of the President’s New Freedom Commission on Mental Health stated that “we are spending too much on mental illness in all the wrong places.” In 2001 SAMSHA estimated that \$85.4 billion was spent treating mental illness. Mental illness care was 6.2% of all health care spending (\$1,372.5 billion). Sixty-three percent (63%) came from public sources (Medicaid, Medicare, states, and local). Thirty-one percent (31%) was for outpatient treatment, 22% for inpatient treatment, 21% for medications, 19% for residential treatment, and six (6%) for insurance administration. This data covers only direct costs.

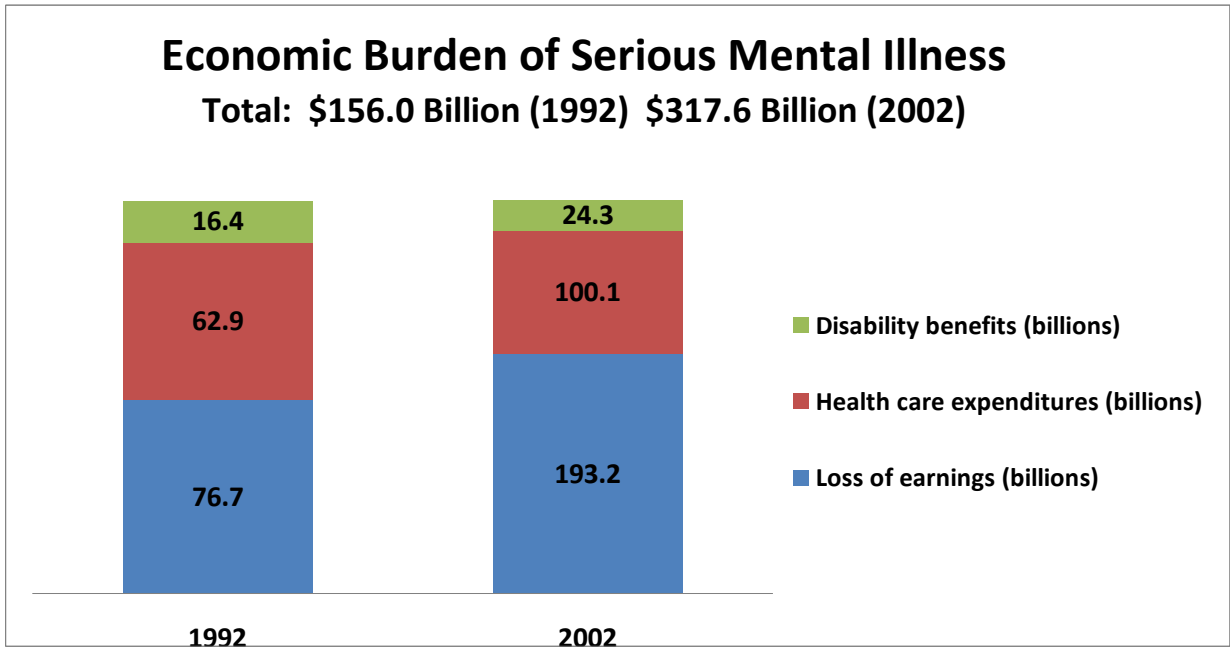
Direct costs are costs associated with obtaining and receiving mental health services including outpatient clinic visits, hospitalizations, residential care, and medications. Direct costs are relatively easy to track. Costs associated with untreated and poorly managed mental illness are indirect and difficult to measure. Indirect costs include reduced educational attainment, decreased employment, increased disability, increased medical co-morbidity, increased addiction co-morbidity, and increased emergency medical utilization. Indirect costs increase over time.

Ronald Kessler, PhD, at the Harvard Medical School Department of Health Care Policy, completed a national study to estimate the loss of earnings for people with mental illness. Between 2001-2003, a representative sample of US households was surveyed (National Co-morbidity Survey Replication). Respondents with serious mental illness earned an average of \$16,306 less than those without serious mental illness during the proceeding 12 months. The estimated loss of earnings for all U.S. households was \$193.2 billion. This study did not include individuals who were hospitalized, institutionalized, incarcerated, or homeless.

In 2002 the economic burden of serious mental illness (excluding the costs of incarceration, homelessness, co-morbid conditions, and early mortality) was \$317.6 billion.



This analysis indicated that the income lost because of mental illness was almost twice the cost of mental health care (even excluding the lost income for those who were hospitalized, incarcerated, and homeless).



Untreated mental illness within a family may become multigenerational. Parent mental health is a powerful determinant of child mental health. Half of all mental illness begins by age 14. Childhood psychological health impacts lifetime earnings. Lifetime income may be reduced by \$300,000 in affected children (Smith, 2010). Economic projections for the nation and Alaska suggest the following:

- If childhood psychological problems impact one in 20 adults nationally (5%), total cumulative lifetime economic loss would be \$2.1 trillion (Smith, 2010).
- If childhood psychological problems impact one in 20 Alaskans (5%), total cumulative lifetime economic loss would be \$10.65 billion.
- If childhood psychological problems impact one in 20 Alaskans less than 18 years in 2009, total cumulative lifetime economic loss would be \$2.8 billion.
- If childhood psychological problems impact one in 20 Alaskans less than 5 years in 2009, total cumulative lifetime economic loss would be \$831 million.

Shortage of Psychiatrists

Psychiatrists are medical physicians who specialize in the prevention, diagnosis, and treatment of mental, emotional, and addictive disorders. Psychiatrists are integral to any comprehensive and coordinated health care system. Psychiatrists provide direct patient care, supervise other health care professionals, and provide consultation for other health and non-health care professionals and organizations.

The shortage of psychiatrists in Alaska is well documented. DHSS, AMHTA, and UA have participated in several studies to determine the number of health care workers in Alaska including psychiatrists.

Accurately determining the supply of psychiatrists is not simple. Determining the number of professionals licensed in Alaska at a given moment in time is only a beginning. A more accurate analysis includes the following elements:

- the number of psychiatrists providing clinical services in Alaska
- the portion of time each psychiatrist provides clinical care (clinical FTEs)
- the geographic distribution of clinical FTEs
- the clinical setting distribution of clinical FTEs
- the number of FTEs providing non-clinical, administrative, and supervisory functions
- the number of non-Alaska resident clinical FTEs
- the number of Alaskan psychiatrists providing psychiatric services outside Alaska
- the annual average number of psychiatrists beginning to provide clinical services in Alaska
- the annual average number of psychiatrists reducing or ending clinical work in Alaska

An analysis that includes this information would provide a clearer picture of the health care system's psychiatric capacity. It would also provide information about how psychiatrists spend their time and about the incoming and exiting pipeline of psychiatrists. No study provides this degree of detail.

The number of psychiatrists in Alaska is dynamic and changing from year to year and community to community. No one has studied or identified possible variables associated with trends or changes in the Alaska psychiatric workforce.

Determining an ideal number of full time equivalents (FTEs) in Alaska for any specific profession is difficult and controversial. Determining an ideal number of psychiatrists is likely even more so. For psychiatry the most controversial methodology may be epidemiological-based population illness projections. This methodology multiplies population size and mental illness prevalence or incidence data. More common and maybe reliable methodologies include surveying provider organizations regarding vacant rates, patient appointment waiting times, and using national professional to population ratios as benchmarks. The best studies use multiple methodologies.

In 2000, the Health Resources and Services Administration (HRSA) **Workforce Profiles** estimated that there were 51 psychiatrists or 8.3 psychiatrists per 100,000 in Alaska. The original national psychiatrist to population ratio was 13.1 psychiatrists per 100,000. The HRSA ranked Alaska 36th in the nation. This national ratio was revised to 14.3 adult psychiatrists per 100,000 and 2.2 child and adolescent psychiatrists per 100,000 for a combined national ratio of 16.5 psychiatrists per 100,000. Alaska would have had 103 psychiatrists (rather than 51) if it had the combined national ratio of 16.5 psychiatrist per 100,000 in 2000. Alaska would have needed 117 psychiatrists if the goal was to have 16.5 psychiatrists per 100,000 by 2010. (The US Census Bureau reported the population of Alaska was 626,931 in 2000 and 710,231 in 2010.)

In 2006, the Alaska Physician Supply Task Force completed **Securing an Adequate Number of Physicians** for Mark Hamilton, President of UA and Dr. Karleen Jackson, DHSS Commissioner. This was a comprehensive assessment designed to answer three questions:

1. What is the current and future need for physicians in Alaska?
2. What strategies are being used to meet this need?
3. What strategies could be used to meet this need?

The Task Force recommended that the Alaska physician to population ratio should be 10% higher than the national physician to population ratio because of Alaska's rural nature, great distances, severe weather, and physicians' greater administrative and supervisory responsibilities.

The Task Force studied all physician specialties including psychiatry. The Task Force concluded that there were 78 licensed psychiatrists in Alaska with 69 psychiatric FTEs during 2004. The Task Force extrapolated that Alaska would have needed 28 more clinical FTE psychiatrists if Alaska had the same psychiatrist to population ratio as the national psychiatrist to population ratio.

The Task Force did not apply the 10% more than national physician to population ratio to specific physician specialties. If done for psychiatry, Alaska would have needed 39 more FTE psychiatrists. This would have been a 56% increase in FTE psychiatrists.

In 2007, the Alaska Department of Labor (DOL) estimated that there were 71 psychiatrists working in Alaska. Fifteen percent (11) were non-Alaska residents. Seventy-seven percent were 45 years and over and 57% were 50 years and over. In 2009, DOL determined that there were 67 licensed psychiatrists in Alaska. Eleven percent (8) were non-residents, 80% were over 45 years, and 63% were over 50 years.

In 2007, the Alaska Center for Rural Health completed the **2007 Alaska Workforce Vacancy Study**. The study was funded by UA and AMHTA. This study tried to answer several questions about many health occupations. The initial question was to determine how many budgeted positions existed in each occupation. The follow up question was how many of those budgeted positions were vacant or unfilled. Approximately 35% of Alaska health care organizations were surveyed. The results from the sample were then used to estimate positions and vacancies for the entire state of Alaska.

The sample had 36 budgeted positions for psychiatrists with 10 being vacant for a vacancy rate of 27.8%. The state-wide projection for budgeted positions was 93 with 18 vacancies for a vacancy rate of 19.0%. The analysis estimated vacancies by geography and clinical setting. The geographic vacancy rates included a 14% vacancy rate in the Southeast, a 25% vacancy rate in the Interior and Fairbanks, a 33% vacancy rate in Mat-Su and Anchorage, and a 50% vacancy rate in the Northwest and Southwest. The clinical vacancy rates included a 16% vacancy rate in offices and clinics, a 22% vacancy rate in behavioral health organizations, a 27% vacancy rate in hospitals and nursing homes, and a 40% vacancy rate in Alaska Native Health Organizations.

Vacancy duration was estimated. The mean time to fill a psychiatric vacancy was 34.5 months (almost three years). This suggested filling these positions is difficult and long standing.

The **2007 Alaska Workforce Vacancy Study** concluded that “vacancies for psychiatrists were not numerous but in particular demand and difficult to recruit.” The vacancy rates for psychiatrists were higher than those for human service workers, behavioral health clinicians, and behavioral health supervisors.

A repeat Alaska health workforce vacancy study was completed in 2009. The **2009 Alaska Health Workforce Vacancy Study** found a lower vacancy rate for psychiatrists than the 2007 study. The study sample had 61 budgeted positions for psychiatrists with 10 vacancies for a vacancy rate of 16.4%. The state-wide projection for budgeted positions was 86.9 with 11 vacancies for a vacancy rate of 12.7%. This analysis also estimated vacancies by geography and clinical setting. The geographic vacancy rates included a 100% vacancy rate in the North (1.0 vacancy), a 20% vacancy rate in the Southeast (2.5 vacancies), a 14.5% vacancy rate in Mat-Su and Anchorage (7.5 vacancies), and a 0% vacancy rate in the Interior & Fairbanks, Gulf & Kenai, and Southwest (no vacancies). The clinical vacancy rates included a 27.3% vacancy rate in Alaska Native Health Organization (3.0 vacancies), a 20% vacancy rate in behavioral health organizations (3.0 vacancies), a 18.5% vacancy rate in hospitals and nursing homes (5.0 vacancies), and no vacancies in medical clinics and physician offices.

Vacancy duration was estimated again. The mean time to fill a psychiatric vacancy had gone down from 34.5 months to 5.0 months. The sample maximum was 15.0 months.

Both the 2009 and 2007 studies were comprehensive. The 2009 Study concluded that the vacancy rate for psychiatrists was “substantial” but the profession was not in the top ten based on estimated positions, vacancies, or vacancy rate. Curiously, the 2009 study found no vacancies in the Interior & Fairbanks or the Gulf & Kenai and less than eight vacancies in the Mat-Su and Anchorage.

Finally, health care reform is driving the creation of patient-centered medical homes in the primary care setting. Given the high prevalence of mental illness in the primary care setting, it is possible that the demand for psychiatrists in medical clinics will grow faster than all other clinical settings.

In 2009, Dr. von Hafften surveyed psychiatric physicians licensed in Alaska. He tried to identify all licensed physicians specializing in psychiatry by going through the 2009 Alaska State Medical Association Medical Directory. This methodology is useful but biased. He estimated that there were 66 licensed psychiatrists working in Alaska. A survey was mailed to each licensed psychiatrist. Twenty-four (24) surveys were returned for a response rate of 36%. Survey results included:

- 77% of respondents' professional time was direct patient care.
- 24 responses correlated to 21 clinical FTEs.
- 16 respondents (66%) were self employed.
- 11 respondents (45%) were employed.
- 3 respondents (12%) were employed and self employed.

Of those who were employed more than half were employed by non-profit organizations. Two were employed by Alaska Native health organizations, one was employed by the federal government, and one was employed by the state of Alaska. One respondent was employed by more than one organization.

While only three respondents (12%) were both employed and in a private setting, it is believed that most all Alaskan psychiatrists have worked in a variety of clinical settings including one or more periods of employment during the course of their professional work in Alaska.

Perhaps the most important information from this survey was an attempt to quantify when respondents anticipated reducing practice or retiring. The survey found the following:

- 29% (7) respondents anticipated reducing or retiring within five years.
- 29% (7) respondents anticipated not reducing or retiring for at least 10 years.

In 2011, a follow up survey was mailed to all identified Alaska licensed psychiatrists. Seventy five (75) surveys were sent out and 21 were returned for a response rate of 28%.

- 14.3% (3) responded that it was very unlikely or unlikely that they would remain working in Alaska for the next 3-5 years.
- 61.9% (13) responded that it was likely or very likely that they would remain working in Alaska for the next 3-5 years.

In November 2001, the Steering Committee surveyed members the Alaska Behavioral Health Association, Alaska State Hospital and Nursing Home Association, and the Alaska Tribal Behavioral Health Directors. One hundred eleven (111) organizations received a request and link to complete a survey using Survey Monkey. Thirty-four (34) organizations responded for a 31% response rate. Twenty-four (24) organizations provided psychiatric services. Twenty-three (23) organizations employed or contracted with psychiatrists. The total cumulative psychiatric physician full time equivalent for 22 organizations was 69.5. (One organization reported more than 10 FTE psychiatrists.)

Twenty-eight (28) organizations would hire a cumulative additional 29 FTEs if available. Nineteen (19) organizations indicated that their business plan supported this need while 15 organizations indicated that their business plan did not support this need.

In July 2009, the Medical Development Specialists (MDS) completed an Alaska statewide physician needs assessment for Providence Health & Services Alaska. Thirty-three medical specialties were studied including primary care. MDS incorporated quantitative and qualitative data analysis. MDS analyzed existing physician workforce measures including number of physicians, FTE status, pending retirements, and estimated clinical demand based on physician-to-population ratio modeling. MDS included Alaska's population demographics and health care provider networks. MDS interviewed senior management and physicians within the Providence Health System, Alaska Native Health System, and the United States Military. A selected summary of the Medical Development Specialists study is included as **Appendix IV**.

MDS estimated that Alaska had 73.2 psychiatrist FTEs and needed 97.6 FTEs to meet existing need. This was an additional 24.4 FTEs, a 33% increase over the 2009 supply. Only psychiatry and internal medicine were in "substantial need." Substantial need was defined as a shortage of more than ten physicians. All other medical specialties (31) were "adequate" or in "slight need."

In summary, the shortage of psychiatrists in Alaska has been a consistent conclusion. The number of psychiatrists in Alaska since 2000 has been estimated between 51 and 75 depending on when and how the data was collected and analyzed. The recommended number of psychiatrists has been between 86 and 108. The smallest shortage was the **2009 Alaska Workforce Vacancy Study** of 11 vacancies state-wide. The **2009 Alaska Workforce Vacancy Study** conclusion that there were no vacancies for psychiatrists in Fairbanks, Mat-Su, or the Kenai is of concern. The **2009 Medical Development Specialists** and the **2006 Physician Supply Task Force** both recommended 97 psychiatrists with a shortage of 24 and 28 respectively. The **2006 Alaska Physician Supply Task Force** recommendation would increase to 108 if the 10% recommendation was applied specifically to psychiatry.

National psychiatrist to population ratios suggest the following psychiatrist supply targets for Alaska:

- 103 psychiatrists Alaska 2000 census (626,931) and revised 2000 national psychiatrist to population ratio of 16.5 psychiatrists per 100,000.
- 117 psychiatrists Alaska 2010 census (710,231) and revised 2000 national psychiatrist to population ratio of 16.5 psychiatrists per 100,000.
- 110 psychiatrists Alaska 2010 census (710,231) and the 2009 national psychiatrist to population ratio of 15.5 psychiatrists per 100,000.

Summary: Supply and Shortage of Psychiatrists

| <u>Year</u> | <u>Study</u> | <u>Recommended Supply or Positions</u> | <u>Current Supply or Positions</u> | <u>Shortage or Vacancies</u> | <u>National Rank</u> | <u>Deficit Vacancy Rate</u> |
|-------------|---------------------------------|--|------------------------------------|------------------------------|----------------------|-----------------------------|
| 2009 | Medical Development Specialists | 97 | 73 | 24 | | 24.7% |
| 2009 | Alaska Workforce Vacancy Study | 86 | 75 | 11 | | 12.7% |
| 2007 | Alaska Workforce Vacancy Study | 93 | 75 | 18 | | 19.0% |
| 2006 | Physician Supply Task Force* | 108 | 69 | 39 | | 36.1% |
| 2006 | Physician Supply Task Force | 97 | 69 | 28 | | 28.9% |
| 2000 | HRSA** | | 51 | | 36 th | |

* Estimate using Alaska Physician Task Force 10% recommendation.
 ** HRSA (Health Resources and Services Administration); Alaska 8.3/100,000; national 12.6/100,000.

2000 Revised National Average of 16.5/100,000 at 2000 Census of 626,931

| <u>Projection</u> | <u>National Match</u> | <u>Current Supply</u> | <u>Shortage</u> | <u>Deficit</u> |
|-------------------|-----------------------|-----------------------|-----------------|----------------|
| 2000 HRSA*** | 103 | 51 | 51 | 50.0% |

*** Projected need to match revised national average of 16.5/100,000 at 2000 Alaska census.

2009 National Average of 15.5/100,000 at 2010 Census of 710,231

| <u>Projection of above analyses</u> | <u>National Match</u> | <u>Current Supply</u> | <u>Shortage</u> | <u>Deficit</u> |
|-------------------------------------|-----------------------|-----------------------|-----------------|----------------|
| 2010 Alaska Department of Labor**** | 110 | 59 | 51 | 46.4% |
| 2009 Alaska Workforce Vacancy Study | 110 | 75 | 35 | 31.8% |
| 2009 Survey of Alaska Psychiatrists | 110 | 66 | 44 | 40.0% |

**** Total supply (67) less out of state workers (8).

Deficit percents are calculated by dividing the workforce deficit (or vacancies) by the recommended workforce. A more useful measure may be dividing the workforce deficit (or vacancies) by the current workforce. This is a more tangible reference point since vacancies may be long standing and filling them is difficult. Little is known about the variables associated with annual changes in the psychiatrist workforce. Deficit percents (or vacancy rates) increase as follows:

- 2009 Medical Development Specialists increases from 24.7 % to 32.9%
- 2009 Alaska Workforce Vacancy Study increases from 12.7% to 14.7%
- 2007 Alaska Workforce Vacancy Study increases from 19.0% to 24.0%
- 2006 Physician Supply Task Force increases from 36.1% to 56.5% (at 10% above national ratio)
- 2006 Physician Supply Task Force increases from 28.9% to 40.6% (at national ratio)
- 2009 Alaska Workforce Vacancy Study increases from 31.8% to 46.7% (at national ratio)
- 2010 Alaska Department of Labor increases from 46.4% to 86.4% (at national ratio)

Some will criticize this as overestimating the shortage of psychiatrists especially since Alaska has always been below national psychiatrist to population ratios. At the same time Alaska has a long history of sending Alaskans with mental illness out of state and to the Alaska Department of Corrections. Alaska's population is increasing and Alaska's senior population is one of the fastest growing in our community. Mental health parity and the redesign of primary care as the patient-centered medical home increases demand for mental health care expertise and resources.

Taking a final look at the **2009 Alaska Workforce Vacancy Study**, the combined vacancy rate for psychiatrists and psychiatric advanced nurse practitioners was 15.2% or 19.6 positions. This is less than the conclusion from several of the other studies for psychiatrists alone. Additionally, there were no vacancies for psychiatrists and only 2.6 vacancies for psychiatric advanced nurse practitioners in medical clinics and physician offices. During the coming decade, primary care clinics will be the clinical sites of greatest need for both psychiatrists and psychiatric advanced nurse practitioners.

Appendix V includes a brief overview of the challenges health provider organizations face regarding budgeting for psychiatrists.

Recruiting and Hiring Psychiatrists

Living and working in Alaska is shrouded in myth. The mystique appeals to some but is an obstacle to others. Effective recruiting is recruiting a family not just an individual. Successful recruiting means helping family members seeing themselves at home in Alaska. This includes providing career opportunities for other family members and promoting community resources such as schools and opportunities in higher education.

Recruiting and hiring psychiatrists in Alaska is challenging and expensive. The Alaska Center for Rural Health completed two health care provider recruitment studies for the DHSS Commissioner.

The first study, **Status of Recruitment Resources and Strategies** (SORRAS I), was completed in 2004 and focused on rural health care sites. The study included physicians, pharmacists, midlevel providers, nurses, dentists, hygienists, psychiatrists, clinical psychologists, masters-level therapists, and LCSWs. Approximately \$19 million was spent recruiting health care providers during 2003. Approximately \$713,000 was spent recruiting and hiring psychiatrists in rural Alaska during 2003. Seventy percent (70%) of the total (\$499,000) was for temporary psychiatrists. SORRAS I calculated that the average cost to recruit a psychiatrist was \$126,000 and the average cost to successfully hire a psychiatrist was almost \$238,000.

The second study, **Status of Recruitment Resources and Strategies 2005-2006** (SORRAS II) was completed in 2006. SORRAS II included health care providers in Anchorage, Fairbanks, Juneau, and rural sites. SORRAS II found that over \$24 million was spent recruiting health care providers during 2005. Urban facilities spent \$9 million and rural facilities spent \$15 million.

Urban and rural facilities spent \$1.1 million recruiting and hiring psychiatrists. Sixty-five (65%) of this amount (\$715,000) was for temporary psychiatrists. Depending on year and recruiting yield, it cost \$65,000-\$119,000 to recruit a psychiatrist and \$106,000-\$238,000 to successfully hire a psychiatrist.

SORRAS II looked at vacancy duration and found the average vacancy duration for psychiatrists was just over eight months.

Temporary Psychiatrists Filling Vacancies

Several of the larger providers of mental health services have relied on temporary psychiatrists for weeks to months at a time. Temporary psychiatrists fill gaps in public sector provider organizations that provide critical access to care. However, locum psychiatrists do not arrive with the goal of long term employment or long term patient and organizational commitment. Regular employment is more commonly associated with building trust and stability in the physician-patient relationship and within the provider organization. Locum psychiatrists are an expensive temporary solution because they may cost 50-100% more than an employed psychiatrist.

Temporary psychiatrists are also associated with other costs such as air transportation, vehicle rental, housing, and agency overhead. Health care provider organizations must put new temporary psychiatrists through orientation like other temporary or newly hired health care workers. The organizational orientation includes federal or state mandated medical records training, confidentiality, integrity, and risk management.

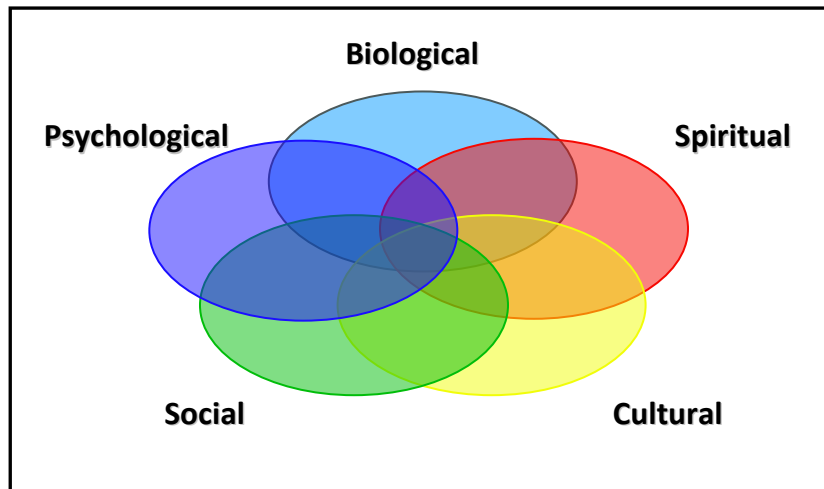
The Steering Committee estimated that at least \$2.9 million was spent in Anchorage alone by the Alaska Psychiatric Institute, Alaska Veterans Affairs Health Care System, Anchorage Community Mental Health Services, and one Alaska Native health care organization for temporary psychiatrists in 2009.

If the past is a predictor of the future, most major health provider organizations have used temporary psychiatrists sometime during the past two years or will sometime during the next two years. That being said, some provider organizations avoid using locum workers including psychiatrists even though it significantly reduces access to care. These provider organizations would rather not have a temporary psychiatrist who may be a poor fit for the organization and/or patient population. A poor temporary worker fit may exacerbate problems related to standards of practice and quality of care.

Definitions: Psychiatrist and Psychiatric Education

What is a psychiatrist?

Psychiatrists are medical and osteopathic physicians who specialize in the prevention, diagnosis, and treatment of mental, emotional, and addictive disorders. Psychiatry focuses on some of the most personal of health concerns. Psychiatrists are trained to consider biology, psychology, social situation, culture, and spirituality in every patient care interaction.



A psychiatrist is a physician who specializes in the prevention, diagnosis, and treatment of mental, emotional, and addictive disorders.

A psychiatrist understands the biological, psychological, and sociocultural components of mental illness and is qualified to order diagnostic laboratory tests, to prescribe medications, to evaluate and treat psychological and interpersonal problems, and to give continuing care for psychiatric problems.

The psychiatrist is prepared to help individuals and families who are coping with stress, crises, and other life problems.

**American Association of Directors of
Psychiatry Residency Training**

Most people have little knowledge regarding the training and qualifications of a psychiatrist. Stereotypes are common such as not being “real” doctors or only being “pill pushers.” Psychiatrists are often the lightning rod for conflicting social values, controversial laws, and failings of the health care system. When behavior or psychiatric evaluation and treatment become a focus of media attention controversy is almost certain.

The profession of psychiatry has evolved as medical science has increased understanding of thought, mood, and behavior. Psychiatry, like other professions, is constantly pressured to do more with less. However, personal interaction and trust are essential to most therapeutic work. Operational necessities frequently conflict with value-based mental health care. When the primary mode of evaluation and treatment is the personal interaction, can patient volumes increase without impacting patient trust? Procedure-oriented health care and medication management are critical therapeutic modalities. However, they are not by themselves comprehensive, coordinated, or quality care. In many

settings, the standard of care is the least extensive, least intrusive, and least expensive. This is often the least effective as well.

Psychiatry is a medical profession. Anatomy, physiology, and pathophysiology are foundations. But, unlike other areas of medicine, it includes intrapersonal and interpersonal dynamics. Psychiatrists try to balance biological and psychosocial interventions despite external pressures.

Having an adequate number of well trained psychiatrists is not the “solution” to Alaska’s public health and mental illness challenges. Yet, having an adequate number of well trained psychiatrists is necessary for all strategies.

Contemporary Psychiatry Education

Psychiatrists must first become physicians. Psychiatrists go to medical or osteopathic school and learn first-hand about biochemistry, anatomy, neuronanatomy, physiology, histology, pathology, pharmacology, pediatrics, obstetrics-gynecology, surgery, anesthesiology, internal medicine, neurology, preventive medicine, primary care, and emergency medicine.

Psychiatrists must then complete a psychiatry residency. After graduating from medical or osteopathic school, psychiatrists-to-be begin residency training. Psychiatry residency is a four year structured education in the evaluation and treatment of emotional, cognitive, behavioral, and addictive disorders. Instruction occurs in multiple clinical settings. Instruction incorporates evolving scientific knowledge and its application in clinical practice. As training progresses expertise for working with specific patient populations becomes the focus. There are no short cuts.

The Accreditation Council for Graduate Medical Education (ACGME) sets national training standards, requirements, and competencies for all graduate medical education programs. General competencies for all residency training fall into six major areas.

- I. Professionalism**
Demonstrating commitment to professional responsibilities, ethical principles, and sensitivity to diverse populations.
- II. Medical Knowledge**
Understanding the application of biomedical and clinical sciences in patient care.
- III. Patient Care and Procedural Skills**
Providing patient care that is compassionate, appropriate, and effective.
- IV. Interpersonal Communication Skills**
Demonstrating effective information exchange with patients, families, professional associates, and fostering an ethical therapeutic relationship with patients.

V. Practice-based Learning and Improvement

Evaluating patient care practices and assimilating scientific evidence to improve practice.

VI. Systems-based Practice

Demonstrating awareness of responsibility to the larger context and systems of health care.

Minimum clinical training in psychiatry includes:

- Four months of internal medicine, family medicine, or pediatrics
- Two months of neurology
- Six months of inpatient psychiatry
- Twelve months of outpatient psychiatry
- Two months of child and adolescent psychiatry
- Two months of consultation-liaison psychiatry
- One month of addiction psychiatry
- One month of emergency psychiatry
- One month of geriatric psychiatry
- Experience in community and forensic psychiatry

Minimum didactic education includes:

- Neuroanatomy, neurophysiology, and neuropathology
- Psychoneuroimmunology and psychoneuroendocrinology
- Behavioral genetics
- Child and adult development and aging
- Developmental, degenerative, traumatic, infectious, and nutritional disorders
- Clinical interviewing and cognitive assessment
- Suicidology and suicidality
- Assaultive behavior and difficult patients
- Gender specific evaluation and treatment
- Relational psychology, couples therapy, family therapy, and group therapy
- Disorders of cognition and consciousness
- Evaluation and treatment of psychiatric diseases and illness (all classes)
- Psychopharmacology (various classes)
- Psychotherapy (various types)
- Evaluation and treatment of addictive disorders and syndromes
- Alternative medicine
- Cross cultural psychiatry and spirituality

Residency is a period of education in a chosen specialty that physicians undergo after graduating from medical school. Most residencies last from three to seven years. Residents care for patients under the supervision of physician faculty and participate in educational and research activities. When physicians graduate from a residency, they are eligible to take board certification examinations and begin practicing independently.

Residencies are sponsored by teaching hospitals, academic medical centers, health care systems and other institutions.

ACGME accreditation is voluntary. However, residencies must be ACGME-accredited in order to receive graduate medical education funds from CMS. Residents must graduate from ACGME-accredited programs to be eligible to take board certification examinations.

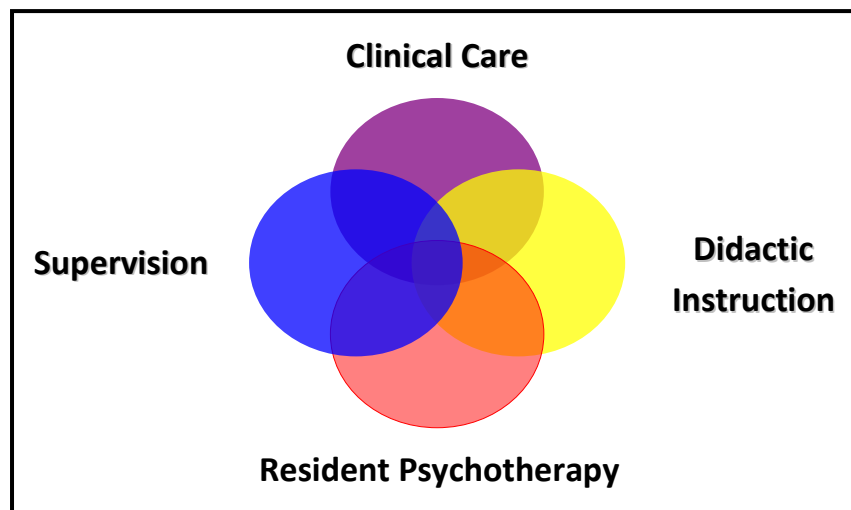
Many states require completion of an ACGME-accredited residency program for licensure.

**Accreditation Council for
Graduate Medical Education**

Forensics and the Law
Professionalism and Ethics
Careers in private practice, research, and education
Basic informatics
Transference and countertransference

Supervision and mentoring are essential elements in psychiatry education since the foundations of psychiatric diagnosis and treatment are direct patient observation, interaction, and dialogue. Psychiatric diagnosis and response to treatment cannot be confirmed by a blood test or x ray.

The ACGME requires a minimum of two hours per week of direct supervision of a resident's evaluation and treatment of patients. The nature and goals of resident supervision change depending on the clinical training site. Supervision changes depending on the knowledge, skill, and expertise of both resident and supervisor. UW Supervision Guidelines are included in **Appendix VI**.



Formal structured education ends when a resident completes psychiatry residency training. The graduate should be qualified to evaluate and treat the common difficulties experienced by individuals, couples, and families. The graduate should know how and when to seek consultation from colleagues and other professionals.

Many psychiatry residents continue formal education by entering fellowship training. Fellowship training is more specialized training in areas such as geriatric psychiatry, child and adolescent psychiatry, forensic psychiatry, neuropsychiatry, consultation-liaison psychiatry, and addiction psychiatry. Fellowship training in psychiatry usually takes an additional one to two years. Residents frequently begin fellowships during the fourth year of residency.

According to the American Psychiatric Association, up to 50% of residents initially considering a child and adolescent fellowship ultimately decide not to enter fellowship because of student loan debt.

Psychiatrists and Psychiatric Practice

Psychiatrists and psychiatry may be a mystery. Some question the professional domain of psychiatry. Stereotypes are common and psychiatrists and psychiatry are sometimes met with distrust. So, what is known about the US psychiatric workforce?

- 34% of psychiatrists are women.
- 51% of those entering psychiatry are women.
- More than half of all psychiatrists are over 55 years.
- Psychiatrists are more likely to work past typical retirement age.
- Psychiatrists are the second oldest medical workforce after preventative medicine.
- Psychiatrists are more likely to work part-time than most other medical specialties.
- 36% of those entering psychiatry are IMGs.
- Those entering psychiatry, like those entering other areas of medicine, are seeking a more balanced lifestyle than their predecessors.
- Less than 3% of residency training positions are in psychiatry.
- Less than 5% of U.S. medical school graduates go into psychiatry.

Psychiatry is a cognitive-based medical specialty. Other cognitive-based medical specialties include general internal medicine, family practice, and pediatrics. Procedure-based medical specialties include surgery, cardiology, and gastroenterology. In general, procedure-based specialties receive higher reimbursement and are more lucrative. The table below shows that cognitive-based specialties are at the bottom of the physician pay scale.

| Medical Specialties and Income | | | |
|---------------------------------------|-------------------------|--|---|
| Specialty | AMGA* (2010) | Merritt Hawkins** (Average, 2010) | MGMA*** (50th Percentile, 2011) |
| Orthopedic Surgery | \$500,672 | \$519,000 | \$585,808 |
| Diagnostic Radiology | \$454,205 | \$417,000 | \$566,920 |
| Gastroenterology | \$405,000 | \$411,000 | \$523,672 |
| Dermatology | \$375,176 | \$314,000 | \$448,265 |
| Anesthesiology | \$370,500 | \$331,000 | \$493,561 |
| General Surgery | \$357,091 | \$314,000 | \$414,778 |
| Obstetrics-Gynecology | \$275,152 | \$272,000 | \$365,022 |
| Emergency Medicine | \$267,293 | \$247,000 | \$335,213 |
| Psychiatry | \$214,740 | \$209,000 | \$263,754 |
| General Internal Medicine | \$214,307 | \$191,000 | \$250,452 |
| General Pediatrics | \$209,873 | \$180,000 | \$245,812 |
| General Family Medicine | \$208,861 | \$175,000 | \$238,893 |
| Geriatrics | \$187,602 | N/A | \$260,968 |

*American Medical Group Association
 **Merritt Hawkins
 ***Medical Group Management Association

According to Merritt Hawkins, a national physician employment and consulting service, between 2009 and 2010, demand for temporary psychiatrists grew faster than for all other medical specialties. Demand increased 47%. In terms of total demand, psychiatry was third behind family medicine and internal medicine. Demand for both family medicine and internal medicine decreased between 2009 and 2010.

Merritt Hawkins also completes annual salary surveys for physicians. In general, the average and high base salaries for US psychiatrists increased during the past decade while the low base salaries slightly decreased.

| Base Salaries of U.S. Psychiatrists: 2006 to 2010 | | | |
|--|-------------------------|----------------|-------------|
| (Merritt Hawkins, 2010) | | | |
| | -----Base Salaries----- | | |
| <u>Years</u> | <u>Low</u> | <u>Average</u> | <u>High</u> |
| 2009-2010 | \$150,000 | \$209,000 | \$310,000 |
| 2008-2009 | \$160,000 | \$200,000 | \$300,000 |
| 2007-2008 | \$120,000 | \$189,000 | \$230,000 |
| 2006-2007 | \$160,000 | \$186,000 | \$230,000 |

CMS does not include psychiatry within primary care. Primary care encompasses family medicine, general internal medicine, general pediatrics, preventative medicine, and geriatric medicine. Most patients with mental illness who are seen within the medical system are seen by primary care providers not psychiatrists. Nationally, almost 80% of antidepressants are prescribed by non-psychiatrists. National estimates are that 11%-36% of primary care patients have a mental illness but less than 20% of those identified with a mental illness receive adequate care. This highlights the vital role of psychiatrists working with primary care providers in patient centered medical homes.

Options for Managing the Shortage of Psychiatrists

Passive Recruiting

Passive recruit is when health care professionals are sent to Alaska for a tour of duty without an Alaskan health care organization having to invest significant resources into marketing and recruiting. Historically, Alaska benefited when someone stationed in Alaska found something they were looking for and remained as long as possible or returned as soon as possible after completing their service obligation.

Historically, the US Public Health Service/Indian Health Service used passive recruiting. A significant proportion of non-Alaskan Native health professionals currently working at the Alaska Native Medical Center originally come to Alaska with the US Public Health Service. During the past two decades, the responsibility for recruiting and hiring shifted from the federal government to Alaska Native health organizations. The transfer of authority gave Alaska Native health organizations control over recruiting and hiring. This reduced the likelihood of hiring someone who would not be a good fit. But it also transferred all of the challenges associated with marketing, recruiting, hiring, and retention to the Alaska Native health organizations.

The US Military is another source of passive recruiting. This continues to be helpful despite overseas deployment pressures. Within the past few years, two psychiatrists retired from military service and remained in Alaska working as civilians, one Fairbanks (Dr. Victor Bell) and one in Anchorage (Dr. Joseph Pace). Passive recruiting via the US Military will not produce enough new Alaska psychiatrists.

Training health professionals in Alaska is the third passive recruiting strategy. Interested medical students and residents have come to Alaska to complete a portion of their training. Most psychiatry residents have come from the UW as part of the Washington, Wyoming, Alaska, Montana, and Idaho (WWAMI) program. Originally residents came for six months. Most elective opportunities were based in Anchorage although some residents were in Juneau or Fairbanks. Anchorage based residents were expected to train at API for 30% of their time in Alaska. Most residents did some correctional and forensic psychiatry as well. The goal was to give residents an opportunity to train in Alaska and for Alaska health care organizations to recruit them while they were here. The psychiatry elective was successful but terminated during the mid 1990s after API began requiring residents to train at API 90% of their time in Alaska. This was not going to be successful because residents had already completed 12 months of inpatient psychiatry and were more interested in outpatient and cross cultural psychiatry. The termination of the original WWAMI Psychiatry Elective also ended the every six week UW clinical faculty grand rounds and clinical consultations in Alaska.

In 2008, the Trust got the WWAMI Psychiatry Elective back into operation and is currently funding it on a time limited basis. The goal is to recruit psychiatrists to Alaska by offering individualized training opportunities in Alaska for interested residents. This psychiatry elective, Elective Rotations, is discussed more below.

Student Loan Repayment

Many health care professionals carry a significant debt burden after completing training. The Association of American Medical Colleges (AAMC) reported that the average debt of graduating medical students was \$154,607 in 2008 and that 79% were at least \$100,000 in debt. The average debt increased 11% from the 2007 graduating class. Student loan debt is expected to increase as higher education including medical school tuition and student fees increase to off-set federal and state funding reductions. The majority of states are combining workforce development and student loan repayment incentives. Alaska should expand student loan repayment opportunities to boost recruiting effectiveness and competitiveness.

In 2007, Pat Carr, Chief Health Planning & Systems Development completed a concept proposal titled **Health Care Professions Loan Repayment Program** for DHSS. In 2007, 44 states had at least one program and 21 states had at least two programs. Currently, 46 states have at least one support for service program.

The Health Care Professions Loan Repayment & Incentive Program (HCPRLIP) is the product of an interagency work group including DHSS, AMHTA, UA, professional societies, and provider organizations. HCPRLIP is for graduates of many health professions. HCPRLIP would provide up to \$47,000 per year of student loan repayment or direct incentive depending on profession and placement. Another Alaska program is the Alaska State Loan Repayment Program (ASLRP) for primary care, dental care, and behavioral health professionals. It is a joint state-federal program.

HCPRLIP and ASLRP provide opportunities to recruit psychiatrists to Alaska. However, in psychiatry it likely appeals to early career psychiatrists who are already coming to Alaska or already working here. It is unclear if they will attract a significant number of psychiatrists not already coming to Alaska. HCPRLIP and other loan repayment programs will likely increase psychiatrist retention when coupled with an Alaska Psychiatry Residency.

Train more Psychiatric Nurse Practitioners, Counselors/Therapists and Psychologists

UA has prioritized providing training for several mental health care professions including: nurses, psychiatric nurse practitioners, counselors/therapists and psychologists. Each of these professions has unique training requirements, professional skills, and expertise. There is overlap in clinical practice. However, the non-overlap is significant enough that one profession does not replace another profession without loss of expertise and quality.

Some believe a psychiatric residency is too expensive and prefer replacing psychiatrists with psychiatric nurse practitioners or psychologists. Psychiatrists complete the most rigorous and intensive training of the mental health professions. There will be missed diagnoses such as delirium and increased patient complications from medical co-morbidities. Short term costs may be less but indirect costs will increase.

The AMHTA, UA, and several provider organizations worked together with the Western Interstate Commission for Higher Education (WICHE) to create the Alaska Psychology Internship. This has eliminated the necessity of PhD prepared psychologists from having to leave Alaska for a one year internship. Increasing the number of psychologists in Alaska is also a priority for a comprehensive mental health workforce.

Psychiatrists working in community mental health are usually multidiscipline team leaders. They come with the broadest and most extensive mental health and medical training and clinical experience. They usually shoulder the ultimate clinical responsibility and supervisory authority. Well trained psychiatrists are instrumental for highly effective clinical teams.

Train More Primary Care Physicians

Increasing the number of primary care providers is essential for the patient centered medical home but insufficient regarding better diagnosis, treatment, and outcomes for the mentally ill.

Several studies have documented the high prevalence of mental illness among patients in primary care settings. The Epidemiologic Catchment Area Study (ECA) of the early 1980s found that more than 60% of individuals with a psychiatric problem never saw a mental health professional. Of those who met full criteria for a diagnosable psychiatric disorder 75% were only seen in the general medical setting. About half of general medical outpatients had some psychiatric symptoms and 25%-35% had a mental illness. Depression was the most common (60%) and anxiety was the second most common (20%). The National Co-morbidity Survey (NCS) of 1990-1992 found a 50% lifetime prevalence and a 30% one year prevalence of a mental illness. Alcohol dependence and depression were the most common.

The National Co-morbidity Survey Replication (NCSR) of 2001-2003 measured mental illness severity and disability. The lifetime prevalence of significant depression was 16.2% and the one year prevalence was 6.6%. Other findings included:

- Approximately 42% of depressed respondents were not receiving any treatment
- Approximately 45% of depressed respondents were receiving treatment in the general medical setting and 55% in the mental health setting

Even though most patients feel relatively comfortable in the primary care setting, there continue to be obstacles to diagnosis and effective treatment of mental illness. A primary care provider may not believe treatment will help or may feel limited in his or her ability to approach mental illness diagnosis and treatment within the 15 minute (or less) primary care appointment.

Several studies have demonstrated that untreated and poorly managed mental illness increases physical health care utilization and costs. In 1990 Wayne Katon, M.D. found that 10% of primary care patients account for almost one-third of all outpatient primary care visits. Unaddressed depression and anxiety increased medical illness co-morbidity and functional impairment and decreased adherence to self-care.

Much of the mental illness research in primary care now focuses on identifying effective collaborative and integrative models of care. Increasing the number of primary care providers is essential but insufficient to improve diagnosis, treatment, and outcomes for primary care patients with mental illness. A better workforce strategy is to increasing the number of psychiatrists with primary care collaboration skills.

Sustainable Elective Rotations

Residents from training programs outside Alaska have come to Alaska to do elective rotations. Residents were usually in their final year of training. Elective rotations provided Alaska health care organizations the opportunity to recruit residents during training. The WWAMI elective has been the most common. Residents from the UW have done elective rotations lasting one to six months. Residents have done elective training at API, DOC, ANMC, ANTHC, ACMHS, Bartlett Regional Hospital (BRH), Fairbanks Community Mental Health, Gateway Mental Health, consumer driven services, and private practice settings. Residents usually finalize their subsequent year's schedule the preceding spring. Consequently, residents considering an Alaska elective must plan one to two years in advance.

The WWAMI Elective was popular. Until the mid 1990s residents came to Alaska for six months. The original WWAMI Elective was terminated during the mid 1990s. Between 1997 and 2004 ACMHS, BRH, PHSA, and DOC tried to continue the WWAMI Elective. However, funding stability and training site sustainability were absent and the second WWAMI Elective iteration faded away.

The Trust began funding elective rotations in 2008. Resident interest has gradually increased. But, residents now prefer the elective rotation to be three months or less. This is likely related to increasing student loan debt and residents entering repayment upon residency completion.

Since 2008 there have been five residents for a total of seven months of elective rotations; four residents from the UW and one resident from Oregon Health Sciences University (OHSU). The elective rotations placement rate is 20%. One of the five residents has returned to Alaska. The former elective rotation resident worked at API and now works at ACMHS. Elective rotations are cost effective in the short-term because the cost is limited. All of the non-Alaska elective costs are the responsibility of the residency program. Alaska's costs include:

- Resident stipend and benefits when the resident is in Alaska
- Residency program (UW or other) overhead
- Air transportation between the residency program and Alaska
- Alaska housing and ground transportation
- Alaska medical license
- At least one trip outside to a rural/remote site
- On-site and off-site supervision
- Alaska coordination, administration, and overhead

Since 2008 the average cost per resident per month has been about \$13,500. This is not sustainable because it was accomplished by aggressively minimizing costs. A more sustainable cost per resident per month is \$17,500.

The Trust is funding elective rotations in FY12 and FY13. Four residents for nine months are anticipated during FY12 and at least three residents for nine months are anticipated during FY13. Residents will be from the University of New Mexico, University of Utah, and UW.

There are three major challenges for elective rotations.

1. Sustainable funding

The Trust has been the only funder since 2008. Trust funding is time limited and prior attempts to rely on provider organization funding were unsuccessful.

2. Sustainable training sites and supervision

Alaska training sites may not have a resident for months to years at a time because different residents have different goals and each elective is designed to meet the goals of that specific resident. Alaska sites are better able to manage patient flow and supervisory capacity when residents are consistently present. It is difficult for Alaska training sites to remain committed and efficient with regards to resident training when resident presence is intermittent.

3. Organizational infrastructure

Alaska must promote the elective rotation opportunity to residents outside of Alaska. Alaska must provide ongoing communication and coordination with interested residents, out of state residency programs, and Alaska training sites. Alaska must follow up with Alaska training sites, Alaska supervisors and instructors, and modify the Alaska resident training options as sites come on line and go off line. Alaska must coordinate the Alaska medical license and specific training site credentialing processes. Alaska must arrange resident transportation and housing. Alaska must document and track agreements and contractual issues such as liability insurance, workman's compensation, and background checks. Alaska must develop and maintain an enthusiastic teaching faculty.

Elective rotations cannot provide psychiatric workforce stability or patient care continuity at Alaska training sites. Elective rotations cannot emphasize the development of statewide primary care integration, telebehavioral health, or rural/remote consultation. (These are core training goals of the Alaska Psychiatry Residency.) Finally, elective rotations cannot generate the same level of interest from psychiatrists not yet in Alaska looking for career opportunities that include resident training and education.

A ten year Elective Rotations budget is included as **Appendix VII**. This budget includes:

1. Twelve months of resident training per year.
2. Four residents per year.
3. Three month elective duration per resident.

4. Transportation to and from the residency (UW or other) program.
5. Resident housing in Alaska.
6. Ground transportation in Alaska.
7. Alaska medical license fees and costs.
8. Alaska administration and supervision.

Appendix VIII is a budget for an Alaska Fourth Year Track Elective. This is a variant of Elective Rotations. Applicants to the UW psychiatry residency would be recruited with the plan of spending their entire fourth year in Alaska. The Alaska Fourth Year Track Elective budget includes:

1. Up to 26 months of resident training per year.
2. Two PGY-4 residents per year for 12 months each.
3. Moving each PGY-4 resident from Seattle to Alaska.
4. Two PGY-2 residents per year for one month each.
5. Transportation to and from UW for the PGY-2 residents.
6. Resident housing in Alaska for the PGY-2 residents.
7. Ground transportation in Alaska for the PGY-2 residents.
8. Alaska medical license fees and costs.
9. Alaska administration and supervision.
10. UW administration.

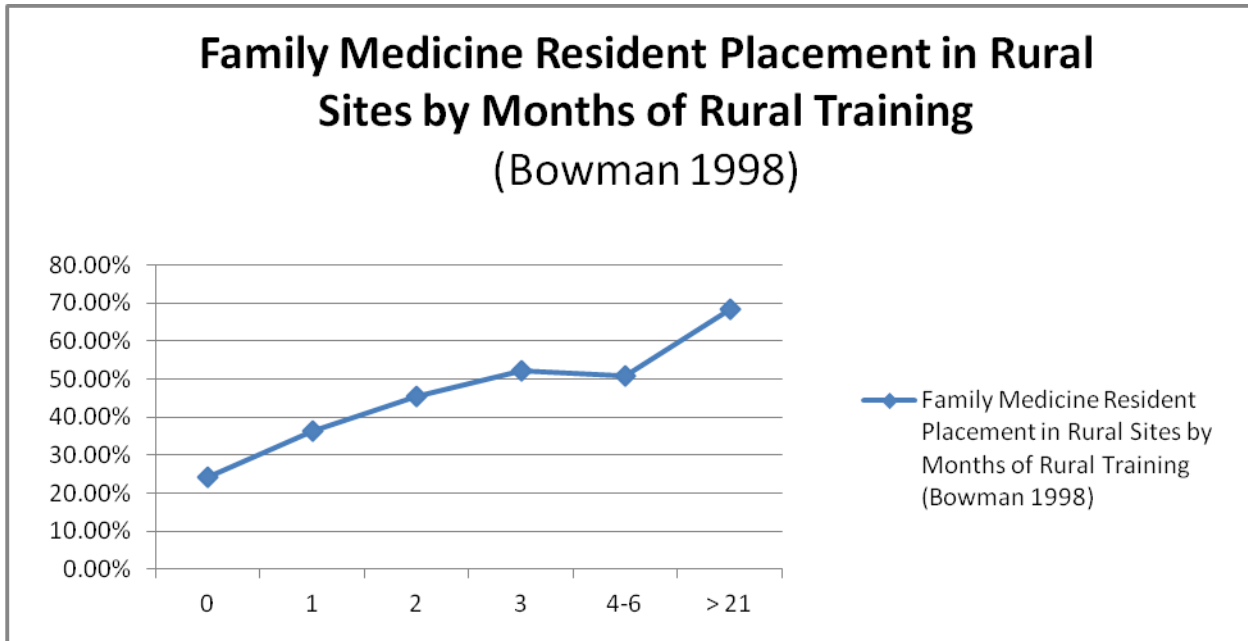
The Alaska Fourth Year Track Elective is less costly than the Alaska Psychiatry Residency and more costly than Elective Rotations. There are more resident months per year and a more structured and sustainable Alaska administration. Residents are in Alaska longer. But, there is no data to project the future Alaska placement rate for graduates of an Alaska Fourth Year Track Elective. If applicant interest is strong enough to recruit competitive residents and the training quality is excellent and the resident training experience satisfaction is good; placement may be fifty percent (50%). The major loss of graduates may be to fellowship training.

This past fall and winter UW recruited three residents for the Alaska Fourth Year Track Elective. Originally, there were 180 applicants for two PGY-1 positions. Ten applicants were interviewed and nine were ranked (National Residency Match Program or NRMP). All of the ranked applicants chose to go to other programs. There were five applicants for one PGY-2 position. Three were interviewed, two withdrew, and two were offered and accepted PGY-2 positions. The remaining position was a PGY-1 position and filled thru the Supplemental Offer and Acceptance Program (SOAP).

Alaska Psychiatry Residency

In general, the most important advantage of an Alaska Psychiatry Residency is the much higher likelihood of an Alaska job placement after residency graduation. The longer a resident trains in a given location the more likely that resident will remain in that same location after training. In 2011, Suzanne Allen, M.D., M.P.H., the UWSOM Vice-Dean for Regional Affairs, reported that the national in-state placement rate for resident graduates after training is 47.4%.

Family medicine is the most successful medical specialty for recruiting and retaining graduating residents into rural and underserved areas. Family medicine residency research demonstrates that the longer a resident trains in a rural area, the more likely that resident will remain in that community after training. In 1998, Robert Bowman, M.D. reported that of residents who trained for at least 21 months in a rural setting, 69% remained after completing residency training.



The Alaska Family Medicine Residency post training placement rate in rural and underserved areas is even higher. Seventy-nine percent (79%) of all Alaska Family Medicine Residency graduates practice in Alaska (AAMC, 2009) and seventy-five percent (75%) practice in rural or underserved areas. Harold Johnston, M.D., the Residency Director estimates that within 10 years half of all family medicine physicians in Alaska will be graduates of the Alaska Family Medicine Residency. The Alaska Family Medicine Residency placement has the highest in-state placement rate for residency graduates in the nation.

Psychiatry resident job placement after training has not been systematically studied. However, UW tracks UW resident job placement after training. The UW Spokane Psychiatry Track was established in 1991 to train psychiatrists to practice in Spokane and rural and underserved areas. Spokane Track residents train at UW in Seattle for the first two years and in Spokane for the last two years. During the past 16 years, approximately 38% of graduates practice in Spokane, 62% of graduates practice in Washington, and 73% of graduates practice in the WWAMI region. Only 5% of Seattle Track graduates work in non-urban settings after training. (Levin, Psychiatric News February 1, 2008)

Unfortunately, the Spokane Track will close in 2014. Two-thirds of the Spokane Track has been funded by the State of Washington. Washington Medicaid invested \$112 million in GME in 2009. State budget shortfalls have led to reductions in GME including termination of Spokane Track funding. The consequences for eastern Washington will be a gradual decreasing supply of

psychiatrists, decreasing access to mental health care, worsening clinical and legal outcomes, and cost shifting over time.

The Alaska Psychiatry Residency is a “grow our own” strategy. Alaska’s unique geography and public health challenges would be incorporated into a training curriculum that attracts nationally competitive candidates. APR would meet all ACGME accreditation requirements. Training would provide a rigorous foundation in biological, psychological, social, spiritual, and cultural competencies. APR would specifically focus on developing expertise in psychiatry-primary care integration, telepsychiatry, and rural/remote community consultation. Training would include collaboration, team building, and leadership development.

During the spring of 2009 Alaska’s psychiatrists were surveyed to determine if there was interest in participating in a APR. Twenty-five (25) of 66 surveys were returned for a 37% response rate. Respondents were located in Anchorage, Fairbanks, Juneau, Ketchikan, Kodiak, Mat-Su, and Sitka. Twenty-three (23) of the 25 respondents were interested in being supervisors or didactic presenters.

Health care professionals from other disciplines including nursing, psychology, and pharmacy are interested in being instructors and supervisors as well.

Alaska Psychiatry Residency: The Independent Option

Some residencies are fully independent. Other residencies are partnerships between two or more primary training institutions. The Alaska Family Medicine Residency is an independent residency (and part of the UW Family Medicine Residency Network). The new Alaska Pediatric Residency is a partnership of an Alaska consortium and the UW Children’s Hospital in Seattle.

An independent APR would have several benefits including the most autonomy to prioritize specific training goals and greater Alaskan ownership and accountability. All funding would remain within Alaska. However, Alaska does not have the educational resources and organizational infrastructure to provide the necessary four year didactic education and clinical training. Alaska would be better to consider the independent option after being fully operational for 10 – 15 years.

Also, Alaska would be at a significant recruiting disadvantage because we only have the Alaska Family Medicine Residency and now the Alaska Pediatric Residency. Alaska has no in state four year medical school.

Psychiatry training slots are in high demand. Approximately 37% of training positions are filled by IMGs (41.5% in 2012) and less than 4% of slots (3.46% in 2012) are unfilled in the National Residency Match Program (NRMP). New residencies, particular in communities without a robust GME presence are likely to attract less competitive applicants. Then, it becomes difficult to attract more competitive candidates.

Alaska's goal should be to create a psychiatry residency that is highly desirable and recruits nationally competitive candidates. This will help recruit practicing psychiatrists and physicians looking for opportunities to teach in a high quality medical education system.

Alaska Psychiatry Residency: The Partnership Option

The most cost effective and efficient way to create an Alaska Psychiatry Residency would be to partner with an established psychiatry residency. A partner would provide expertise and infrastructure and academic and clinical curriculum not currently available in Alaska. Alaska would receive assistance in meeting and maintaining ACGME accreditation.

Partnering with a well respected residency program would help recruit competitive candidates. Graduating medical students and physicians seeking a psychiatry training position at a highly selective residency would be introduced to the Alaskan opportunity even if that was not an original interest or preference. And residents specifically interested in Alaska would benefit from training at the partner's institution.

Several possible partners exist including the University of Colorado, Oregon Health Sciences University, University of Arizona, University of New Mexico, University of Hawaii, University of Washington, and Pacific Northwest University of Health Sciences. This analysis focuses on UW for the following reasons.

UW is the hub of the five state collaborative WWAMI program. UW and the University of Alaska (UA) have collaborated in educating and training medical students and physicians since the inception of WWAMI 40 years ago. UW is ranked 1st of primary care medical schools for the 18th consecutive year. UW is ranked 1st in family medicine, 1st in rural medicine, 6th in internal medicine, 8th in pediatrics, 9th in women's health, and 9th in psychiatry (US News and World Report).

UW has most consistently promoted elective psychiatry rotations in Alaska. Since the inception of WWAMI, UW has facilitated residents doing psychiatry electives in Anchorage, Fairbanks, and Juneau. The UW psychiatry residency is one of the most competitive training programs in the country. On average, 40% of all US graduating medical students interested in psychiatry apply to UW. UW fills all of its training positions. Also, UW is a magnet for physicians who are shifting careers within medicine and do a second residency.

The mission of UW's psychiatry residency is to provide the following:

- outstanding, state-of-the art, evidence-based education in psychiatry and behavioral sciences
- prepare clinicians to provide excellent and compassionate clinical care for individuals with mental illness
- foster intellectual curiosity, a spirit of inquiry, and the pursuit of lifelong scholarship
- train highly qualified scientific investigators to advance knowledge of the brain and behavior, and develop effective treatments for mental disorders

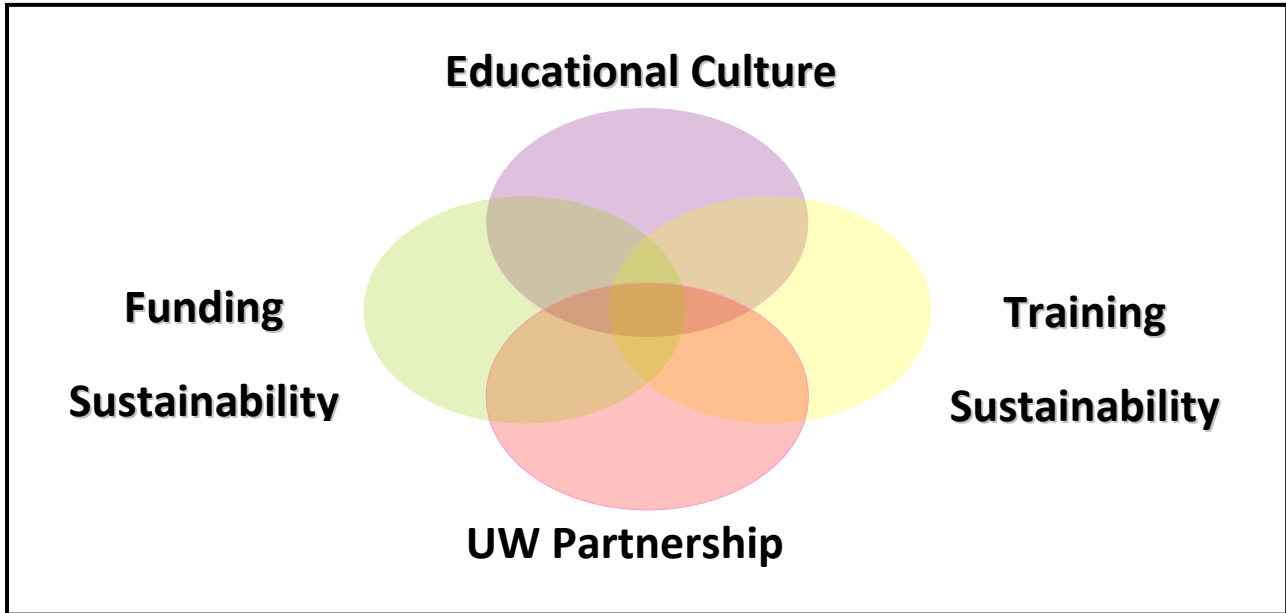
- encourage excellence in teaching
- promote collegial relationships and effective consultation between mental health and primary care providers, to best serve the medically and mentally ill
- serve the needs of disadvantaged and chronically mentally ill
- serve the needs of the WWAMI region

UW has a long history of helping Alaska health care organizations find effective strategies to meet public health and mental health needs. The UW IMPACT is an evidence-based program using physician extenders and technology to more effectively diagnose and treat depression in primary care. The UW Center for Advancing Integrated Mental Health Solutions (AIMS) is researching and guiding the implementation of mental health care integration within primary care (the patient-center medical home).

UW psychiatry residency has 20 years of experience collaborating with local partnerships to meet community needs within the WWAMI region. The Spokane Track was created in 1991 and the Idaho Track was created in 2006. The Spokane Track was originally funded and operated by a consortium including the Spokane Community Mental Health Center, Eastern State Hospital, and Sacred Heart Medical Center. Unfortunately, the Spokane Track lost two-thirds of its funding and will close in 2014. Residents completed the first two years of training in Seattle and the last two years in Spokane. The Spokane Track emphasizes adult and child & adolescent inpatient evaluation and treatment and primary care consultation. The Spokane VA Medical Center recently became a partner and training site. The closure of the Spokane Track will have a detrimental impact on eastern Washington. Access and quality of care will decrease. Indirect costs associated with inadequate care will increase.

The Idaho Track is jointly funded and operated by a consortium including the Boise VA Medical Center, St. Alphonsus Regional Medical Center, St. Luke's Regional Medical Center, and the State of Idaho. Residents complete the first two years in Seattle and the last two years in Boise. The Idaho Track emphasizes primary care consultation. Residents train at the Idaho State Hospital in Pocatello for two months during year four. The Idaho Track has had difficulty recruiting residents. It has been operational for six years and may now be transitioning into a more mature training program and gaining a reputation as a good psychiatry residency.

UW assisted Spokane and Boise design educational objectives and training experiences to best match local strengths and needs. Spokane and Idaho designed unique curricula. Dr. Deborah Cowley, the UW Psychiatry Residency director; and Dr. Mathew Layton, the Spokane Track director; and Drs. Larry Dewey and Jeralyn Jones, the Idaho Track directors; have all been invaluable in sharing information with the Steering Committee.



The Steering Committee recommends that an Alaska Track be created similar to the Spokane and Idaho Tracks. The total number of residents in training would be eleven (11). Residents would complete the first two years in Seattle and the last two years in Alaska. Beginning the second year of operations, one resident would be recruited for entrance into the second year of training. This recruit would be a physician who has already been working as a physician and has decided to switch into psychiatry. Physicians in medical specialties such as family medicine, internal medicine, oncology, and anesthesiology are sometimes drawn to psychiatry since much of their clinical work is mental health care. As noted above, UW attracts and recruits physicians seeking a career shift into psychiatry.

An Alaska Track would occasionally attract the interest of residents wishing to complete general training in three years to begin a fellowship during year four. In this situation, these residents would be in Seattle for 18 months and then in Alaska for 18 months. These residents would then need to obtain fellowship training outside of Alaska and may or may not return. The necessity for going outside Alaska for child & adolescent fellowship training may change depending on future child & adolescent fellowship training opportunities in Alaska.

Ideally, three residents would graduate from the Alaska Track each year. The Steering Committee has the following minimum goals for a successful Alaska Psychiatry Residency:

1. 66% of each graduating class remains in Alaska (at least two of three graduates per year).
2. 75% of all graduating residents over a 10 year period remain in Alaska (at least 22 of 30 graduates).
3. 90% of residents in training rate their experience as very good to excellent.
4. All residents perform at least as well as other WWAMI region psychiatry residents on standardized assessments during training and board certification after training (American Board of Psychiatry and Neurology).

The proposed four year curriculum and third year and fourth year Alaska curriculum are included as **Attachment IX**.

Alaska Psychiatry Residency: Ten Year Budget

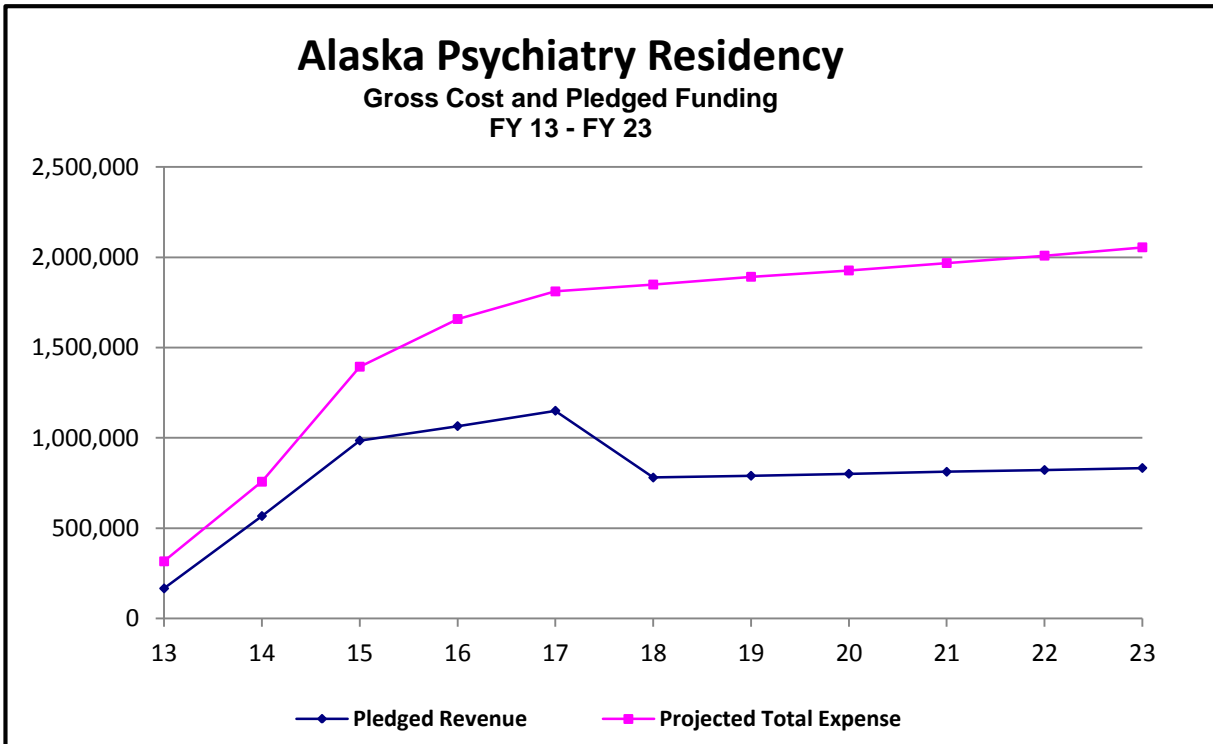
The Steering Committee has consulted with the psychiatry residency directors of new programs, track programs, the Spokane Track, the Idaho Track, and UW. The Steering Committee has tried to capture all recruiting, training, and “in kind” costs. The Alaska Psychiatry Residency – Ten Year Budget is included as **Appendix X**.

Once the residency is fully operational, the net cost will be approximately **\$100,000 per resident per year**. The cost gross cost without revenue offsets will be approximately \$172,000. The first five years will be ramping up. By the end of year six 19 residents will have been recruited, 11 residents will be in training, and eight residents will have completed training.

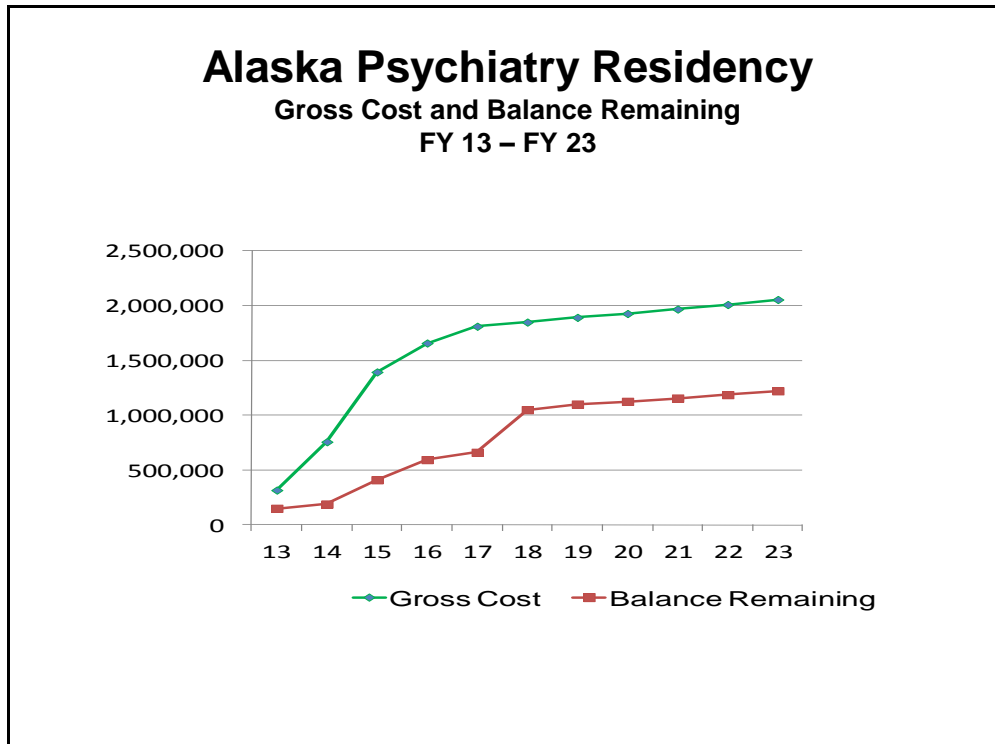
Year one will be recruiting the first cohort of residents. The net remaining cost is \$150,000. **Year two** will be recruiting the second cohort of residents and training four residents in Seattle. The net remaining cost is \$190,000. **Year three** will be recruiting the third cohort of residents and training five residents in Seattle and two residents in Alaska. The first residents will arrive in Alaska in July 2014. The net remaining cost is \$410,000. **Year four** will be recruiting the fourth cohort of residents and training five residents in Seattle and five residents in Alaska. The first residents will graduate in June 2016. The remaining net cost is \$594,000. **Year five** will be recruiting the fifth cohort of residents and training five residents in Seattle and six residents in Alaska. Year five will be the transitional year. All recruiting and educational costs will be operational. Year five will be the last year of AFHCP, APF, and AMHTA funding. The remaining net cost is \$661,000. The **year six** remaining net cost is \$1.05 million.

| Pledged Financial Support | | | | | | | |
|---------------------------|-------------------|-------------------|-------------------|-------------------|-------------------|------------------|------------------------|
| Program Fiscal | <u>1</u> FY 13 | <u>2</u> FY 14 | <u>3</u> FY 15 | <u>4</u> FY 16 | <u>5</u> FY 17 | <u>6</u> FY18 | Total FY 13 - FY 18 |
| AFHCP | \$ 20,000 | \$ 45,000 | \$ 50,000 | \$ 50,000 | \$ 50,000 | \$ - | \$ 215,000 |
| AMHTA | \$ 26,000 | \$ 100,000 | \$ 320,000 | \$ 320,000 | \$ 320,000 | \$ - | \$ 1,086,000 |
| APF | \$ 10,000 | \$ 10,000 | \$ 10,000 | \$ 10,000 | \$ 10,000 | \$ - | \$ 50,000 |
| AVAHS | \$ - | \$ 64,000 | \$ 133,000 | \$ 208,000 | \$ 290,000 | \$ 295,000 | \$ 990,000 |
| ACMHS | \$ 10,000 | \$ 10,000 | \$ 10,000 | \$ 10,000 | \$ 10,000 | \$ 10,000 | \$ 60,000 |
| FMH | \$ 30,000 | \$ 50,000 | \$ 100,000 | \$ 100,000 | \$ 100,000 | \$ 100,000 | \$ 480,000 |
| NSBH | \$ 10,000 | \$ 10,000 | \$ 10,000 | \$ 10,000 | \$ 10,000 | \$ 10,000 | \$ 60,000 |
| PHSA | \$ 30,000 | \$ 50,000 | \$ 100,000 | \$ 100,000 | \$ 100,000 | \$ 120,000 | \$ 500,000 |
| SCF | \$ 30,000 | \$ 30,000 | \$ 50,000 | \$ 50,000 | \$ 50,000 | \$ 50,000 | \$ 260,000 |
| UWSOM | \$ - | \$ 198,000 | \$ 201,000 | \$ 206,000 | \$ 210,000 | \$ 214,000 | \$ 1,029,000 |
| Total-Partners | \$ 166,000 | \$ 567,000 | \$ 984,000 | \$ 1,064,000 | \$ 1,150,000 | \$ 799,000 | \$ 4,730,000 |
| Balance | \$ 150,000 | \$ 190,000 | \$ 410,000 | \$ 594,000 | \$ 661,000 | \$ 1,050,000 | \$ 3,055,000 |
| Total | \$ 316,000 | \$ 757,000 | \$ 1,394,000 | \$ 1,658,000 | \$ 1,811,000 | \$ 1,849,000 | \$ 7,785,000 |
| Recruiting | 4 | 3 | 3 | 3 | 3 | 3 | 19 |
| Training WA | 0 | 4 | 5 | 5 | 5 | 5 | 24 |
| Training AK | 0 | 0 | 2 | 5 | 6 | 6 | 19 |
| Graduating | 0 | 0 | 0 | 2 | 3 | 3 | 8 |

The graph below shows the projected total yearly costs and the pledged partner funding.



The graph below shows the projected total yearly costs and the net balances remaining.



The cost of training residents is difficult to determine. Graduate medical education (GME) funding is separated into direct funding and indirect funding. Medicare GME reimbursement was fixed during the 1980's with subsequent increases for inflation. Different hospitals training equivalent residents are reimbursed differently depending on several variables including historic costs, number of residents, number of hospital beds, and Medicare utilization. Cromwell report that Medicare GME funding ranged from \$47,000 to \$127,000 per resident in 2001. Steinman reported that total government reimbursement ranged from \$104,000 to \$133,000 per resident in 2007. These amounts are GME funding not GME costs.

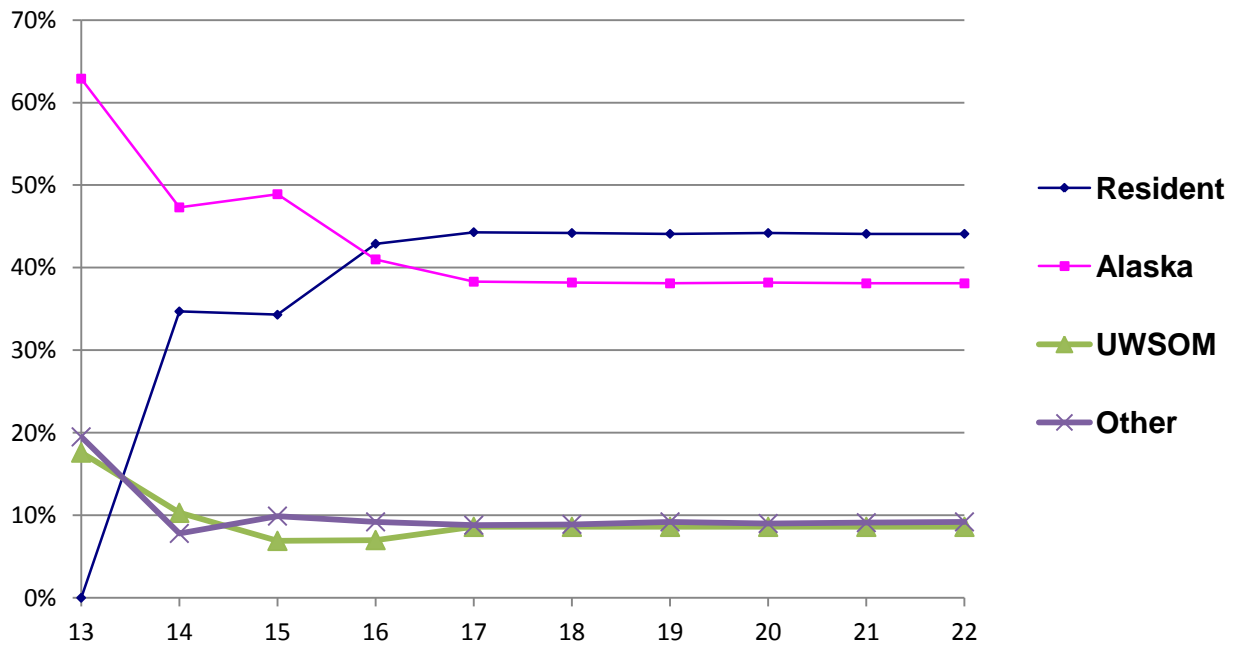
The Steering Committee consulted with Jed Magen DO. Dr. Magen is Associate Professor and Chair, Department of Psychiatry, College of Osteopathic Medicine, Michigan State University. Dr. Magen is a member of the American Association Directors of Psychiatry Residency Training (AADPRT) and has researched psychiatry residency costs and funding. In 2009 he estimated that it would cost \$150,000-\$200,000 per resident per year for Alaska.

The Steering Committee analyzed APR projected costs. When fully operational, resident salary and benefits will be 44%; Alaska administration, faculty salary, and overhead will be 38%; UW administration, faculty salaries, and overhead will be 9%; and other costs such as recruiting and moving residents from Seattle to Alaska (beginning of training year three) will be 9%.

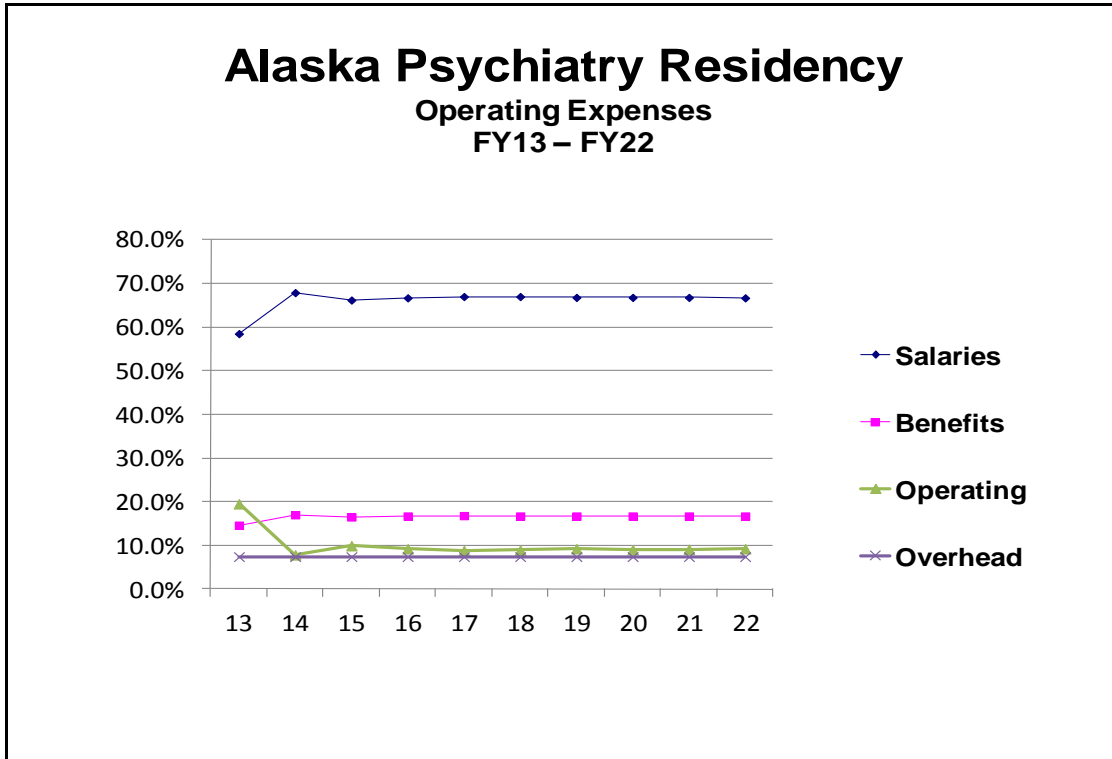
Alaska Psychiatry Residency

Operating Expenses

FY13 - FY22



Alternatively, when fully operational, salary will be 67%; benefits will be 17%; other costs will be 9%; and overhead will be 7%.



Currently, no Anchorage, Fairbanks, and Mat-Su hospital is eligible for direct Medicare GME funding for a psychiatry residency. (Fairbanks Memorial Hospital and Pacific Northwest University of Health Sciences College of Osteopathic Medicine may be considering seeking federal GME funding for a family medicine residency.)

Residents provide patient care. The Steering Committee has projected resident clinical work and possible revenue. However, using resident revenue to offset program costs is impractical. The clinical services provided by residents will be reimbursed differently depending on the clinical site and third party payer. Some clinical sites receive a patient daily encounter rate. The encounter rate may be stepped depending on both the number and specific sequence of services provided. Some clinical sites are fee for service. Moreover, it would be infeasible for one organization (ie. PHSA) to be responsible for the billing and reimbursement of resident and supervising psychiatrist services at other training sites (ie. ACMHS, AVAHS, FMH, SCF, SEARHC, or TCC). The Steering Committee recommends that resident revenue be the responsibility of each specific training site. Resident service revenue may help offset training costs at training sites. Finally, it must be emphasized that the purpose of residency is training not clinical service delivery or patient revenue production.

The Steering Committee believes that APR will provide indirect benefits as well as resident clinical service. Ten indirect benefits include:

- Recruiting psychiatrists to Alaska who want to be faculty.
- Reducing the costs of temporary psychiatrists.

- Increasing access to mental health care services.
- Improving quality of mental health care services.
- Increasing integration of psychiatry and primary care.
- Increasing the number of psychiatrists skilled in telepsychiatry.
- Improving mental health care outcomes.
- Reducing costs of inadequate mental health care services.
- Improving satisfaction of those receiving mental health care services.
- Improving satisfaction of those interfacing with the mental health care system.

A Primer on GME Funding

The US health care system lacks a comprehensive workforce plan regarding physician supply, specialty mix, and geographic distribution. This has contributed to the absence of consistent clear national goals in physician workforce efforts.

The graduate medical education system is complicated. Graduate medical education is operated by medical schools, teaching hospitals, community-based sites, the Veterans Health Administration, and the US Military.

Accurately determining investment in GME is difficult. The costs of operating GME depend on the type of institution. In general, costs fall into direct costs and indirect costs. Direct costs (DGME) include resident stipends, teaching physician compensation, administrative costs, and overhead. Indirect costs (IME) include those not directly related to teaching activities. IME payments help with the higher cost of patient care due to training. Residents are learning and less efficient. In teaching hospitals this translates into more tests and procedures, increased demands on other staff, and longer lengths of stay. IME payments also provide extra funding for the additional costs associated with the sicker patients in tertiary care teaching hospitals. Indirect costs are approximately twice direct costs.

Wynn estimated that total GME investment was \$18.7 billion in 2003. There were approximately 100,000 residents in training. Consequently, the total investment per resident was \$187,000.

The Veterans Administration is the largest provider of GME. The Veterans Administration trains approximately 10,300 full time residents, 9% of all full time training positions. The Veterans Administration provides at least some training for another 26,700 residents. Consequently, the Veterans Administration trains approximately 30% of all US residents.

Medicare is the largest public investor in GME. When establishing Medicare in 1965, Congress concluded the following:

“...education activities enhance the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees, as well as compensation of teachers and other costs) should be borne to an appropriate extent by the hospital insurance program” (House Report, 1965)

Medicare payments for GME are formula-based and linked to patient care costs. Medicare invested \$7.89 billion in 2003. Direct GME (DGME) accounted for \$2.59 billion or 32.8% and Indirect GME (IME) accounted for \$5.3 billion or 67.2%. Medicare invested \$8.8 billion in 2007.

During the 1980s and 1990s the Council on Graduate Medical Education (COGME), Graduate Medical Education National Advisory Committee (GMENAC), and Institute of Medicine (IOM), concluded that

the US had or would have a surplus of physicians. In 1997, The Balanced Budget Act reduced GME funding and capped the growth of Medicare funding. In 1999, the Balanced Budget Refinement Act offered rural hospitals the opportunity to obtain direct GME Medicare funding.

Medicare funded resident positions may be reduced if training positions are not used. Periodically there are reallocations of Medicare funded training positions from residencies that are not using them to residencies with a high need.

In 2010, the National Commission on Fiscal Responsibility and Reform recommended a 50% reduction in Medicare GME funding. If implemented, this will have a major impact on the health care system because one of every seven actively-practicing physicians in the US is a resident physician or fellow. Primary care may be the most vulnerable since 44% of all training institutions have only one program and of the single program institutions, the most common residency is primary care. Moreover, this may lead to termination of many rotations at Veterans Administration facilities for non-full time Veterans Affairs residents.

Alaska has two graduate medical education programs, the Alaska Family Medicine Residency and the Alaska Pediatric Residency. The Alaska Family Medicine Residency receives some Medicare GME funding. However, it has more residents than the Providence Medicare cap number (the number of Medicare funded resident positions). Consequently, Medicare will not fund any new residency training at Providence Alaska Medical Center without a reallocation of funded positions from elsewhere. The Alaska Pediatric Residency is a partnership with the University of Washington Children's Hospital. Pediatrics is a three year residency. Pediatric residents will be in Seattle eight months per year and in Alaska four months per year. At this point, the Alaska Pediatric Residency anticipates being self sustaining and funding the Alaska training through Alaska patient care billings.

Medicaid is the second largest public investor in GME. State Medicaid programs are not required to invest in GME. Nevertheless, most states do. There are no federal requirements regarding how states fund GME. The Centers for Medicare and Medicaid Services (CMS) use Medicare GME policy when evaluating federal Medicaid funds for GME.

In 2005, Medicaid invested approximately \$3.2 billion in GME. This was a significant increase from prior years. On average 7-9% of total Medicaid inpatient hospital expenditures have been for GME. In 2007, CMS recommended terminating federal Medicaid investment in GME. This recommendation was not implemented.

Alaska invests in Medicaid GME. Since 2002 Alaska Medicaid's goals for investing in GME have been:

- encouraging training in primary care
- encouraging training at ambulatory sites, rural locations, and in medically underserved communities
- increasing the supply of health care professionals serving Medicaid beneficiaries
- improving the geographic distribution of the Alaska health care workforce

The insurance industry does not directly fund GME because training is not a part of their core mission. However, insurance companies indirectly fund GME through the negotiated patient care payments with training hospitals. Accurately calculating insurance industry GME funding may not be possible.

Finally, the Steering Committee has considered requiring clinical service payback from resident graduates. Only the US Military and Public Health Service exchange education for service. Neither of these federal programs is comparable to a state residency program.

Increasing student loan debt itself is already discouraging residents from entering lower-paying medical specialties such as primary care, internal medicine, and psychiatry. These are the areas of most need.

How Competitive is Psychiatry? The National Residency Match Program

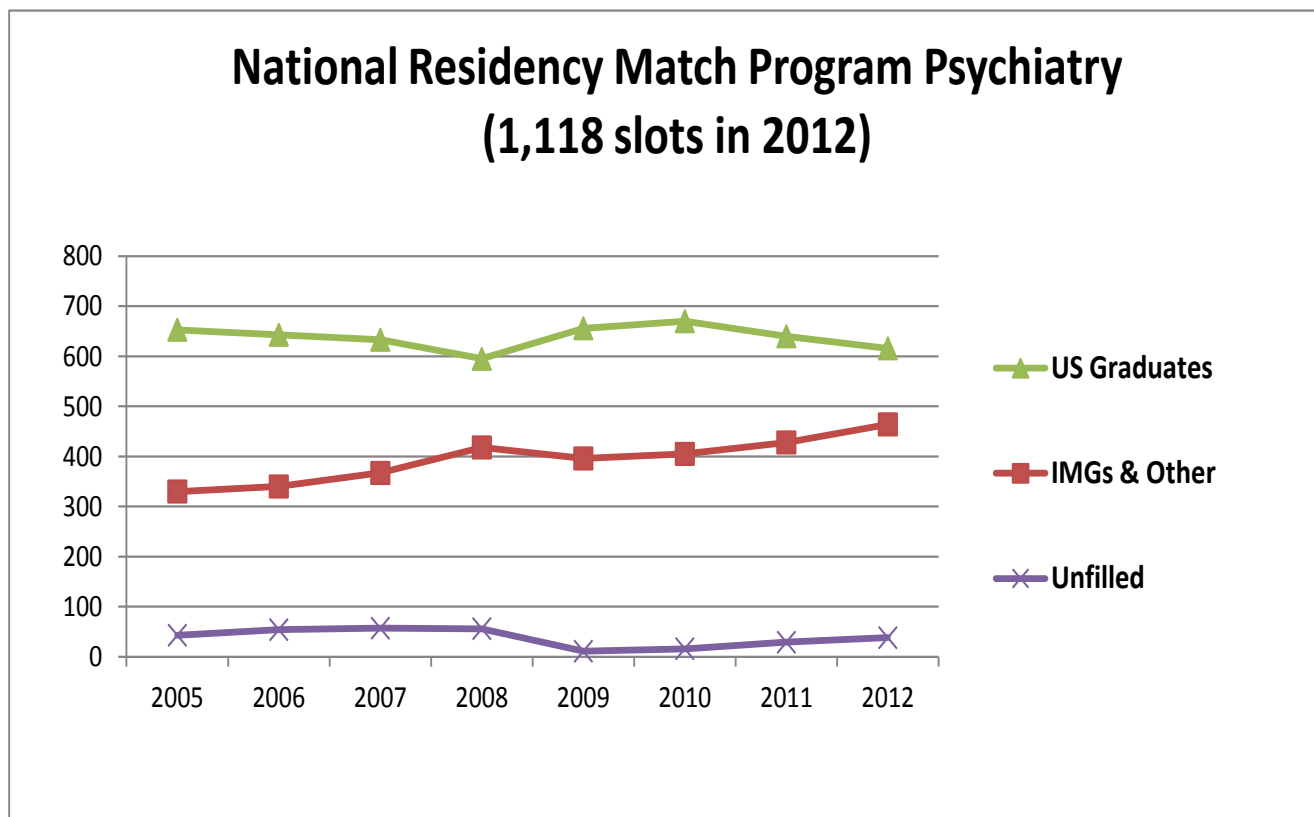
The National Residency Match Program (NRMP) sorts senior medical students into residency training programs. Graduating senior medical students rank desired training programs. Training programs rank desired graduating medical students. The results of the “match” are announced in early March.

There are three groups of possible psychiatry residency candidates:

- Graduating seniors of U.S. medical schools
- Graduating seniors of international medical schools (IMG)
 - U.S. citizens attending a medical school outside of the U.S.
 - Non-US citizens attending a medical school outside of the U.S.
- Physicians switching from another area of medicine into psychiatry

Since 2005, 2.8% of all first year training positions are in psychiatry and 4.3% of all graduating US medical school seniors go into psychiatry. US medical school seniors fill approximately 60% of first year training positions and international medical school graduates (IMG) fill the remaining 40%.

Since 2005, 3.6% (low of 1.0% in 2009 and high of 5.4% in 2007) of first year positions did not fill in the NRMP. Most training positions were subsequently filled after programs recruited medical school seniors who did not match to a training program.



Timing is of the Essence

The mission of the APRSC is to increase the number of psychiatrists in Alaska. The Steering Committee believes creating an Alaska Psychiatry Residency is the best long term strategy to increase the number of psychiatrists in Alaska.

The Alaska Psychiatry Residency will provide a steady stream of new psychiatrists and help recruit psychiatrists to Alaska seeking teaching opportunities. Residents will be learning and providing clinical care. The Alaska Psychiatry Residency will improve access and quality of mental health care and reduce the economic and social costs of inadequate and poorly managed care.

The Steering Committee envisions an Alaska Psychiatry Residency, not just a psychiatry residency in Alaska. Alaska needs to integrate psychiatry into primary care and realize the potential of telebehavioral health. The Alaska Psychiatry Residency needs the support and commitment of all Alaska. Organizations from across Alaska and all health care systems are necessary to make this a reality.

The Alaska Family Medicine Residency, Alaska Native Medical Center, Alaska Psychiatric Institute, Alaska Veterans Affairs Healthcare System, Anchorage Community Mental Health Services, Fairbanks Memorial Hospital, Joint Base Elmendorf Richardson, North Star Behavioral Health, Providence Alaska Medical Center, Southcentral Foundation, Southeast Regional Health Consortium, and Tanana Chiefs Conference have pledged to be training sites.

Psychiatrists and health care providers in many disciplines will participate as instructors and supervisors.

The Alaska Federal Health Care Partnership, Alaska Mental Health Trust Authority, Alaska Psychiatric Foundation, Alaska Veterans Affairs Healthcare System, Anchorage Community Mental Health Services, Fairbanks Memorial Hospital, North Star Behavioral Health System, Providence Health & Services Alaska, Southcentral Foundation, and the University of Washington have pledged \$4.73 million over the first six years. Letters of Support are included as **Appendix XI**.

The Alaska Veterans Affairs Healthcare System will participate in the Alaska Psychiatry Residency. Four of the 11 positions will be in Veterans Affairs hospitals and clinics. The Veterans Affairs will provide the direct education costs for residents training in Veterans Affairs hospitals and clinics.

The Alaska Veterans Affairs Healthcare System, Anchorage Community Mental Health Services, Fairbanks Memorial Hospital, Providence Health & Services Alaska, Southcentral Foundation, and the University of Washington have pledged more than \$799,000 annually beginning year six.

Providence Health & Services Alaska has agreed to be the administrative host.

Most graduate medical education programs are unable to be financially self sustainable without public support. If there was such a business model there would not be a shortage of residency

programs or physicians. The overwhelming majority of all residency programs receive a combination of federal and state investment. At the same time there will likely be turbulent times ahead for residencies dependent on federal and state GME investment.

The Alaska Psychiatry Residency needs a sustainable funding plan. This is required by the ACGME and before further steps forward can be taken. The Steering Committee believes that the State of Alaska needs to invest in the Alaska Psychiatry Residency. Only with this support will the Alaska Psychiatry Residency be able to create a sustainable funding plan.

Time is of the essence. If further development moves forward without delay, the first group of residents will be recruited during the fall of 2012. The first group of residents to begin training will be in July 2013. The first residents to begin training in Alaska will be in July 2014. The first residents to graduate will be in June 2016.

The Alaska Psychiatry Residency organizational overview is included as **Appendix XII**.

The proposed Alaska Psychiatry Residency agreements are included under separate cover.

Conclusions

- 1. Alaska has a critical shortage of psychiatrists.** Alaska is short at least 25-30 psychiatrists. The current US psychiatrist to population ratio suggests that Alaska may be short more than 50 psychiatrists. The Alaska Department of Labor estimates that there are only 59 psychiatrists in Alaska with 63% 50 years of age or over.
- 2. The shortage of psychiatrists is expensive.** This shortage increases costs associated with mental illness and inadequate mental health care access and outcomes. Costs include decreased employment, increased medical illness, increased medical services utilization, increased substance use disorders, and family harm. Inadequately addressed psychological problems in even 5% of Alaska's children may reduce their total lifetime earnings by \$831 million. National data suggests that lost earnings because of mental illness cost almost twice as much as treatment. Alaska pays top dollar to fill gaps in the psychiatry workforce. In 2009, four critical care provider organizations spent \$2.9 million for temporary psychiatrists in Anchorage alone. The cost premium was at least 50%-75%.
- 3. There is a shortage of psychiatrists nationally and Alaska is competing with most other states.** There are only three states without psychiatry residency programs (Alaska, Montana, and Wyoming). There are not enough US medical school graduates to fill psychiatry residency training positions and there is a very low vacancy rate in psychiatry residency training (3.4% in 2012). A leading physician placement company reports that demand for psychiatrists grew faster than for all other medical specialties in 2009-2010.
- 4. The best strategy to increase the number of psychiatrist in Alaska is to recruit them during training.** Alaska used to have elective rotations for psychiatry residents training outside of Alaska until the 1990s. The Trust has been funding **Elective Rotations** since 2008. One of the five residents who participated in Elective Rotations returned to Alaska and is now working at ACMHS. Elective Rotations are a step in the right direction will not be cost efficient in the long term because the Alaska post training placement yield may be 20% or less. An **Alaska Fourth Year Track Elective** is a variation of Elective Rotations. It costs more than Elective Rotations but we do not know how successful it will be in retaining graduates after training.
- 5. The best long term train and retain strategy is to create the Alaska Psychiatry Residency.** Alaska should partner with UW to create the Alaska Track. Forty percent (40%) of all US medical school graduates going into psychiatry apply to UW. UW is a leader in psychiatry primary care integration. UW is a leader in telepsychiatry. UW has effectively worked with consortiums in Spokane and Boise to develop psychiatry tracks to meet local needs. The first two years of training would be in Seattle and the last two years of training would be in Alaska. Psychiatry and primary care integration, telepsychiatry, and rural/remote consultation would be the three areas of specific expertise. The Alaska Psychiatry Residency would be the first residency to have telepsychiatry an integral requirement of the training curriculum. The goal of the residency would be to retain 75% of all graduates over any 10 year period. Partners have pledged \$4.73 million over the first six years and more than \$799,000 annually beginning

year six. The Alaska Veterans Affairs Healthcare system will be a principle partner and training site. The balance remaining for FY13 is \$150,000. The balance gradually increases to \$1.05 million in year six.

| Pledged Financial Support | | | | | | | |
|---------------------------|-------------------|-------------------|---------------------|---------------------|---------------------|---------------------|------------------------|
| Program Fiscal | <u>1</u> FY 13 | <u>2</u> FY 14 | <u>3</u> FY 15 | <u>4</u> FY 16 | <u>5</u> FY 17 | <u>6</u> FY18 | Total FY 13 - FY 18 |
| AFHCP | \$ 20,000 | \$ 45,000 | \$ 50,000 | \$ 50,000 | \$ 50,000 | \$ - | \$ 215,000 |
| AMHTA | \$ 26,000 | \$ 100,000 | \$ 320,000 | \$ 320,000 | \$ 320,000 | \$ - | \$ 1,086,000 |
| APF | \$ 10,000 | \$ 10,000 | \$ 10,000 | \$ 10,000 | \$ 10,000 | \$ - | \$ 50,000 |
| AVAHS | \$ - | \$ 64,000 | \$ 133,000 | \$ 208,000 | \$ 290,000 | \$ 295,000 | \$ 990,000 |
| ACMHS | \$ 10,000 | \$ 10,000 | \$ 10,000 | \$ 10,000 | \$ 10,000 | \$ 10,000 | \$ 60,000 |
| FMH | \$ 30,000 | \$ 50,000 | \$ 100,000 | \$ 100,000 | \$ 100,000 | \$ 100,000 | \$ 480,000 |
| NSBH | \$ 10,000 | \$ 10,000 | \$ 10,000 | \$ 10,000 | \$ 10,000 | \$ 10,000 | \$ 60,000 |
| PHSA | \$ 30,000 | \$ 50,000 | \$ 100,000 | \$ 100,000 | \$ 100,000 | \$ 120,000 | \$ 500,000 |
| SCF | \$ 30,000 | \$ 30,000 | \$ 50,000 | \$ 50,000 | \$ 50,000 | \$ 50,000 | \$ 260,000 |
| UWSOM | \$ - | \$ 198,000 | \$ 201,000 | \$ 206,000 | \$ 210,000 | \$ 214,000 | \$ 1,029,000 |
| Total-Partners | \$ 166,000 | \$ 567,000 | \$ 984,000 | \$ 1,064,000 | \$ 1,150,000 | \$ 799,000 | \$ 4,730,000 |
| Balance | \$ 150,000 | \$ 190,000 | \$ 410,000 | \$ 594,000 | \$ 661,000 | \$ 1,050,000 | \$ 3,055,000 |
| Total | \$ 316,000 | \$ 757,000 | \$ 1,394,000 | \$ 1,658,000 | \$ 1,811,000 | \$ 1,849,000 | \$ 7,785,000 |
| Recruiting | 4 | 3 | 3 | 3 | 3 | 3 | 19 |
| Training WA | 0 | 4 | 5 | 5 | 5 | 5 | 24 |
| Training AK | 0 | 0 | 2 | 5 | 6 | 6 | 19 |
| Graduating | 0 | 0 | 0 | 2 | 3 | 3 | 8 |

Recommendations

1. Create the **Alaska Psychiatry Residency**. The Alaska Psychiatry Residency has the highest probability of creating a consistent supply of new Alaska psychiatrists. It provides the opportunity to design a curriculum to specifically prepare future Alaskan psychiatrists. Partners have pledged \$4.73 million over the first six years and more than \$799,000 annually beginning year six. The balance remaining in FY13 is \$150,000. The annual balance gradually increases to \$1.05 million in FY18 (year six). This needs to be a long term State of Alaska commitment.
2. Continue **Elective Rotations** until the Alaska Psychiatry Residency is fully operational. The goal of Elective Rotations is to recruit psychiatrists to Alaska while they are in training. Investment should include funding up to 12 months of resident training per year. Elective Rotations must provide residents a diverse clinical and geographic training experience. Support the **Alaska Fourth Year Track Elective** until the Alaska Psychiatry Residency is fully operational.

These steps are doable. Our current pathway will further limit mental health care access, quality, and outcomes. Our current pathway will decrease productivity of the Alaska workforce, increase medical disability, and increase overall health care costs.