UTAH MEDICAL EDUCATION COUNCIL

Meeting Minutes
May 28, 2015
Held 12:00 p.m. UMEC offices

Council Members Present:
Wayne Samuelson (Chairman)
Mark Hiatt
Doug Smith
Mary Williams
Sue Wilkey (by phone)
Larry Reimer
Gar Elison

Council Members Excused:
John Berneike

Other Individuals Present:
Sri Koduri

Staff Present:
Ric Campbell
Jenna Christensen
Julie Olson
Clark Ruttinger
Elizabeth Nagelhout
Rachel Richards
Andrew Salt

Motions:

- The February 3, 2015 meeting minutes were approved unanimously.
- The report was approved for printing pending the approval of the Dental Workforce Committee.

Action Items:

- Ric will talk to SUU about creating a hierarchy for rural rotation participation. That hierarchy will be brought back to the Council.
- Sri will add an emphasis statement in the Dental report on the need for continuing and strengthening preventative treatment for Medicaid children.

Handouts:

- Agenda for 5-28-2015 Meeting
- Minutes of the 2-3-15 Meeting
- Dental Workforce Report

1. **Call to order and approval of 2-3-15 minutes – Wayne**
   The 2-3-15 minutes were approved unanimously.

2. **Enhancements to online Retention Data - Ric**
   Ric began by introducing Rachel Richards, who is a new intern for the Council. Ric demonstrated the enhancement that Jaron had made online to the retention data. The map shows where residents are going upon completion of their residency. That map can be viewed at: http://www.utahmec.org/retention2.php

3. **Rural Rotation Program – Funding Medical Students – Ric**

   SUU (which administers the rural rotations funded by the UMEC) has inquired as to whether we expand the scope of funding to medical students. The federal funding for medical student rural rotations has gone away. In as much as the Council will be revamping the rural rotation program next year as the OB/GYN support is phased out (eventually freeing up $200,000 in funding), the

funding for medical students might be considered through that allocation process. Dr. Smith asked if it would only be U of U medical students doing the rotations. Ric indicated it would certainly include U of U students, but there would need to be a screening process to make sure that students have Utah ties. Dr. Smith thought it would be beneficial to know the hierarchy that is used to determine who gets funding – he has heard anecdotally that it's hard to get those positions and they are often taken (not funded by the UMEC) by out-of-state DO students (who often even pay for the rotations themselves). Dr. Samuelson mentioned the DO school that is potentially going up in Cedar City and the possibilities for students from that school. The only concern in that regard is that Rocky Vista might send students from other schools in the nation to use those rotation slots. Sue Wilkey expressed the need to make sure that the students have a deep interest in understanding rural health in Utah. Dr. Hiatt suggested using a RIP, rural index probability which would indicate the candidate's probability of practicing in Utah – the key factor being their place of birth. Sri added that Oregon has instituted a charge for anyone coming in from out of state to do a rotation. This practice might be something Utah could institute. Also, an assessment of the number of rotations needed for all medical profession rotations would be helpful in order to prioritize among in-state institutions.

Action Item: Ric will talk to SUU about creating a hierarchy for rural rotation participation. That hierarchy will be brought back to the Council.

4. **Dental Workforce Report – Sri**

Sri presented her findings on the dental workforce.

Highlights

- 1,667 active provider dentists in Utah
- Dentist-to-100,000 population ratio at 58.4 (56.8 in 2006)
- One dentist in Utah for 1,723 Utahns (one dentist per 1,760 Utahns in 2006)
- Race & Ethnicity
  - 1.3% (22) dentists belong to races other than Caucasian compared to 8.3% of Utah population
  - 1.0% (17) of the Utah's dentist workforce is Hispanic compared to 13.3% of Utah population
- Gender
  - 2.5% (42) of Utah's dentist workforce is female (1.6% in 2006)
  - 14.9% of the mountain region is female
  - 22.2% of the national dentist workforce is female
- Average age of 48 years, 49.8 years nationally
- Average age of retirement 67, about 44/yr will retire over the next decade along with 7.8 FTE/yr loss to reduction in hrs.
- 77.8% (1,296) are general dentists and 21.8% (364) are specialist dentists
- Average annual gross production: $534,149 Average annual net income: $159,141
- 34.5 hours per week in patient care
- About 7.5% of Utah dentists earn more than 20% of their gross production in the form of Medicaid dollars
- About 76.4% of dentists reported providing charity
  - A general dentist provided $16,910 worth of dental care to about 37 patients in a year (~$457/patient)
  - A specialty dentist provided $23,901 worth of dental care to about 24 patients in a year (~$996/patient)
- Of the 29 counties in Utah, 25 are classified as a full or partial county Health Professions Shortage Areas

- 17 full-county low income; 2 full-county geographic; 9 Comprehensive Health Center; 5 Native American Tribal population

Workforce Projection Summary

- Utah does not face a shortage of dentists.
- There is not enough evidence to support an over-supply projection.
  - Fewer dentists retiring
  - Significant decline in patient wait times
  - Average patient care hours per week remained the same for most specialties (exception: periodontics declined and oral surgery increased)
  - Slight decline in gross production and net income levels. However, this decline is in line with the income trend of the healthcare industry given the recession of 2007-2009 (Bureau of Labor Statistics, 2012) and with the national dentist income trend which was at its peak in 2005 and has not recovered growth with the economic growth post-recession. (Munson & Vujicic, 2014)
- Access to under-served areas and populations continues to be a problem

Recommendations

1. Improve the Public Awareness of Oral Health
    1. Team: Utah Oral Health Coalition and the Utah State Department of Health Oral Health Program, Dental schools, the Utah Dental Association, the Utah Dental Hygiene Association and the various other oral health champions in Utah
    2. Approach: Public awareness campaign – both as a health and a social justice determinant
2. Address the racial and ethnic imbalance in Utah dentist workforce
    1. Team: Dental schools, Utah Oral Health Coalition, Utah Medical Education Council, and the Utah State Department of Health Oral Health Program
    2. Approach: Admissions criteria and cultural competency training in the two dental schools in Utah
    3. Approach: Promote awareness and availability of dental education resources like scholarship and loan reimbursement programs for minority populations
    4. Approach: Create partnerships between high school counselors and Utah pre-dental and dental programs
3. Address the gender imbalance in Utah dentist workforce
    1. Team: Dental Schools, Utah Dental Association, Utah Medical Education Coalition, and the Utah State Department of Health Oral Health Program
    2. Approach: Consider changes to admission criteria of the two dental schools in Utah
    3. Approach: Increase efforts through the Utah Department of Health and Utah Dental Association to attract and retain more female dentists
    4. Approach: Understand why there are so few female dentists in Utah and address the identified causes through combined efforts of the Utah Medical Education Council and the Utah State Department of Health Oral Health Program
4. Improve access to dental care for the underserved
    1. Team: Utah Department of Health, Utah Division of Occupational and Professional Licensing, Utah Medical Education Council, Utah Oral Health Coalition and other stakeholders as appropriate for each approach
    2. Approach 1: Strengthen and promote loan reimbursement programs that encourage dentists to practice in rural areas which encompass underserved areas and populations
    3. Approach 2: Increase provider capacity to provide care through improved Medicaid reimbursement rates and inclusion of preventative and restorative oral health services for adults in Medicaid and Medicare programs.

4. Approach 3: Oral health services should be included in the Essential Health Benefits package defined by the Affordable Care Act and the Essential Health Benefits covered by Medicare programs
5. Approach 4: Encourage portable and mobile service programs like the Family Dental Plan
6. Approach 5: Encourage student and resident subsidized rotations
7. Approach 6: Encourage charity care drives and provide incentives to dentists and hygienists participating in these programs (CE for volunteer work etc.)

5. Assess and meet changing workforce needs
    1. Team: Utah Medical Education Council, Utah Oral Health Coalition, Utah DOH Oral Health Program, Dental Schools, other stakeholders
    2. Approach 1: Demand and Access Assessment – Develop a system that periodically assesses demand and need for dental services in Utah. This system could include need for services, service availability and its utilization, quality, outcomes and sustainability in the state.
    3. Approach 2: Workforce Supply Assessment – Retention rates of the dental school graduates in Utah should be closely monitored along with practice location choices to measure their impact on Utah's workforce supply and distribution.

Dr. Smith expressed concern over the needed emphasis for preventative care for children – Medicaid children having difficulty getting access.

Action Item: Sri will add an emphasis statement in the Dental report on the need for continuing and strengthening preventative treatment for Medicaid children.

Motion: The report was approved for printing pending the approval of the Dental Workforce Committee.