Committee of Interns and Residents
SEIUHealthcare

RECOMMENDATIONS ON MEDICAL STUDENT DEBT AND PHYSICIAN TRAINING

SUBMITTED TO THE CALIFORNIA 1115 WAIVER RENEWAL EXPERT STAKEHOLDER WORKGROUP ON WORKFORCE

Introduction

A well-functioning Medi-Cal system that innovatively tackles questions of cost, quality, and equity requires planning to ensure that California has not just an adequate healthcare workforce today, but the best possible healthcare workforce of tomorrow. Nowhere is that more true than in the physician workforce.

Every major study of what works and what doesn't in terms of cost-control and quality improvement finds that a "bought in" physician workforce that sees the benefit of rigorous delivery system reform for themselves and for their patients is essential to success. Given their leadership role within the care team, physicians are critical to delivering both high quality, cost-conscious care, culturally appropriate and linguistically sensitive care. Although there are good points to be made on both sides of the debate as to whether the nation is facing a calamitous physician shortage or not, everyone can agree that the system we have in place today has created a mismatch between the available physician supply and the needs of a well-functioning healthcare system[i]:

- A surplus of specialists and insufficient numbers of primary care physicians;
- Health professional shortage areas juxtaposed with areas with an overabundance of doctors; and
- Further mismatches between the communities and patient populations who are most in need of high quality, culturally-competent care, and the background or skill sets of available physicians.

The Committee of Interns and Residents/SEIU Healthcare (CIR/SEIU), the nation's oldest and largest union of resident physicians, with 13,000 members nationwide and over 3,000 in California, believes that this latest Medicaid Waiver could make meaningful progress on matching the skills of future physicians to the needs of a transformed Medi-Cal system. Over the past few years, our union has focused not just on representing the interests of today's doctors-in-training, but also on partnering with our employer teaching hospitals to foster intensive work in the areas of education and competency that will yield the physician workforce we need for tomorrow.

Given this experience, we have a few recommendations on how to create incentives to make sure our physician supply is not just adequate, but is producing the right skills to execute the core mission of delivery system reform while improving quality and reducing health disparities.

The problem: medical student debt and its effect on physician supply.

There are two primary economic drivers that determine what specialty a physician decides to practice, for which patient communities, and for what coverage programs. These are the reimbursement rates from different payers (Medicare, Medicaid, private insurance, or other) they can expect to be paid for their work and their debt burden from medical school and other higher education. Successive rounds of cuts to Medi-Cal reimbursement rates have certainly made it more difficult to retain and attract new physicians in private practice to treat the patients

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who rely on Medicaid. But medical student debt has played a role as well in making it more difficult to accept those reimbursement rates.

Educational debt is an area that must be addressed to attract diverse candidates into the profession and to have qualified physicians practice in geographical areas or practices with relatively poor remuneration. According to 2011 data from the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine, the average debt for a recently graduated physician was $205,674 for osteopathic medicine residents and $162,000 for allopathic residents. CIR members consistently cite student debt as an issue that concerns them personally. Since the elimination of the deferment program known as the "20/220 Pathway," residents are faced with either having to repay their loans from their salary during residency or forbearing. Forbearance can save them from making payments during training, but on many occasions, can double or even triple their debt since interest continues to accrue depending on the loan. The size and repayment of loans clearly factor into future decision-making for many.

Recommendation 1. Design the Medicaid Waiver to expand medical school scholarships and/or tuition-free opportunities for under-represented minority and low-income students and to provide additional support for those who commit to serving in health profession shortage areas upon completion of residency training.

California has benefited from programs like the National Health Service Corps, its own state loan repayment programs, and debt relief for healthcare workers through the Health Professionals Education Foundation. These programs have demonstrably yielded a pipeline of new physicians who choose to practice in shortage areas and in primary care. California has also benefited from the Song-Brown program, which has created incentives at the institutional level for health professional education, including medical schools, to increase the number of underrepresented minorities working in primary care.

These programs have a clear track record of success, and provide a natural link to help serve California's Medicaid population now and in the projected future. As such, they ought to be expanded, both in terms of funding, but also in terms of mission, as we outline in Recommendations 2 and 4.

Recommendation 2. Increase the amount of debt relief to state loan repayment recipients who have demonstrated additional training, competency and skills to provide culturally and linguistically appropriate care to an underserved population relying on the Medi-Cal program.

Clinical and policy researchers have unequivocally documented that health disparities exist in the United States because of socio-economic status, race and ethnicity. Significant gaps exist in virtually all health indicators from infant mortality and life expectancy, to the management of chronic disease and access to potentially life-saving or life-extending procedures.[ii] The U.S. Department of Health and Human Services has repeated and consistently urged health systems to focus on cultural and linguistic competence as a critical tool to reducing health disparities, with additional benefits for patient safety, improved quality, and reduced cost.

Many medical students, resident physicians, and post-residency physicians have recognized the importance of culturally competent care and the benefits of that care for their patients. They have gone above and beyond the requirements of their educational institution or residency program to seek out elective opportunities to improve their competencies in this area. This includes elective rotations in community health centers, learning a new language to better serve a current or future patient population, international rotations to better understand the unique circumstances and health challenges of recent immigrants, and other cultural-competence training programs.

As part of the application process for debt relief, recent physicians ought to qualify based on demonstrated additional training or proficiency in delivering culturally and/or linguistically appropriate care for a high-need Medi-Cal population.

Recommendation 3. Expand the funding for the Song-Brown program or develop a parallel program to incentivize public healthcare systems and teaching hospitals to achieve the elements of the HHS Office of Minority Health (OMH) National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care.

In addressing the problem of persistent health disparities, the Song-Brown program has always taken an expansive approach – focusing on registered nurses as much as physicians, and not just on who gets to become a health professional but how they are trained. This year's application for educational institutions to receive Song-Brown funding gives an array of priority areas to focus on, including community engagement and health literacy, developing more career pathways for under-represented minority groups, fostering more team-driven care, and increasing opportunities for e-health and telemedicine.

Although culturally and linguistically appropriate care is one of these priorities, more could be done to create incentives for health systems to engage in the cultural change needed to successfully provide robust culturally competent care.

The HHS Office of Minority Health has recently revised its CLAS standards by which organizations can demonstrate their commitment to reducing health disparities and measure their progress towards creating culture and systems that truly take the specific needs of their patient population into account. Already, healthcare organizations in California have voluntarily adopted a number of these standards. An article in the *New England Journal of Medicine*[iii] cites the Alameda Alliance for Health for its robust model of language assistance and Kaiser Permanente for its National Diversity and Inclusion body that ensures full compliance with the CLAS standards.

Specific funding should be made available through an expanded Song-Brown or other parallel program for institutions wishing to transform themselves using the standards as a blueprint. This is particularly important for teaching hospitals, as the culture of these institutions that leaves an indelible mark on the career choices physicians-in-training will make.

Recommendation 4. Increase the amount of debt relief to state loan repayment recipients who have demonstrated additional training, competency and skills in Quality Improvement and who will work post-residency in a public or safety-net hospital in a role that is focused on quality improvement and patient safety.

The Accreditation Council on Graduate Medical Education (ACGME) now requires that residency programs and teaching hospitals train residents in quality improvement and systems-based practice. With the contemporary paradigm of team-based care and systems-based practice, this is essential for the financial survival of teaching hospitals – particularly those serving large numbers of Medicaid and uninsured patients. In a punishing economic environment, safety-net hospitals with low profit margins will not survive if they face cuts to reimbursement rates due to high-cost substandard care.

Residents understand the case for quality. They are well aware that inefficiencies are a main driver of healthcare costs in the United States limiting equitable access to necessary care, and that there can be no health justice

without the *safe* provision of care. "Do No Harm" is a powerful appeal to their professionalism, and residents' staggering workloads are a prime incentive to identify and address inefficiencies to the provision care.

Yet our experience has shown that most resident physicians are insufficiently utilized by their employer hospitals. "One off" educational projects designed solely to fulfill an individual resident's educational portfolio requirement are not the same as the real life experience of being included in ongoing quality improvement projects, root cause analyses, or team-based problem solving. Too often residents are bogged down in service requirements and treated as "renters, not owners" – disengaged from the hospital's larger safety and quality goals.

CIR believes that residency and fellowship curriculums need to emphasize education that will develop physician leadership skills so that graduates will be fluent in leading multi-disciplinary heath care teams. Our organization has championed a collaborative approach to improving safety, quality and efficiency at the teaching hospitals that employ our members.

But it's also critical to retain those new physicians who have demonstrated an aptitude for quality improvement and systems redesign to instruct and influence the next generation of physicians.

As part of the application process for debt relief, recent physicians should qualify for additional relief based on demonstrated "above and beyond" training or proficiency in quality improvement and patient safety if they choose to practice in a medically underserved area. Physicians, regardless of specialty, should also qualify for debt relief if they agree to work for a public or other teaching hospital that treats a patient population that is majority Medi-Cal or uninsured, regardless of whether situated in a shortage area, in a role related to quality improvement, patient safety or delivery system reform.

Summary

The physician workforce necessary to accomplish the goals of delivery system reform in the *Affordable Care Act* and successive Medicaid Waivers needs to be properly balanced in terms of geographic distribution, primary care vs. specialization, and representative of the diverse communities that it serves. California now has the opportunity to experiment with new incentives to recruit and retain physicians who have demonstrated the ability to deliver culturally and linguistically appropriate care, are able to recognize and more effectively treat health disparities, and who can lead the delivery system reforms necessary to improve safety and quality. We urge you to take these recommendations as your starting point for creating a physician workforce of the future to better serve Medi-Cal's patient population.

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[i] Health Resources and Services Administration, Bureau of Health Professions, *The Physician Workforce: Projections and Research into Current Issues Affecting Supply and Demand*, December 2008.

[ii] *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, National Academies Press (2003). *Racial/Ethnic Differences in Cardiac Care: The Weight of the Evidence*, Henry J. Kaiser Family Foundation and the American College of Cardiology (2002). *The National Healthcare Disparities Report*, DHHS (2006). *CDC Health Disparities & Inequalities Report – United States* (2011). The *Role of Unconscious Bias in Surgical Safety and Outcomes*, Surg. Clin. N.Am.137 (2012).

[iii] *Culturally and Linguistically Appropriate Services — Advancing Health with CLAS.* Howard K. Koh, M.D., M.P.H., J. Nadine Gracia, M.D., M.S.C.E., and Mayra E. Alvarez, M.H.A. N Engl J Med 2014; 371:198-201