Physician Workforce: The Next Generation

Alliance for Health Reform
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[START RECORDING]

ED HOWARD: If you want to try to take a seat, we'll get started. I appreciate your taking note of and observing the earlier start than normal so that we can accommodate some of the schedules of our speakers.

My name's Ed Howard with the Alliance for Health Reform and I want to welcome you on behalf of Senator Rockefeller, Senator Collins and our board of directors to this program on how our healthcare workforce, especially physicians, will be able to handle the demand, or maybe more precisely, the need for doctor services in an era of health reform.

Now, one aspect of this has to do with the likely spike in demand for physician services, particularly primary care physicians, when 30 plus million more Americans gain coverage in the coming years. Another important strand relates to how our physician education and training structure is able to keep up with even current needs. As a smaller proportion of new physicians choose primary care and the nation ages to look more like me than like you, we're going to have some disconnects there.

Now, today's program is going to help us learn more about both of those aspects of the workforce situation and the impact of the new reform law on it. Now, we want you to know

that we know there is a lot more to the healthcare workforce than doctors and their training.

That's why we're planning to look at the supply and use of other healthcare professionals in a briefing on December 2nd in cooperation with our colleagues at the Robert Wood Johnson Foundation. And then later in December, we're going to take a look at how delivery system changes and payment changes might affect the situation.

As I alluded to, our partner today in sponsoring this briefing is the Robert Wood Johnson Foundation, the nation's largest philanthropy devoted exclusively to health and healthcare.

And we're pleased to have with us today Dr. David Krol who's the senior program officer for RWJ's Human Capital Initiative, and, as we were noting before the program, he's also a pediatrician. In fact he was selected as a pediatric leader of the 21st century by the American Academy of Pediatrics and the Johnson & Johnson Pediatric Institute.

David, thanks very much to you and Brian Quinn and your colleagues for support and help in putting this briefing together. Let me turn to you at this point for some words about the foundation and your role in it.

DAVID KROL: Great. Thanks, Ed, and thanks to the team for putting together such a great program this afternoon. The

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mission of the Robert Wood Johnson Foundation is to improve the health and healthcare of all Americans.

Through our Human Capital portfolio, we've invested in preparing health professionals for leadership, enhancing the skills and careers of frontline health workers, training scholars to conduct health policy research, and encouraging the diversity of people working in health and healthcare to better serve the needs of a demographically and culturally changing America.

Many of the individuals in whom we've invested have been physicians, through programs such as the Clinical Scholars Program, the Harold Amos Medical Faculty Development Program, the Physician Faculty Scholars and Generalist Physician Faculty Scholars and others. We recognize that physicians are but one member of what, ideally, is a team of individuals who work to maintain the health of our society.

We also recognize the physician workforce conversation should not only be about the numbers of physicians, but is, importantly, about the diversity of individuals who enter medical schools, the content of their training, the roles they play in inter-professional healthcare teams, their distribution throughout the country and the environment within which they work, which in so many ways is affected by the educational, legislative and professional policies we'll touch upon today.

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I look forward to the discussion. Thank you all for joining us today and Ed, thanks again to you and your team.

ED HOWARD: Great. Thanks, David. Before we get into the program let me just do a little housekeeping. In your packets, you're going to find a lot of background information including extensive biographical information on our speakers, more than I'll have time to give them. You'll also find PowerPoint presentations that you can follow along.

There are things we did not put in the packets to save a few trees. You can read those at allhealth.org, our website, and we'll have a webcast and a podcast available of this briefing tomorrow on the Kaiser Family Foundation website, kff.org. Thanks to them for that service. And we'll have a transcript of the briefing in a few days on our website.

There are green cards that you can use for questions as well as some microphones that you can use to ask them at the appropriate time and a blue evaluation form that I would urge you to fill out to help us improve these programs as we go along. Now, let's get to the program.

We have assembled an incredibly knowledgeable group of panelists today and they're going to give some brief presentations and we'll get to the Q&A and the interchange among the speakers that we find so useful, forever, in this series. And we're going to lead off with Ed Salsberg.

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Ed is the director of the brand new National Center for Health Workforce Analysis in HHS's Health Resources and Services Administration, HRSA. I'll let Ed describe that center and its relation to the also new National Healthcare Workforce Commission. Many of you know him from his service as the director of the Center for Workforce Studies at the Association of American Medical Colleges, or from when he founded and directed the Workforce Study Center at the University of Albany's SUNY. Ed, thank you for being with us and we look forward to your comments.

ED SALSBERG: Thank you. It's a pleasure to be here and I really appreciate the focus and the interest on health workforce which we recognize as really being critical to the success of our efforts at improving the healthcare delivery system. The – let me start my brief comments by noting some – making some general comments around where we are.

Now clearly, an adequate supply and distribution of health workers, including physicians, is essential to assuring access to quality care. Even before the Accountable Care – the Affordable Care Act, the nation was facing a shortage due to a growing and aging population and an increasing array of interventions.

And so health care reform will add to the demand for services, but the nation was facing serious challenges in any

case with the growing population and the aging of the US population. In fact, the impact of health care reform on demand is less than the impact is going to be of the aging of the US population and the growth of the population.

The procedures, the programs and policies supported by the Affordable Care Act and the American Recovery and Reinvestment Act will increase access and reduce the likelihood of shortages in the future. And I'll come back to this because I think this is a key point.

The question of whether there are going to be future shortages really reflect what's going on with both the supply and the demand for health services and healthcare reform, while it will increase the demand for services by covering an additional 30 million Americans, it will also give us tools that I think will help us avoid serious shortages in the future.

The nation faces both general shortages and distribution problems, and I know sometimes it's hard to separate those two out, and we know that there are significant shortages in underserved areas, both urban and rural. Some of that is caused by the general shortage and then there are communities that are not currently facing shortages that we worry will be facing shortages in the future.

There are also significant gaps in our knowledge and this is particularly important if we want to design more effective programs both for the supply and for the use of health workers. And so, more information and data is needed if we're going to design effective programs. In the end, increasing the supply, whether it be physicians or nurses or other health professionals alone is not going to be sufficient to assure access. We really need to look at how we can redesign the delivery system to make more effective use of the workers that we do have.

The Affordable Care Act includes numerous provisions that will encourage innovation and systems redesign. Just real briefly, let me mention the workforce planning and workforce information provisions of Healthcare Reform that I think are going to be critical in the longer term.

First is the creation of the National Health Care Workforce Commission, and I'll leave it to Tom to talk a little bit more about the commission. But as you know, the commission was recently appointed by GAO and it has a significant role in terms of workforce development.

The second piece is the National Center for Health Workforce Analysis, which is located in HRSA in the Department of Health and Human Services, and the center, which will work closely with the commission when it is established, that has

already started to do more to collect data and analyze data that will hopefully inform policy makers across the country.

And I really view our audience as being not only federal policy makers in the commission, but also states and local communities who play a critical role in decision making around the health workforce. So, health care reform also includes a program to support state health work force development grants.

Some of you may know HRSA awarded 26 grants in late September, 25 of which were planning grants to states that developed their workforce plan in capacity and in the long run, theses are going to be critically important to effective workforce planning at the state level.

And then finally, a health care workforce program assessment. The ACA includes additional support and focus on the need for evaluating which workforce programs are effective. And that's going to be critical as we try and identify strategies that work in the future.

Real briefly, the center, the National Center is going to be involved in developing workforce capacity and we're going to be looking, doing projections on a wide range of workers, health workers. Not just the licensed workers, we're concerned with the whole health workforce across the board.

We recognize it's going to be critical for us to disseminate that information and make it easily available to policy makers, to people across the country, through universities and others that are trying to assess their investments in the health workforce. We're going to support research and we're going to support an expansion of the evaluation of Title VII programs and as I said, we'll work with the state health workforce development grantees.

Let me briefly touch on what are some of the key physician workforce issues that we are concerned about. Clearly, the general shortages; we're concerned not only about the general shortages, there's a particular concern about primary care – if you're going to redesign the delivery system to be more effective and efficient in the long run, you have to assure there's an adequate primary care practitioner workforce; clearly mal-distribution; and then inadequate diversity of the existing workforce.

As many of you know, the American Recovery and Reinvestment Act included significant funding for health professions. Over $200 million was spent on expansion for health professions ranging from primary care to public health, nursing and diversity programs and other programs. This was a significant investment. In addition, the Affordable Care Act

included additional funding and programs to try and increase the supply of primary care practitioners.

I think these are going to be important contributions, but no doubt, we're facing major challenges in assuring an adequate overall supply of health workers. But it's really not just the supply, and as I mentioned, you're going to have to look at other strategies in addition to increasing supply if we're going to assure an adequate workforce to meet the future needs.

And so the healthcare reform legislation included major expansion and support for the National Health Service Corps, one of the most effective programs in addressing the problem of mal-distribution; major support for community health centers critical to serving Americans in underserved communities; support for oral and behavioral health; higher Medicare and Medicaid reimbursement rates around primary care; as you know, some support for teaching health centers; a major, major investment in health information technology; and policies around insurance billing simplification.

Again, I think you need to look at the whole picture. Increasing the number of physicians alone is not going to be sufficient to assure that we have access to quality care in America. Let me finish by saying that, as I said, that assuring adequate supply is going to be a major challenge.

We recognize that this is really a top priority for HRSA, the Bureau of Health Professions for this administration, to identify effective strategies that will both increase the supply and address the problems of mal-distribution.

The Affordable Care Act provides us with very valuable tools that will help us. There's a lot more that we need to do to understand which tools can be used most effectively where, but it really does provide us with the infrastructure and the support, I think, to go forward and build the health workforce that we need for the future. Thank you.

ED HOWARD: Great, thanks very much, Ed. Next, we're pleased to welcome Dr. Tom Ricketts who's on the faculty of UNC - Chapel Hill School of Medicine, also the Director of Health Policy in the Cecil Sheps Center for Health Services Research at the university. He's also a nationally recognized expert on access to care for rural and underserved populations, and as Ed Salsberg just alluded to, he has been just named to this National Health Care Workforce Commission that Ed Salsberg and his colleagues are going to be providing data and analysis for. So we're very pleased, Tom, that you could be with us and give us sort of an on the ground look at some of these things.

DR. TOM RICKETTS: Thank you very much. I'm sorry I have a little scratchy throat. I got too exuberant on my bicycle last week in the cold air.

But I'm presenting good news and bad news about the health workforce provisions of the Affordable Care Act and then future policy decisions that are looming before us in workforce. And I think we can look at things from the Pollyanna standpoint and be happy or we can look at them from the Grinch standpoint, but let me start with the Grinch first off and say that really, what congress did in the Affordable Care Act was really reauthorize a lot of existing programs.

The Affordable Care Act really brought together a reauthorization package for many Title Seven and other workforce related programs. It did new things, but in the main, it really reauthorized existing programs. And it did them in a way that did not reflect very much on the past performance of those programs and it was good to hear that Ed was talking about performance assessment and evaluation because we really have pushed out a lot of programs without understanding what they do and how well they do it. And especially comparing those places where they're done very well with those places where they're not done so well at all.

These programs that include geriatric education centers, area health education centers, special training programs for diversity and focused primary care in the main seem to work well, but specifically, we don't know which ones

work best and which ones maybe we ought to think about either getting rid of or dealing with in a different way.

We do need to have more evaluation in the programs. We can't go from an assessment in the prior administration of our workforce programs as being, as I quote "not effective" to them being really the centerpiece of what we're going to do in health workforce policy in the United States. So we have to focus on performance and really do some honest and objective assessment.

The commission that was created -- when I first thought about this before becoming part of the commission, I called it a debating society, potentially a debating society -- in my Grinch point of view because it really reports to everyone. That's good news and that's bad news. It really doesn't have a specific mandate for setting policy or making policy, but in reporting to the people, the congress and the administration.

So it's a policy-recommending commission and it functions right now in a de jure sense rather than a de facto sense. In fact, I am not talking about the commission to you as a commissioner because I'm not allowed to talk about commission business at all. So, you either didn't hear that or you heard it from someone else [laughter].

We are taking – there is a – we're upsetting some of the apple cart in terms of graduate medical education by

proposing some things that are going to perhaps destabilize a GME system that has worked for so long. We have new mechanisms for supporting graduate medical education in the Affordable Care Act, but they may in turn actually be a little bit more of an irritant to the system than a stimulant to improvement in the distribution of practitioners.

Now taking Pollyanna's view, we do have experimentation. We have new things; we have new ideas that have come about. We're talking about teaching health centers. We're talking about doing things that we've wanted to do for a long time which is train practitioners in ambulatory care settings to give them the practical experience so that they're on the ground running doing the things that we need to do in primary care. This is promoted strongly in the Affordable Care Act.

And we're also creating outreach structures. We're trying to bond together the elements of the health system with the training system so that we have a more realistic process of preparing physicians in the healthcare delivery system that we have.

We have, perhaps a – if we look at it as bringing all these things together in this reauthorization, we might have created a tipping point where we really are moving toward inter-disciplinary practice and inter-disciplinary training and

that's a – there is potential there for this tipping point to have been achieved to where we are beginning to talk about not just inter-professional care, but within accountable care organizations that function as coordinated systems that bring paid for services together with inter-professional training in a way that's going to make the system work much better.

Now, I was reminded when I put up the point about nurse leadership that this was a physician-focused discussion. But really, when we talk about nurse leadership assuming a role in these coordinated systems, we are talking about some accommodation in the physician leadership or the physician-dominated system.

And so, just by saying that and proposing that, especially with the release of the IOM report recently, we are asking the physicians to accommodate, we're asking the systems to rebalance the leadership structures in their organizations. So we're looking at coordination and we're looking at integration across the system in this Affordable Care Act.

Now, there are new things in the bill as well, not just reauthorization, but we took the excellent example of the performance with trauma systems and added in provisions that would help support the training and the expansion of trauma care systems.

We have — trauma care is one of those examples of well-coordinated systems which were able to show excellent outcomes and excellent impact. And they're implemented in a cost-conscious way in the systems where they're implemented. They're not necessarily cost efficient, and as anyone who runs a helicopter program will tell you. But they are a model for how you can manage across institutions, across problems, across professions. The same for transplant, cancer care and some other specially focuses services.

We have a new provision that provides a 10-percent bonus for surgeons in HPSAs. This is an expansion of this HPSA notion into specialties. And that's a dramatic —

ED HOWARD: Tom?

DR. TOM RICKETTS: Yes?

ED HOWARD: I was just going to say you might just tell some of us who don’t get steeped in acronyms what HPSAs are.

DR. TOM RICKETTS: HPSAs are Health Professional Shortage Areas and I'm sorry, they — I spent nine years developing a proposal for revamping the HPSAs which is now being argued out here in Washington, and it's a way in which you allocate, you identify populations in places that are underserved and that are eligible for various types of support, primarily for National Health Services Corps. But also, they

become eligible for bonus payments for all Medicare patients for physicians who practice in those HPSAs.

We have some focus loan repayment models in this program, in the Affordable Care Act. We also have some direction for redistributing GME toward primary care. That's not so new, we have redistributed GME slots, and the way in which the system works is we designate places where people can be trained called slots to become specialty physicians.

But the ACA has a strong primary care bent and that is the dominant policy in workforce – is to move toward a primary care coordinated system, and we're doing this through various mechanisms in the Title VII program, but we are not necessarily creating a primary care led system. We're talking about incentives toward that end.

The unresolved things that are going to have a huge effect on distribution and numbers of physicians were not resolved. We didn’t really specify what we're going to do in the balance between generalists and specialists. We talked about primary care medical homes and accountable care organizations, but we have left up the leadership and coordination to the organizations themselves to resolve, and this is going to create not just fights over turf, it's going to create real practical management problems as to how you do coordinate services within complex systems.

We are talking about geographic adjustment to payments and we're talking about relative values in bundling. We've got some things that need to be done by commissions and committees that are going to affect, in the way they pay physicians, the distribution of physicians. We have to remember there is a real economic effect in our physician supply.

Now, the legislative things, if you – I haven't, I don't know, I haven't – my cell phone hasn't gone off to tell me what the latest plan for SGR is, but it's a moment by moment thing. But it's a big deal. It's a really big deal. It's a really big deal symbolically and practically to physicians, and it's got to be solved.

Tort reform -- the Simpson-Bowles Commission had a lot to say about tort reform, and a lot to say that would favor the position of physicians. So maybe the dam will break on that, but it's left up to the Congress to decide. And GME in general, really, we haven't solved that problem of whether we're getting our money's worth in GME and whether we're spending too much and how we can efficiently pay for GME.

So medicine is going to be, I said – mentioned – the nurse policy, it is going to be affected, but we're also – there is market response to the facts that Ed has brought out about a shortage of physicians. New medical schools are emerging, new programs are emerging. There is incremental

addition into the supply, but we've done that without changing the GME mix and that's what we need to do because a doctor trained in a medical school is not a doctor prepared for practice.

So if I'm – I started my professional career in Washington working for the Washington Monthly and I was a journalist and you always ask – you've got to know – who, what, where, when, why and how. And my ”who’s” are really, are we going to have the same advocacy groups fighting each other as the Grinch would think about, or are we going to create a new inter-professional culture that is going to allow us to make these integrated systems work well?

We've got states doing different things. Some states do marvelous jobs and others don't do so well in this. Are we going to pay attention to the good ones or are we just going to smear the system to where it's going to really allow for inconsistency across states?

We've got problems, an urgency of reform running up against both politics and the training cycles that we have. You can not start right now and have doctors on the ground in one or two years. But have we turned the corner about patient centeredness with our new HCOs and primary care medical homes? That's to be answered, but we're doing it one more time in trying to coordinate care, and maybe this time is the charm.

So, the how, will the commission ever get money to meet, I don’t know. Will the money run out that we have? Will things ever get off the ground? I mean, these are big questions. And Mr. Grinch answers one way and Pollyanna answers the other.

ED HOWARD: Thank you for those two presentations, Tom [laughter].

DR. TOM RICKETTS: It's cost efficient.

ED HOWARD: Finally, let's hear from Dr. Jay Crosson who's the Senior Fellow at the Kaiser Permanente Institute for Health Policy. He was the founder and first head of the national group representing Kaiser Permanente's total physician workforce. He spent the last six years on MedPAC, the last two as vice chairman and curiously, he too is a pediatrician by training, in addition to some fellowships in infectious diseases and I want to know, where are the geriatricians we need? But I guess we'll be privileged to have two pediatricians on the panel. Jay, thanks for being with us.

DR. JAY CROSSON: Thanks, Ed, and the only difference between David and I is about 30 years or so. So this is what it looks like after you've been a pediatrician for 40 years, David [laughter]. Just to warn you.

Well, thank you, Ed, and thank you, David for inviting me here. What I'd like to do is talk about an interface

between some of the work that I did while I was on MedPAC and some of the work that we've done and the experience that we've had in Kaiser Permanente.

So the question – and in your packet there, it's the nice robin's egg blue pages if you can't find it – the question really has to do with not necessarily the number of physicians or distribution or the like, which are important issues, but the question of whether physicians coming out of training now have the knowledge, skills and sense of professionalism that we're going to need for future healthcare: this notion of, whether it's 21st century medicine or accountable care organizations or system based care or whatever you want to call it.

So as I said, I spent six years on MedPAC and one of the issues we worked on was this question, at least some aspects of GME. For those of you who don't know MedPAC, and I suspect most of you do, is an advisory body to the Congress. It's been around now for 13 or 14 years and if you're interested in the work that MedPAC does, and you don't know already, you can access that at the website that I have below there, which is www.medpac.gov and all the proceedings of MedPAC, as well as the official reports are available on that website.

In general, MedPAC provides two bodies of advice to Congress. One of those has to do with how much the Medicare program should pay for services across the various types of payments. And that generally is most of the body of the report that comes out in March.

In June, based on deliberations during the year, MedPAC publishes an additional report which tends to focus more on advice around policy changes, structural changes or the like for the Medicare program. And in this June report in 2010, we focused on some issues relating to graduate medical education, and I think that chapter is in the material as well.

So this report was based on a series of discussions over a series of years. And it's basically predicated on the fact – and I think many of you know that, perhaps you don't – that the Medicare program pays a substantial amount of the money that it takes to educate residents in American hospitals. In fact, it's in the range of about $9.5 billion a year that the Medicare program pays to educate physicians.

Technically, that money is divided up into two pools. One is called direct medical education or direct graduate medical education, and that pays for the salaries of the individual residents. And then there's another pool of money called indirect medical education payments which are meant to

compensate hospitals for intangible costs they incur in the training program.

One of the questions that we entertained on MedPAC during that period of time was this question: Is the money that's being spent by the Medicare program being spent wisely and are there some changes that could potentially be made to get better value for the American taxpayer? Specifically, areas of concern about the undersupply of primary care physicians, you've heard that discussed already.

Questions about whether that has to do with the fact that the site of training for residents is often primarily in the hospital, whereas for many physicians, the site of practice actually is not in the hospital anymore – it's in the office and the like – and that the role models the physicians may be experiencing in training may not be the role models for the rest of their life.

But we specifically also focus on this question about whether the knowledge-based skills and the sense of professionalism that physicians are going to need to practice in health systems in the future are being inculcated systematically during residency training, or whether in fact, as our experience has been, they often have to be learned later.

And maybe that's just the way it is, but maybe it doesn't have to be that way; that in fact, training could be adjusted to some degree so that that's not quite such a difficult transition.

So we addressed this issue and made, I think, what I would probably say is rather bold recommendations, some would say rather controversial, some would say misguided recommendations in the June report. Ashley is looking at me – no, she's just teasing me, I guess. Okay.

And despite the fact that we fully recognize that US residency training programs are among the best in the world and that the ACGME, the Accreditation Council for Graduate Medical Education, has urged many of these changes that we're talking about for some years through their initiative which they call competencies, that in fact the rate of change has not been fast enough and that the specialty mix continues to be a problem, and that there are issues around the skills and knowledge as I said.

And we found in our April public meeting the following: that the GMA system should embrace a more systematic effort to instill the skills and perspectives needed to accelerate the development of high quality, high value and efficient delivery systems including, but not limited to, issues such as evidence

based medicine, team based care, care coordination and shared decision making.

We then proceeded to make the following recommendation: that Congress should authorize the secretary to change, in the future, the funding of graduate medical education in a specific way. That after consultation with appropriate groups, and this would certainly include individuals in associations involved with training, that there should be the creation of certain standards that would direct training to solve some of those issues that I described.

And that, in fact, in the future, half of that IME payment, approximately $3 billion, should be redirected. Not taken out of training, but redirected towards those institutions who are leading in the direction of changing the educational process in a way that I think even they wish that they would do.

So one of the questions that I then had going back home after finishing my six years in June was, you know, what was our own experience in Kaiser Permanente with respect to the readiness of physicians as they came out of training programs? So we have a very large organization as you know. I focused on northern California which is where I have spent my career, 33 years or so.

There we have 21 hospital based medical centers, about 7,000 physicians, and each year, we hire somewhere between 200 and 500 physicians. So we have a lot of experience in this and we have a lot of experienced individuals who do this. These are the department chairmen or the chiefs, we call them, of medicine, surgery, ob/gyn, et cetera, et cetera.

I actually took the summer and did a survey of these individuals, about 80 chiefs of internal medicines, family practice, pediatrics, et cetera, and asked them what they thought about the knowledge base, the skill levels and the sense of professionalism that were coming out of residency training programs, and these are programs all across the country. We ended up – it was a pretty open-ended survey, I didn't try to guide it in any way – and we ended up with information regarding seven areas.

First of all, I have to say this: the general sense was the quality of residents was excellent. We, as I said, we have wonderful training programs in the United States. But the survey focused on what was missing. So I'm going to talk about what was missing. It's not in any way meant to suggest that we don’t have very competent residents.

And the results ended up in seven areas, and I'll go through those rather briefly. We can talk more later if you'd like. Office-based competencies, care coordination, continuity

of care, clinical information, technology capabilities, leadership and management skills, something called systems thinking and then certain procedural skills.

In each area, there were deficiencies. Nearly half of the chiefs who were hiring individuals noted that they often lacked basic office practice skills. This is not a surprise. As I said, most of the training takes place in the hospitals. We have recommendations from MedPAC that that should change to the extent that it can.

Things like managing minor depression, anxiety, chronic pain, simple dermatology, headaches, minor orthopedic problems, the kinds of things that bring all of us, particularly those athletically-inclined or under stress, which is probably everyone in this room, to the doctor's office.

I think sometimes, physicians actually learn on the job as opposed to in residency training programs. I think more concerning are issues around care coordination. This was noted spontaneously by about a third of the chiefs, issues like long term consistent care for chronic diseases like diabetes, congestive heart failure, asthma. The ability to use what we call panel management tools which are tools physicians can use to track how their patients are doing over the long term – a bit of a surprise to most residents.

Nearly two thirds mentioned issues of continuity of care. That means the notion that when you're a physician and you take care of a patient and that patient is ill, really, that patient remains your responsibility until you're sure that there has been a confident set of – a hand off to other individuals who have taken care of that person.

That's still a part of physician professionalism, but it feels to many of our physicians like it has changed a little bit as a consequence of perhaps different attitudes about work and time and perhaps led to more hand offs than we would like to see in our medical system.

We were surprised to find that in the area of information technology, there was not quite as much of a difference as I had thought. And I just noted when David was giving his comments a few minutes ago, he didn't have a pile of paper in front of him like I did. He had this little device that he was looking at and I was quite amazed. I'm going to ask him later what that was [laughter].

Some issues in the area of leadership and management skills, issues that we don't really expect in residency, but are important in an institution, like running a meeting, managing a project, solving problems and the like, I think need to be taught later and, perhaps, could be part of residency training.

What we call systems thinking is the sixth one. That's a little complicated area, but it has to do with things like does it really matter how much the cost of care that the physician creates, does that matter or not? Or should all tests be ordered on everybody all the time? Or is there some responsibility that physicians have for the overall cost impact of their decision-making processes? Population management again, and particularly, I think, experience with systematic management and improvement of quality which we like to see in systems and I think there could be more focus on in training programs.

The last one was a surprise to us and had to do with the lack of certain procedural skills. And I know a number of the specialty societies, ob/gyn particularly, are becoming concerned about whether the training programs as they exist now, because of changes in technology or changes in work hours and the like, are actually allowing residents to come out of training programs with the sense of confidence and competence that they need to do complicated surgery and the like. And we have actually had to add to the mentoring and proctoring program over the last few years because of that problem.

So in summary, I think the data that we've put together suggests that MedPAC's recommendation was, albeit controversial

from a financial perspective, was based on reality and directed in the correct direction.

And that if Congress chooses to go in this direction, then based on what you heard earlier about the Affordable Care Act, there will be an organization hopefully soon to be funded, the Workforce Commission, and others who can actually work on this issue and incorporate issues around competencies into a larger set of questions about the size of the physician workforce and the size of its distribution, et cetera. Thank you.

ED HOWARD: Great. Thank you very much, Jay. Now we get to the point of your being part of this conversation. There are microphones on either side toward the rear of the room. There are green cards if you will fill out a question and hold them up, we will snatch them from you – there's one right over there – and bring them forward.

Let me just ask very quickly, sort of a remedial education question. A couple of folks were kind of scratching their heads when the discussion of SGR came up. Would someone like to flesh that notion out a little bit? It actually is a lot more immediate and potentially painful than a lot of the things we're talking about. Tom?

DR. TOM RICKETTS: I mean, Jay – the MedPAC.

DR. JAY CROSSON: Oh yeah, MedPAC always takes it in the neck on the hard stuff [laughter]. This has to do with how physicians in fee-for-service Medicare are paid. And the issue as you probably know is the Medicare program pays fee-for-service for office visits and procedures and the like. But there is no part of the legislation authorizing Medicare that allows Medicare to take into consideration directly the volume of services, the number of services provided.

So in 1997, Congress, after discussions with the American Medical Association decided to support a new payment formula called the Sustainable Growth Rate or SGR formula which essentially was designed to auto-correct year after year for the number of services provided by the physician community.

And to make it – to simplify something that's very complicated -- physicians, the pool of income for a physician payment in Medicare would go up by roughly the gross domestic product, whatever it happened to be, minus a percentage decrease for the increase in the number of services provided during that observation year.

And that formula, which appeared to work for the first few years, over the last decade or so has provided negative so-called updates if there's such a thing, negative updates to physicians because the volume of services has exceeded the correction for increases in the gross domestic product.

Most of the years except one, Congress has overridden the formula. The formula is cumulative and so, based on what's called current law, there is a huge deficit that has accumulated over that period of time which I think is somewhere in the range of about $300 billion or roughly that. And in order to change the formula and scrap it, Congress is faced with a deficit-raising conundrum because that money would then be added to the deficit.

So what has gone on, and the debate every year now is should we, in effect – Congress, this is – can we resolve this fundamentally and create a new formula, but then have to deal with a deficit issue? Or should we make a temporary correction and continue working on the long-term solution? And that debate is underway again.

ED HOWARD: Go ahead, Ed.

ED SALSBERG: I would just add in terms of – the practical fact is the current extension patch expires at the end of November. Physician payment rates under Medicare would drop about 23 or 24 percent December 1st, which would obviously cause a good deal of disruption to many physician practices, and there's a real need for Congress to address this in the coming weeks.

ED HOWARD: Take note of that. Tell your bosses. Yes, go ahead and I'd ask all of our questioners to identify themselves and keep their questions as concise as possible.

BOB ROEHR: Bob Roehr with BMJ. Two sort of inter-related questions. One of the more recent creations in this matrix is…PCORI effectiveness and patient centered are some of the key words in there. What is the role of this group, body, or do you foresee a role for this body in terms of physician education, and if so, what is that? And secondarily, the question is what is the physician's role in terms of educating their patients to be able to make informed healthcare decisions?

ED HOWARD: Sure. Jay?

DR. JAY CROSSON: Okay, I'll take the PCORI question and this is a little embarrassing because I can speak about it primarily because my wife was appointed to it. But I don't have any secrets.

This was – PCORI, of course, was again, an issue addressed at MedPAC during the time there and that was just – question is, you know, is there – are there – things about how medical care should be delivered that are obvious kinds of questions, like is this treatment better than this treatment, that are not getting answered currently because nobody is funding research on those questions.

And sometimes, you know, there are relatively simple ways of taking care of a medical problem, and some relatively costly and expensive ones, and nobody wants to fund the research to answer the question, which one works better? And sometimes, people call that comparative effectiveness research.

And its information would be very helpful for practicing physicians among others, and so PCORI was created and was called the Patient Centered Outcomes Research Institute, I believe, to try to address those questions. Not to do the research at the federal level, but to answer the question about what are some of those important questions that need to be answered? How often do you need back surgery verses other treatments to get rid of chronic low back pain? Simple one, but not an uncontroversial one for those who remember AHCPR's history.

So the notion here is that PCORI is going to be a group of experts appointed by the GAO from around the country and they are going to ask the question: what sort of research is needed? And then provide federal funding to university medical centers and other researchers around the country to answer those very important questions. And they have – the commission is, the board, I guess, or whatever it is -- has been appointed and have started their discussions.

ED HOWARD: Can I bring you back to the question? I'm not sure there's an answer to the actual question, but is there a role for this institute in physician education, in forming the curriculum or emphasis or admissions policies?

DR. JAY CROSSON: You want me to answer the question? [Laughter] Sorry. You know, I don't know and I think that would be out of my competence to talk to. But I think to the extent that the distribution of this information that is created by this new body of research is spread not just to practicing physicians in training, especially physicians in training for that matter, would be an important piece.

ED HOWARD: Anybody want to take a crack at the other question having to do with the physician's role in educating the public? Ed?

ED SALSBERG: Just that physicians obviously do have a role, but it's really only part of the responsibilities for public education. The Affordable Care Act did include a good deal of – a number of – provisions related to prevention and patient education. And again, I think physicians will play a role in this, but certainly not the sole responsibility.

WHITNEY ZATZKIN: Thank you for taking my question. Good afternoon, everybody, Whitney Zatzkin, the American Association of Colleges of Pharmacy. I'm actually here speaking on behalf of the Pharmacy Manpower Project, we have

not changed the name yet, Ed. I am curious if the panel might be able to speak a little bit or reflect upon how your work has changed as you look towards the idea of a medical home team and at what kind of efforts you're doing to quantify exactly how many we need of what health professional?

ED SALSBERG: Well, the National Center for Health Workforce Analysis will be looking at these sorts of questions. We haven't done a specific study yet on the impact of the patient centered medical home. There will be a number of demonstrations supported by the ACA to promote and experiment with the patient centered medical home and it's going to be extremely important to assess the workforce implications.

You know, at this point, it's actually a little unclear whether an effectively functioning patient centered medical home will actually increase the need for health workers or whether it will decrease the need. One hopes that in the long run, that increasing attention to efficiency and coordination will reduce the demand for health workers, but in the short run, it may be that giving more attention to the needs of individuals will in fact increase the need for health professionals.

I think there has been an effort and there needs to be an effort to target the patient centered medical home to those people with chronic illnesses and other high need users that

require the coordination of care as well as other interventions.

So I think there's a tremendous potential, and I should note in general that inter-professional, inter-disciplinary education and training and practice is really, I think, part of the solution, And that if you say what are we going to do about the likely physician shortage, and if you look at some of the numbers, you realize there's – we can't fill that gap with just physicians.

And so some recent estimates that were published by the Association of American Medical Colleges which suggested a shortage of around 90,000 physicians by 2020. That's about a 10 percent shortfall. There's no way we're going to produce an additional 90,000 physicians in this short term, but we are producing physician assistants and nurse practitioners and other health professionals.

So then the team becomes critical and how you design that team in the patient centered medical home is clearly one of the models that people are very interested in looking at to understand, "Is this a good way to put the team together and improve effective delivery?"

ED HOWARD: Tom?

DR. TOM RICKETTS: The patient centered medical home should be defined by what it does, not who it is. And that's

what people are tying to do and that's the transformation. And when I said let's not have stakeholder-driven definitions, let's think more about outcomes and defining this by what it does.

ED HOWARD: If we can ask patience by the folks at the microphones, we want to try to give a chance to those of you who filled out a green card and came forward.

DAVID KROL: Sure, so here are two questions for Dr. Ricketts. The first is, you'd mentioned in one of your slides about a potential tension that can result from the teaching health centers and the primary care extensions. If you could just give a little more detail on that. And then, do you think that HPSAs will continue to be the organizational framework for addressing mal-distribution?

DR. TOM RICKETTS: Well, I – when we shift post-graduate, post-medical school education away from hospital settings to ambulatory care settings, you are changing the location of oversight and you're changing some of the pathways of responsibility for who is responsible for the training of physicians when they're outside a traditional educational framework.

The medical schools are most often associated with hospitals and inpatient care and in those settings and when you move it out to an ambulatory care setting, you have different

oversight, different management, different responsibility tracks.

So there's going to be some – there is already discussion about how that can be resolved and how are we to make these things work. Because the accreditation of these programs is an open question. I think it will be resolved as people understand that these are complex processes and it's complex and difficult to do in the long run. And so there's going to be a merging of goals and procedures as we go along.

The HPSA process is something that was put in place when it was very obvious that we needed more practitioners in places in the United States that were obviously underserved. And the old commission or committee that was developed to try and develop standards for it, the consensus was, we know one when we see one.

But turning that into a formula has proved very difficult because we seem to have – everyone is racing to be underserved these days [laughter]. And that's not necessarily healthy because we need to prioritize the policies that we have in place. We need to prioritize our distribution of resources.

HPSA is like any American solution, really, the one that you come to after trying everything else that's bad and then ending up with the least worst. So we're, for the

foreseeable future, it is there and will be unless something superior emerges from the committee that Ed is working on.

ED SALSBERG: Let me jump in on that. The ACA actually authorized a process called negotiated rule-making that required that the key interest groups get together and, in this case, have about a year to develop an acceptable methodology for updating the Health Profession Shortage Area designation and the Medically Underserved Area designation and Medically Underserved Populations. Those designations influence where funding under about 30 federal programs go.

Clearly, they influence a very significant share of the resources. We're committed to targeting the limited available federal dollars to the highest need communities and the designation process is clearly critical to that. As Tom alluded to, though, it is, in fact, technically difficult to identify the right criteria or the best criteria or the appropriate criteria for designating underserved areas.

The Negotiated Rule-making Committee, which consists of 28, has been meeting for the last three months. They're meeting again this week Wednesday, Thursday. They are obligated under the statute to make recommendations by April or preliminary recommendations by April, final recommendations by July. If the negotiated rule-making process leads to unanimous

consensus on the part of the committee, then the Secretary will accept that guidance in the rule-making.

The bottom line is we're in the middle of a process to try and reassess, as Tom said, a very difficult challenge to reassess how, in fact, do we measure under-service so that we can target our resources?

ED HOWARD: David?

DAVID KROL: These questions, I think may be for you, Dr. Crosson. They all revolve around GME funding and specifically the Medicare payment for GME. So one of the questions that gets asked is how can we use GME funding to influence the workforce composition? One questioner noted that the Fiscal Responsibility Commission suggested significant cuts to the payments. What kind of impact is that going to have? And then how do we increase the accountability, specifically for IME funds by hospitals?

DR. JAY CROSSON: Well, let me just say I think probably -- to start the discussion -- you have to go back and ask the fundamental question, which is why is the Medicare program funding a large amount of the cost of educating residents in the United States?

I'm not suggesting that that should change. I'm just saying that it is not a given that it has to work that way. It doesn't work that way in other countries, for example, that the

cost of taking care of this 65-plus population is, it also takes care of residents. That happens to be something that we devised, Congress devised in the past.

Having said that, it's one of those things where, you know, it has been going on for so long and so many institutions are dependent on this money and so many other organizations, entities, if you will, who could be providing funding are not and haven't planned for that, that if it were to change dramatically, it would have to do that over a relatively long period of time to allow educational institutions to adjust.

Having said that, I think there are things that could be done. And there is a lever here. I didn't make a point of it in the presentation, but in that pool we call indirect medical education funding, there's a controversy buried in it and that is that if you actually calculate as MedPAC has done recently, how much those intangible costs, as best as you can tell, really cost. It's about half of the level of funding that is currently being provided, or it's about $3 billion of $6.5 billion or something like that.

The rest of the money is hard to justify in a strict manner of speaking. And so it does become money, I think, that over time and done carefully, could be used to create incentives for better value out of training programs, whether that has to do with issues like the specialty mix of

physicians, which is hard for residency programs to control because it's driven by the marketplace. Nevertheless, the sense is that perhaps there's something that can be done there.

In terms of the Fiscal Responsibility Commission, as I think everybody understands, the initial recommendations are kind of broad shotgun recommendations and they touch a lot of areas. Again, I think if residency – the money for residency training programs is going to be reduced, it would need to be done slowly to give organizations, institutions time to adjust.

It seems to me probably this would not be a good time for that to happen because even though the situation hasn't been resolved, it seems like there are issues around the nation's supply of physicians that need to be addressed first as a policy issue and then the funding, the source of funding and the amount of funding should follow.

So I would hope that recommendations to reduce funding for residency training programs would follow after the work of the Workforce Commission. But again, and as I focused on, I do think from the perspective of an organization that uses physicians who come out of training programs, that efforts similar to what MedPAC has recommended, and that is to redirect some of that excess, if you will, medical education money into an incentive program for driving towards better quality, better skills, better professionalism and better knowledge base of our

physicians is just the kind of pay for value that we need to do in healthcare in general.

ED HOWARD: Very good. Ed, quick comment?

ED SALSBERG: Ed, on the critical role of GME, you know, in my prior hat that, when I was at the Association of American Medical Colleges, we strongly recommended an increase in US medical school capacity and support for graduate medical education. What is happening with medical education and osteopathic education is that there has been a response and there's a growing number of medical school slots.

And over the next decade, medical school and osteopathic school graduates will grow by about 7,000 a year from about 20,000 to about 27,000. What's critical is you can't become a physician unless you've gone through the graduate medical education.

We currently bring in around 7,000 international medical school graduates, so if you don't increase graduate medical education, what's likely to happen over the next decade is that more US MDs and DOs will go into training because they've graduated schools, and international medical school graduates may be displaced.

And so the debate is about whether, what to do to support additional training if you believe we need more physicians. And then the second piece, as Jay referred to, is

really, how do we align the workforce policies with – or workforce needs, really, with the GME policies. And I think that one of the challenges people haven't focused on is we haven't had the information to really systematically assess what are those workforce priories?

We certainly heard a lot about primary care and we do need more primary care practitioners. But you know, the reality is we've heard bits and pieces about other specialties, whether it be general surgery or oncology or child psychiatry. It's hard to know and I think it's very hard for the legislators around the country to know which of those specialties really deserve whatever extra funding that might be available.

The national center will certainly try and bring more data to this so that we can systematically assess which of those specialties, in fact, appear to have the greatest needs and that if you were going to put in some additional dollars, well, which ones should it go to?

Right now, many, many specialties present a pretty persuasive case that they have needs. And again, sort of like the geographical distribution, the challenge for the nation is going to be how do you assess among those competing needs which ones should be priorities?

ED HOWARD: Yes, you've been very patient.

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SHANNON BROWNLEE: Thank you. I'm Shannon Brownlee from the New America Foundation. There's considerable controversy around whether or not we do have a physician workforce shortage and given the amount of unnecessary care -- the estimates of 20 to 30 percent in current utilization -- I think it's hard to say that if health care reform starts to reduce that avoidable care that we really are going to have this huge physician shortage.

So my question is, it seems to me that the places in the best position to be able to really know what kinds of physicians we need and how many for given populations are closed systems like Kaiser and people like Brent James who are making a very concerted effort to figure out things like how many endocrinologists do you really need for a given population of diabetics? So if Ed Salsberg and Jay could comment, I would appreciate it. Thanks.

ED SALSBERG: Yes, as many of you know, there's been a debate over the last decade or so about whether we will be facing a significant shortage or not. The data certainly, that I've looked at led me to conclude that we were going to be facing significant shortages.

The question of whether, if we improve efficiency and effectiveness, whether we will be able to meet our needs, my sense is we have to improve our efficiency and effectiveness

and increase our supply. That it's not a question of either/ or, and as I suggested, even if we wanted to produce 50- or 90,000 more physicians over the next decade, we can't do it. It just takes too long to produce those physicians.

So we really do have to look at how do we make better use of our physicians and other practitioners? Some of the studies that came out in the early 1990s pointed out that Kaiser used workers and physicians very efficiently and if we all looked like Kaiser, we wouldn't need so many physicians.

And I would agree if we all had health systems that were as effective as our most effective systems, we would be better off. I just don't think as a planner, we can assume that we're going to get there over the next few years and that we really have to look at, again, a multi-faceted strategy.

DR. JAY CROSSON: Similar comments, Shannon, as you may or may not know, I think probably do, what Ed was referring to is the Jonathan Weiner study 25 years ago or so which was, to a certain degree, reflective of the physician/patient ratios in Kaiser Permanente and other organizations like that and did predict that we would not need as many physicians in the future if we had that sort of transition to systematic organized care delivery. We did not have that for a whole variety of reasons over that period of time, and in fact, subsequent research has

continued to show the apparent need for more and more physicians.

In Kaiser Permanente, our ratio is still significantly less, as you know, than it is around the country. There is the question of, you know, whether the "supply-demand marketplace" works in medicine or works in the physician part of medicine, or whether, in fact, some physician demand is in fact induced, beyond a level that is healthy for the population. And I think you wrote a book on that as I remember or something like that [laughter].

So it's a very complicated question. I think, as I said a few minutes ago, I hope we just don't stop funding medical education until we've answered the question, or the set of questions, about what the supply really needs to be. I think we can learn from organizations like ours, and I hope that that information is incorporated into the thinking around the future.

But the question, in the end, I think, is going to largely be predicated on what sort of health system we're going to have, both structurally and what sort of incentive's going to be inherent in the payment of physicians and health systems in the future. Because I think those issues, both structure and payment incentive are going to be the major driving issues. The absence of those changes, I believe, in the last two

decades that made Jonathan Weiner's predictions invalid. But going forward, it's an open question.

ED HOWARD: Yes, sir?

ANDREY OSTROVSKY: Hi, my name is Andrey Ostrovsky, I'm a fourth year medical student at Boston University. I'm working out of Senator Cardin's office. I think there's a lot of potential for technology and innovation technology to solve some of our problems here, everything from, you know, diagnosis with pharmacogenomics to Tweeting, you know, using Twitter for patient updates. Is there anyone taking the lead on infusing these of technology into resident training or physician training?

DR. TOM RICKETTS: When you said leadership, it's hard to say that there's a single unitary place that is at the forefront of this. Institutions themselves are re-examining the process of medical education with undergraduate and graduate. One of the big questions is why do medical students spend four years in medical school? That's a – when we're talking about Tweets on one end and an entire year, let's think about the entire process.

We're having to shortcut some specialty training from going through long preliminary stages going directly into focused specialty training. These are big, big changes that are happening and they're being facilitated by technology.

Technology in itself is not a solution toward efficiency. We were going to have robotic surgery that was going to make things better, more efficient and faster. It hasn't quite worked out that way. Technology has to be fed itself.

So we've created a demand for support of technology that sometimes overwhelms the efficiencies that it is to be – that it's supposed to bring itself. So let's take those things that are useful and efficient and understand those because the rush to technology is one of the reasons we've gotten into some of the trouble that we have in terms of overuse, high cost and inefficiency. So I just want to turn the question back on you a little there

ED HOWARD: Ed?

ED SALSBERG: I just comment about innovation and I think what we are seeing both in the delivery area and some in the education area, is really an awareness of the need for change and that cost increases are not sustainable in the long run. And so there is a tremendous amount of rethinking, both in the education and practice side, about how we might do things differently in the future.

This makes it a very exciting time. Clearly, the ACA and the Center for Medicare and Medcaid Innovations are tremendously – tremendous potential. So I think that we're

going to see over the next decade, really, a lot of experimentation and exploration about how to do things differently. Evaluation becomes absolutely critical to know which of these innovations in fact are working. But I think it's again, a very exciting time with a tremendous potential.

ED HOWARD: Yes, David, you want to give one of our card writers a chance?

DAVID KROL: Happy to. This goes more along the lines of the medical school education and this may be a question for Dr. Salsberg putting on his previous hat. Dr. Crosson mentioned the shortcomings that the department chiefs in Kaiser Permanente saw in the individuals coming out of medical training.

How do you see some of the medical schools specifically adjusting their curricula to address some of those shortcomings and how are they addressing the diversity issue? How are we getting, how are we meeting the challenges of expanding the diversity of our physician population?

ED SALSBERG: I might defer to Jay on some of the medical education –

DAVID KROL: Well, sure, if you've seen any models of medical schools that are addressing some of their shortcomings that your department chiefs have been seeing in the past.

DR. JAY CROSSON: You know, we're going to do lateraling here because I'm not an expert on that at all. I do know from discussions that the ACGME has a program for innovation in training and they have a number of pilot studies underway, a number of which are dedicated towards resolving some of these issues.

I did see a presentation, I believe from the University of Virginia – I'm not sure about that, but I believe it was there, that was one of those programs that was dedicated in this area. This is not an unknown issue. It's not unknown to ACGME, they have been stressing this for some years. But again, there are a lot of things that are sort of standing in the way.

Some of them are Medicare payment rules, for example the site of care. There is some rigidity about what Medicare will pay for depending upon where the site of care is and that has inhibited some of these changes.

I actually asked – I didn't say this earlier, but we have our own training programs in Kaiser Permanente – and I've asked our own people to what degree did they feel like they have latitude to make changes in site of service and other things? And they have some and we have, I think, a little bit of a different experience with our own trained residents, but

not entirely because some of it is a bit hide-bound by tradition and payment rules and the like.

So I think there is interest in the education community to do this. Perhaps not as much interest as there would be if there were financial incentives directing some of this, but there is some interest and recognition of this, but it's a little spotty.

ED SALSBERG: I would, you know, comment on the second part about diversity. Clearly, increasing the diversity of the medical profession and other health professions is a priority and should be a priority for the nation. There was some funding in the ACA to support increasing or continued efforts at increasing diversity.

There are a number of programs that touch on it indirectly and a number of direct scholarship-type programs that touch on it indirectly and a number of direct scholarship-type programs that are important. I know the AAMC also has been a strong supporter of efforts to increase diversity.

Having said that, there is interest and commitment, but we obviously have not been as successful as we need to be if we're going to have a more diverse workforce, so that should continue to be an important priority for all of us.

ED HOWARD: Can I just follow up? Ed, you were talking about the negotiated rule-making with respect to HPSAs and

Medically Underserved Areas. Is any of that likely to result in greater flows of money toward efforts to increase diversity or [interposing] -

ED SALSBERG: I think that's really in two different paths. The, again, a whole variety of programs that are impacted by the HPSA and MUA designation, by community health centers and the National Service Corps, a little bit the Title VII and Title VIII programs that take some of the location of training into consideration, but are not a primary factor. So I guess I still view them as being on separate paths, both critical.

ED HOWARD: Okay. Yes, please.

ROBERTA LILLY: Roberta Lilly from George Washington University. I'm a general surgeon who left my practice a number of years ago in order to take care of my family and when I wanted to resume practice, I found a number of barriers to re-entry.

Some of these were as simple as being granted permission to re-take the board exam in general surgery – which is something you can take, but you have to show that you're clinically active in order to take it, so it requires special permission – to things as complicated as trying to find a place that would let me gain more clinical training.

When I finally did find a place that would re-train me at Johns Hopkins, I found that there was no funding for it. So I was paying out of pocket almost $45,000 for the retraining. My question is, if there are others like me out there who are fully credentialed, board certified willing workers who would like to resume their place in the workforce, is there anybody who's trying to identify that population? And if they are is there any money that could be put for that effort?

DR. TOM RICKETTS: I'll speak. At the Sheps Center, we worked with the medical board in North Carolina to try and determine the number of people who might be ready for re-entry and determine how big this was in potential for the supply in North Carolina and then the costs associated with it and then what we had to adapt and adjust to fit with the re-entry and re-licensure and that.

And we found that first, the assumption that there were a lot of people out there was not quite right. It was right on the margin in terms of making it efficient to develop an entire new program and bring people through a common structure. We also found that it was going to be much more difficult to adapt some common elements to make that efficient.

In the end, we found that we didn't feel that we could – I say we, the medical board – could not really support a

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program of this type and so we've let it go back to where it is.

And what you've described is essentially a retail individual by individual process. So the scale is difficult on this and the diffusion, we would have a general surgeon in one area, hematologist in another, and trying to fit them all through one system was difficult.

ED SALSBERG: There is a national, growing national effort and concern about the issue of re-entry and the American Academy of Pediatrics really leading this effort, a multi-specialty effort, and if you see me after, I can put you in contact with the people who are doing it. The concern is not just about women, but it is important in terms of women because many women have taken off time from practice to raise a family and then they find if they've been out of practice two or three years, that there are barriers.

In fact, there are some states that you will have to go back and be re-tested if you've been out for more than two or three years. And so there is concern that over the next several decades as more and more women are in medicine, that the number of physicians wanting to re-enter will be growing. And so there is this effort underway to try and figure out what the strategies are and I think Tom is right.

Currently, it's been a person here in one specialty, and another specialty in another place and so there's really a need now to think about, is this an increasing phenomenon and how do we set up a national programs and policies to allow for re-entry into practice?

ROBERTA LILLY: Thank you.

ED HOWARD: Let me just say that Dr. Crosson has indicated early on that he's going to have to leave in just a couple minutes, so if there's anybody standing in line that has a question specifically for him, you better take the opportunity and maybe your colleagues will allow you to jump to the front of the line.

RUSSELL BUHR: Hi, I'm Russell Buhr. I'm a resident physician at Georgetown University Hospital and probably the only intern in DC who's not taking care of a patient right now [laughter].

But the points that have been made have been really, I think, well received by the audience, and one thing I don't know that's been teased out is the tremendous cultural paradigm shift that will be asked of the physician workforce to implement a lot of these changes.

I'm wondering especially, Dr. Crosson, if you could comment on any resistance based on the MedPAC changes that you had talked about in graduate medical education and so on. The

pushback you're getting from groups like the individual specialty organizations, the state medical boards, those sorts of groups and how you approach that and especially in the kind of entrenched medical institution, whereas younger providers like myself who have not yet been indoctrinated may be ready and willing to receive a multi-disciplinary practice, and wanting to know how to train in that way the attendings who are teaching me may not feel the same way.

And I think that the second component of that would be realizing there's a fixed amount of time. Something's going to have to give somewhere. When can I stop learning about biochemistry and start learning more about systems-based practice and how you implement that into training. I know it's a broad question, but –

DR. JAY CROSSON: Yeah. Well, I – in terms of resistance to what I was describing, there's sort of institutional resistance to the notion of anybody fooling around with the flow of revenue, you know, changing it in some way creating winners and losers. This should not come as a great surprise to anybody in the room.

So that just is, and anytime you try to change things that have to do with the flow of money, you get that sort of resistance, but I think you're talking about something else which is – and I kind of alluded to that a little bit and it

has to do with, you know, the kind of models that young physicians in training are exposed to in the large tertiary-quaternary medical center.

And the question of whether that actually – those models, our wonderful physicians and teachers, actually represent in activities or in, you know, philosophy, the realities of medical practice not only as it is, as it's going to be in the future. And I think there is, I personally believe there's a significant gap there.

You know, I experienced, when I came out of residency training program and entered the world of practice, which happened to be here at Naval Medical Center, some years ago for a couple of years, that's where I actually learned how to be a doctor in the full panoply of skills and professionalism and the like.

And I think narrowing that gap and making the training program more aligned with the reality of medical practice is the goal. And I think it's a goal that's shared by many medical educators, but it's not moving as quickly as it should.

ED SALSBERG: One comment on the cultural shift. I think there are significant changes happening in medicine in terms of the perspective of young physicians. Some of this relates to the increasing number of women in medicine who are trying to balance families and the sense that young male

physicians are also trying to balance their personal life and their families.

The reality is that the practice of medicine is evolving and I think the changing demographics of the physician workforce will move this along quickly, and I think in the long run, it's positive. You know, we are finding, as most of you, I'm sure, are aware, there's less and less solo practice, physicians going out on their own and practicing medicine in America.

More and more groups, more and more larger groups — some of that's driven by the economics of practice. It's hard to have a modern up-to-date information system hooked into networks as an individual solo practitioner.

Younger physicians, if they're trying to balance their lives, actually don't want to spend their time in administration and billing, they want to actually see patients. And so they — as systems evolve, I think it offers potential for improvements in efficiency and quality so the pressures, I think are moving in the direction of organized systems of care which can deliver, I think, improved care in the future.

ED HOWARD: Very small example of that, Senator Collins' staffer was telling me just last week that the majority of physicians in Maine are now employed by other entities as opposed to being in practice. Yes, ma'am?

BARBARA TOMAR: This question is for Dr. Crosson, but I would also be interested in anyone else's response. I'm Barb Tomar —

ED HOWARD: Jay, do you have time?

DR. JAY CROSSON: Yeah, I do have to go.

BARBARA TOMAR: Can you do it?

DR. JAY CROSSON: I actually do have another appointment I'm going to have to go to. Jay dot Crosson at KP, for Kaiser Permanente dot org. I'll answer all and any questions, even tonight.

ED HOWARD: There you go.

BARBARA TOMAR: Okay. Well, anyone else can take this —

ED HOWARD: Before I let you proceed, let me just take this opportunity -- we're down to our last ten or so minutes and if you would, remember to fill out your blue evaluation forms before we let you loose. That would be much appreciated. Yes? Thank you very much for waiting.

BARBARA TOMAR: Barbara Tomar, I'm with the College of Emergency Physicians, those expensive and inefficient sites of care under this administration. But my question is really about incentives for primary care and I'm just wondering, knowing, hearing about the data that back in the '80s, primary

care physicians earned about 80 percent of specialists and these days, it's more like 50 percent of what specialists earn.

Do you think there are enough incentives in PPACA between the redistribution, the 10 percent payment, the expansion of National Health Service Corps to really move the levers to get more medical students to go into primary care?

ED SALSBERG: I think that more medical students will go into primary care. One of the key challenges, however, is to make sure we're also increasing the number of primary care training slots and so that the increase in the US medical students going into primary care doesn't merely replace international medical school graduates who are going into primary care. The goal has to be to increase the total number of primary care practitioners.

There are a number of levers, I think. The increasing interest in general in primary care will have an impact. We saw that in the early 1990s, a very significant increase in interest in primary care not because of any federal policies, but because the whole discussion was around managed care and what managed care was going to do. And then we saw a significant decrease over the past 13 years, again, not due to any particular federal policy, but due to the marketplace.

So I think that we're likely to see an upswing in primary care supported by a whole series of new federal

programs and policies to encourage primary care. So I think we will see an expansion, but the reality is just like I said in terms of the overall physician workforce, physicians alone aren't going to be sufficient.

One of the really encouraging things is the growth in the number of physician assistants being educated and trained in America. There were about a thousand new PAs each year in 1990. We're closing in on about 6,000 new PAs per year now. They're going to have a significant impact.

The number of nurse practitioners and other advanced practice nurses is growing, so we're not going to meet the primary care needs solely by increasing primary care physicians, but we're hopeful that with other health professionals, we will be able to meet the needs of the nation.

GARY FILERMAN: Can I follow up on that? My question relates directly to it.

ED HOWARD: Yes, go ahead, Gary.

GARY FILERMAN: Gary Filerman from Atlas Research. We've gone a long way in this conversation without mentioning scope of practice and I would like you to comment on where you see the scope of practice issue being engaged by the commission or across the board going forward. Last week, I was in a discussion about rural diabetes that led to a discussion of optometrists that led to a discussion of ophthalmologists.

The family physician, getting between two hours and one week of eye training as an undergraduate in medical education, verses the optometrist, getting four years of training, being barred by scope of practice from working up to their competency in providing rural service as an example.

DR. TOM RICKETTS: I'm stupid enough to answer a question about scope of practice [laughter]. When I worked in the North Carolina General Assembly, the Speaker of the House once told me – he said, "Don't ever touch that." But it's actively debated and discussed, and in the laboratories of democracy, states work on this quite a lot every year.

The transition that we might find that might be different is that we might go from a legislatively structured and regulatory oriented scope of practice more toward an institutional and professional based scope of practice that is negotiated within organizations and structures.

That's a radical idea that I doubt anybody's going to confront immediately or in that way. But there's going to be a certain amount of tolerance within integrated health systems to allow this type of activity to take place.

The stark situation that you described of a rural situation where there are individuals contending over ownership of certain types of treatments will remain with us for a long time. The resolution is going to be in integrated systems and

I think we're going to be stuck with the kind of thing where the individuals in small places are going to be fighting over that.

I did want to answer the question, the person who said are there going to be enough incentives for people to go into primary care, and the answer is no.

ED SALSBERG: On the question of scope of practice that was raised, I think it's a critical question. You know, on one hand, we have this incredible place to do experimentation and exploration, 50 states, each with their own scope of practice, laws and statutes.

It would be a great opportunity to sort of assess when one state does change scope of practice, what the impact is. Unfortunately, we've really not devoted the resources to do the evaluation.

So one state may lead the nation and allow a particular practitioner to do specific activities. There's no way for the neighboring states or the rest of the nation to know whether that was a good idea or a bad idea. So in my mind, a critical element over the next decade in terms of scope of practice is investing more in the evaluation, systematic evaluation of what the outcomes are, health and effectiveness outcomes are, of allowing an expansion of scope of practice.

And I agree with Tom, it's a very hazardous area to be in, and I've heard over the years many professions talking about why they should be allowed to do more, but why the profession behind them should not be allowed to do more. So it's an area where it would be good if we actually had some hard data and knowledge.

ED HOWARD: Okay, we have two folks at the microphone and time for two more questions, amazingly coefficient.

ASHLEY THOMPSON: How perfect. Ashley Thompson at the American Hospital Association. The Balanced Budget Act of 1997 placed a cap on the number of Medicare-funded GME residency slots and we talked a little bit today about GME funding and the IME amount and what's the appropriate IME amount.

And my question is really, as we talk about workforce shortages and physician barriers, what are the thoughts of the panel in terms of the need to lift that cap or increase the number of Medicare-funded slots given population growth now we have 32 million uninsured that are going to have access to the healthcare system, et cetera?

ED HOWARD: Tom?

DR. TOM RICKETTS: The current Medicare GME structure is not the only way that you can accomplish or fund GME. And I think that's what people are ready to do now is say let's begin to think about all payer, or let's think about some other

mechanism toward supporting GME. If we're caught in a zero sum budget neutral game constantly within Medicare, we're stuck with a barrier that can't be easily overcome.

So there has been growth in GME outside of Medicare after the cap was placed on it. People have found creative ways to accomplish what they needed in the institutions where they felt there was that need and have funded those. So we may find ourselves more and more about how those processes worked and how we can make them work and move away from this box that we have in terms of Medicare supporting the majority, and now not the overwhelming majority of GME slots. I hope that answers.

ED HOWARD: Okay. Yes, go right ahead.

ALLISON SCHNEIDER: Hi, Allison Schneider with the Kaiser Family Foundation. I was wondering if you could speak a bit to the issue of mental health resources, especially considering how big of an issue it's going to be for this returning generation of veterans and whether – I guess it goes back to the scope of practice issue a bit, but how you train physicians and kind of also increase the mental health workforce to be able to accommodate the growing need.

ED SALSBERG: I don't have a specific answer of how we're going to address those needs. We are aware of those needs. HHS and HRSA are exploring how do we not only build the

behavioral health workforce, but how do we better use and tap into the primary care workforce to assure that those in need of services get services.

As I mentioned, ACA had some additional funding for behavioral health and that we're looking at a number of initiatives. Again, it's not an area that I'm an expert in. If you come up to me afterwards, I can put you in touch with the folks who can answer that question better.

ED HOWARD: Yes, Tom?

DR. TOM RICKETTS: I'm glad you raised the issue because there are two apparent specialties in medicine that are, I think we would find – a lot of consensus that there is a shortage of, though. And that is in community psychiatry, community-based psychiatrists and mental health services, and in geriatrics.

No one's raised geriatrics. We actually had two pediatricians on the group, but there's clear evidence and clear consensus that we have a problem in distribution of the physicians trained at these levels, largely because of changes in the pathology and in the aging of the population.

So with – specific to veterans, we have been creative in some programs, creative in the response that has come up from the community, not necessarily from the top down. I was a member of the Veterans' Rural Health Advisory Committee and we

found many, many solutions that were being offered by very, let's say, diffused programs that were effective, but this was not nationally coordinated and organized because of the lack of resources.

And one of the resources that was lacking was sufficiently trained physician and other professionals for mental health services. And I think the situation will be repeated in terms of geriatrics where we're looking at very complex issues related to aging and we need the individual practitioners or small teams of practitioners who can bring together the knowledge and resources to care for these patients with complex illness that can be resolved and to extend healthy living.

So you've touched on one of the two things that I think are very important for the nation to resolve the issues in health workforce and that is mental health and geriatrics.

ED HOWARD: Nice segue to our conclusion, thank you very much, Dr. Ricketts. Let me just say while you're listening to me do my 90 seconds of wrap-up, you should be filling out that evaluation form if you would, if you haven't already.

I do want to reiterate our appreciation of the role of the Robert Wood Johnson Foundation in both helping us to put this program together and supporting it and lending us David

Krol for the purpose of moderating the discussion. And for allowing us to continue the conversation on workforce issues on December 2nd, when we're going to be talking about some of the, not just the nursing aspects, but also the other health professionals who are going to have to be part of this mix. And Deanna Okrent is going to be pleased to make sure that we have a good scope of practice description in the course of that conversation, so it's an important issue and one we want to come back to.

Thank you for being part of this part of it, and I ask you to thank our panel with me for a very illuminating beginning to a tough discussion [applause].

[END RECORDING]