ACHI
Arkansas Center for Health Improvement

ISSUE BRIEF

ACHI is a nonpartisan, independent, health policy center that serves as a catalyst to improve the health of Arkansans.

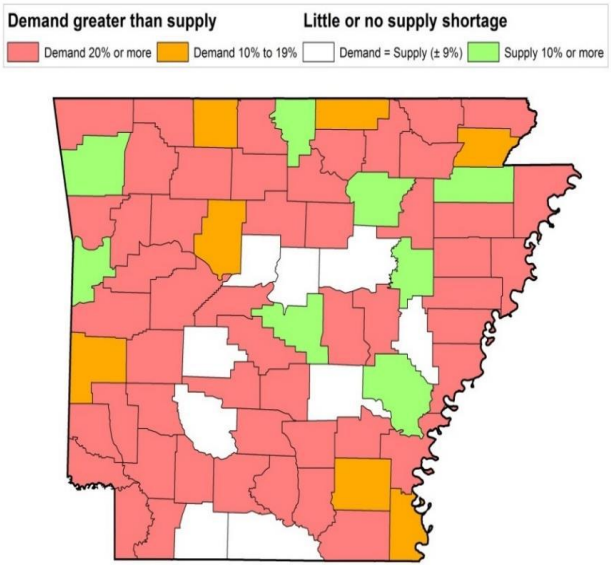
Arkansas Health Care Workforce: Forward Momentum • August 2014

Arkansas is a leader among states in health care coverage expansion under the Affordable Care Act (ACA), having the greatest percent reduction in its uninsured population compared with all other states in the country.[1] *Extending opportunities for coverage to low-income Arkansans is a major step toward improving access to the health care system, but the state must take additional measures to ensure a healthier Arkansas. Among these important measures is a focus on enhancing the state's health care workforce. In response to this need, the state engaged in comprehensive workforce strategic planning beginning in 2011, which led to the state's first health workforce strategic plan entitled* Arkansas Health Workforce Strategic Plan: A Roadmap to Change*. Since the strategic plan was published in 2012, the state has made meaningful progress toward meeting the plan's goals. Although the development of new health profession schools was not among the recommendations of the strategic plan, two new osteopathic medical schools have been proposed as a means to address health workforce challenges. This issue brief will explore the state's progress toward addressing health workforce shortages, the emergence of plans for two osteopathic medical schools in Arkansas, the education and training requirements for the doctor of osteopathic medicine (DO), and the status of clinical training positions for physicians in the state.*

ASSESSMENT OF THE STATE'S PRIMARY CARE WORKFORCE

National and local studies have identified the state's primary care workforce deficiencies, with critical shortages in a majority of rural counties.[2,3] A recent study by the Arkansas Center for Health Improvement (ACHI) confirmed the presence of primary care workforce shortages relative to service demand in the population, but identified provider maldistribution as the overriding concern (see Figure 1).[4] The study estimated that as of 2012, Arkansas had a supply of 2,077 primary care physicians with a 15% (360) shortage in primary care physicians relative to the demand in the population. The state's primary care physician workforce shortages—although somewhat mitigated by the state's supply of advanced practice nurses (APNs) and, to a lesser extent, physician assistants (PAs)—and the more evident provider maldistribution issues will not be remedied without policy changes.

Figure 1: Adequacy of Supply and Demand of Primary Care Providers by County (2012)



Source: Arkansas Center for Health Improvement. *Arkansas Health Care Workforce: A Guide for Policy Action*, March 2013.

Expanded coverage for Arkansans is expected to result in increased demand for health care services. Consistent with the trend across the nation, Arkansas's elderly population is ever increasing, which corresponds with mounting health care needs.[5] The *Arkansas Health Workforce*

Strategic Plan: A Roadmap to Change highlighted many of the state's current and upcoming challenges and provided recommendations on how to meet these needs. The plan set forth the following goals:[3]

- Support the implementation of and transition to team-based care that is patient-centered, coordinated, evidence-based, and efficient;
- Enhance and increase the use of health information technology;
- Increase the supply and improve the equitable distribution of primary care providers; and
- Adopt new financing, payment, and reimbursement policies and mechanisms.

The plan was intended to be the first step in a larger commitment to ensure that the health workforce in our state would meet the present and future health and health care needs of Arkansans.

Progress on primary care workforce supply

Higher education institutions have mobilized and are beginning to make progress toward improving primary care workforce supply. The University of Arkansas for Medical Sciences (UAMS) increased medical school enrollment from 150 to 174 beginning with the matriculating class of 2009. Plans for two new osteopathic medical schools—one in Fort Smith and the other in Jonesboro—have been approved by the Arkansas Higher Education Coordinating Board. A new PA program has begun at UAMS, which will graduate its first class in 2015. Harding University admitted 36 students in its PA program for the 2013 fall semester, an increase of almost 119% since 2005.[6,7] Since 2012, UAMS, Arkansas State University (ASU), the University of Arkansas (UA), and the University of Central Arkansas (UCA) have been offering doctor of nursing programs. These are in addition to the nurse practitioner programs currently offered at UAMS, ASU, and UCA.[8]

The federal residency cap and physician population growth

Despite the progress of the higher education institutions in generating more graduates, bottlenecking issues plague the physician pipeline. A cap on graduate medical education (GME) residency positions has been in place since the implementation of the Balanced Budget Act of 1997 (BBA),[9] which capped residency funding based on a snapshot of 1996 residency position needs. Medical school graduates must complete a GME residency program to become a practicing physician. The GME residency program is primarily supported by federal funds flowing through to accredited hospitals. Under the Affordable Care Act (ACA), initiatives are underway to recruit and retain primary care providers in rural and underserved areas; however, the ACA provided only minimal increases to what is the biggest limiting factor to increasing the health care workforce—the federal limit on residency positions.

The cap on residency positions severely impacts Arkansas's primary care physician supply. This is recognized in Arkansas's health workforce strategic plan, which recommended that the number of residency slots in primary and preventive care—especially those dedicated to rural practice—be expanded. Among the most telling factors for determining where physicians are likely to practice is where they serve their residency.[10] Consequently, increasing the number of primary care residencies in rural areas is an effective way to increase physician supply in medically underserved areas.

UAMS has added 30 additional family medicine residency slots with funding that became available through the ACA. These positions are being phased in at six per year from 2011 through 2016.[11] In addition, UAMS was recently the recipient of a $900,000 grant to support six family medicine

residencies at UAMS West in Fort Smith.[12] While this represents some progress toward addressing supply issues, these additional primary care residencies will not be sufficient to fully address Arkansas's demand for primary care services.

Federal support falls short by capping residency spots

With federal funding for residency spots only increasing minimally, additional medical school graduates from UAMS and the two new osteopathic medical schools will increase the pool of graduates competing for Arkansas's residency spots. The Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine have both spoken out recently about their concerns regarding the cap on residency programs.[13,14] Increasing the number of medical school graduates in Arkansas—both allopathic and osteopathic—without increasing the number of residencies in Arkansas, will inevitably drive the state's medical school graduates out of state for their residency training.

Several hundred US medical graduates—including 18 from UAMS—did not procure a residency position during the 2014 residency match.[14] If residencies do not increase lock step with increasing numbers of medical school graduates, the projected physician shortage nationally cannot be adequately addressed. A compounding factor is that one-third of the current US physician population is projected to retire within the next 10 years and 10,000 baby-boomers turn 65 and eligible for Medicare every day.[14]

Allopathic and osteopathic medical school graduates both compete for the same residency spots, and beginning next year, medical school graduates from both disciplines will use the same match system. As plans for the educational component of osteopathic medical schools progress rapidly, neither Arkansas osteopathic program has put forth a comprehensive plan to address the insufficient number of residency positions available in the state. It is also unknown whether the new osteopathic schools in Arkansas will employ a minimum enrollment quota for state residents, as is the legal requirement for UAMS.[15]

Conclusion

Arkansas has embarked on a complex set of interrelated initiatives designed to transform our health care system by achieving greater access, improved quality, and contained cost. Recommendations in Arkansas's health workforce strategic plan highlight the most promising methods for meeting our access challenges. Maldistribution of health care providers must be addressed with corrective actions. Simply adding new health professional graduates in the pipeline is not sufficient. State and federal officials and our educational institutions must take a more comprehensive approach to addressing health care workforce issues and more accurately identify the leverage points for improving the state's supply of primary care providers and incentivizing them to locate in areas where they are most in need.

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