UNIVERSITY OF NEW ENGLAND
INNOVATION FOR A HEALTHIER PLANET

Biddeford Campus
11 Hills Beach Road
Biddeford, ME 04005
U.S.A.
(207) 283-0171

Portland Campus
716 Stevens Avenue
Portland, ME 04103
U.S.A.
(207) 797-7261

Tangier Campus
Rue Abi Chouaib Doukkali
Tangier 90000
Morocco
+212 05 38 80 24 00

www.une.edu

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Senator Rafferty, Representative Brennan,
and members of the Committee on Education and Cultural Affairs,

My name is Jane Carreiro. I am the Dean of the University of New England College of Osteopathic Medicine (UNE COM) and a family doctor by training. I am testifying Neither For Nor Against LD 129. I thank Senator Baldacci for identifying a very difficult and critical problem facing Maine, a lack of physicians, and indeed a lack of all healthcare professionals practicing in rural Maine and underserved areas of the state.

UNE has been working closely with Northern Light, MaineHealth, Maine General, Central Maine Health, the Maine Hospital Association, and the Maine Primary Care Association, for many years on addressing the specific problems of training, attracting, and retaining physicians in health professional shortage areas throughout Maine. UNE's College of Osteopathic Medicine is the number one provider of physicians for the state of Maine. Our graduates make up the majority of physicians in every health care system in Maine, with 67% of them practicing primary care compared with 32% of other medical school graduates practicing in the state. Progress is being made on the physician shortage, but there is still much work to be done. This past year we extended our coalition's efforts to all health professions, and the University of Maine system and the Maine Community College system joined this group in sponsoring a proposal to develop a mechanism to better identify opportunities to train medical students and other health professions students in Maine.

Years ago, prior to moving to UNE, I had a very busy family practice in Waterville, which I loved. When I first when into practice, I became very busy, very quickly. I was astonished that some of my patients were driving 60-90 minutes to see me because there wasn't a family doctor with an open practice any closer. This was early 1990s, and our neighbors in rural areas were already dealing with a physician shortage. Since then, it has only worsened. I decided I could help more patients by training medical students who would want to practice in rural areas, and so I took a position at UNE. Almost thirty years later I am now dean of a medical school, and I am still working to get more medical students to practice in rural areas. However, in those thirty years I have learned some things, and I would like to share them with you. The answer to getting more physicians to practice in rural areas is not simply creating more students.

The two best predictors of where a physician will practice is where they do their clinical training, (years 3 and 4 of medical school and then their residency), and where their partners are from.

After two years of mostly classroom training, medical students do 2 years of clinical training and then enter a residency program. Doing clinical training in community and rural-based hospitals as a student, increases the likelihood a physician will choose to return to those communities to practice. From 2012 to 2018, between 35% and 53% of UNE COM's graduates who completed third year training in a Maine community hospital returned to practice in those communities, regardless of where they did their residency or where they were from. Likewise, medical school graduates who complete their residencies in rural and community-based settings are also more likely to practice in those settings. In Maine there are two bottlenecks to increasing our physician workforce: our capacity to train third- and fourth-year medical students in Maine and the number of residency positions that are available. The first limits how many medical students we can train and the second limits how many physicians we can graduate, and these both effect the choice to practice in Maine.

UNE is a private university with a public mission. We understand the health care workforce shortage and are trying to respond in real time by increasing our medical school class. As part of that process, medical school accreditors require that we research the capacity to train students in clinical settings. Our recent analysis of Maine's capacity for training medical students demonstrated that the Maine health care system can accommodate an additional 35 students. That's it. Thus, UNE is increasing our class size by 35 students. If the healthcare system in Maine could accommodate more than that we would not be limiting ourselves to 35.

What are the factors that limit capacity? Medical students need to be trained by physicians, and Maine has a physician shortage. Training medical students results in a loss in productivity, calculated at 25% nationally. Put another way, if a doctor can typically see 4 patients in an hour, the addition of a medical student will slow them down and only allow them to see 3. This results in lost revenue, and hospitals, especially our community hospitals, are struggling to keep up with patient loads and expenses. They do not have the personnel or financial resources to take on more students. There are 223 third year students enrolled in Maine-based medical schools each year. Our state's health care system currently trains only 120 third-year medical students - that is 70 from UNE, 45 from the Tufts Maine track program and 4-5 from Quinnipiac and Brown. The remaining 103 must leave the state to get their third-year clinical experiences. Thus, each year, the State effectively loses the opportunity to retain 103 physicians. Absent a total overhaul of healthcare payment in the US, we need to find ways to make up for the lost productivity associated with sponsoring student trainees by perhaps subsidizing hospitals, clinics, and/or clinicians that participate in training students.

The second bottleneck is the limited number of residency positions in Maine. Unlike a short-term "rural rotation," embedded training in a rural or community-based residency program engages physicians with their communities and prepares graduates to practice in those environments. In the entire State of Maine, considering all hospitals and programs, we can only graduate 65 primary care physicians each year: 4 obstetricians, 7 pediatricians, 31 family doctors, 4 psychiatrists, 13 internal medicine, and 4 combined internal medicine-pediatrics. Each

year 223 medical students graduate from Maine-based medical schools, but only 65 of them can complete primary care residencies in Maine. Residency programs are accredited through the Accreditation Council for Graduate Medical Education (ACGME) and supported by Center for Medicare and Medicaid Services (CMS) funding. The ACGME accreditation process can pose challenges for rural community hospitals. The (CMS) payment calculation system for graduate medical education (GME; i.e., residencies) favors academic medical centers; places caps on successful rural residency programs making expansion difficult; and penalizes community hospitals that may have previously allowed "visiting residents" from GME institutions. Some states, such as Washington and Utah, have stepped in with funding to assist and support community and rural hospitals with GME expansion to train and retain a larger physician workforce.

Lastly, physicians in rural areas tend to see fewer but more complicated patients, and our reimbursement system is based on procedures and volume, not spending time teaching someone, for example, how to care for their diabetic mother. Physicians finishing residency are often overwhelmed by the difference between the debt they carry and their predicted income from rural practice. The Doctors for Maine's Future program has made a significant impact on those students fortunate enough to receive it, and expansion of that program could help many more.

Many of us in the state are working collaboratively to address our healthcare workforce crisis. Recently, members of the aforementioned group worked together to submit proposals to DHHS's Maine Healthcare Workforce Initiative. As a result, MaineHealth received funding to expand resident training in rural areas, and both Northern Light and UNE were signatory supporters on that proposal. The larger group efforts were also extended to all health professions, and as I mentioned, the University of Maine system and the Maine Community College system joined this group to help identify opportunities to train medical students and other health professions students in rural Maine.

These are all small steps, and we need to do more. Even if the University of Maine successfully launched a medical school, without additional clinical training slots and residencies, the result would be more students seeking training and placements out of state and rural Maine would likely continue to be underserved.

Later this session, President Jackson will introduce legislation to expand clinical training, residencies, and loan repayment for health professionals to incentivize the healthcare workforce to train and stay in underserved areas throughout Maine. With or without a new medical school at the University of Maine, these opportunities and incentives are critical to retaining students in Maine to practice and contribute to their communities.

Maine has been facing a growing physician shortage since I left my practice 30 years ago to help tackle this issue. Since that time, I have learned that increasing the number of students is the

easy answer, but not necessarily the most effective part of the equation. Without significantly increasing the number of opportunities available for students to train in rural and community settings, and expanding residency opportunities throughout the state, increasing the number of medical students will only result in more students leaving Maine to train and practice.

Thank you