## CEPRI Medical Education Needs Analysis Advisory Committee
### University of South Florida College of Public Health
### Tampa, Florida
### June 17, 2004

### Meeting Participants

| Name | Title | Affiliation |
|------|-------|-------------|
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| Dr. Carlos Martini | Medical School Project Director | FIU |
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| Ms. Linda Rackleff | Director | Council of Florida Medical School Deans |
| Dr. Lynn Romrell | Professor and Associate Dean for Medical Education | UF |
| Dr. Mark Rosenberg | Provost and Vice President of Academic Affairs | FIU |
| Dr. Anthony Silvagni | Dean, College of Osteopathic Medicine and Chair of Council of Florida Medical School Deans | Nova Southeastern University |
| Dr. Steve Ullmann | Vice Provost, Faculty Affairs | UM |
| Dr. Robert Watson | Sr. Associate Dean for Educational Affairs, UF College of Medicine | UF |

**Meeting Summary Outline**

## I. Establishing a Process for Measuring and Identifying Need

### A. Factors to Consider

The committee presented the following factors that should be considered in any assessment of need for additional physicians:

1. Demographics of the physician workforce
    i. Age
    ii. Race/Ethnicity
    iii. Gender
2. Place of training
3. Number of active physicians – those involved in patient care
4. Difficulties involved with investigating need by specialty
5. Quality of care and safety of practice
6. Population growth by
    i. Age group
    ii. Ethnic group
    iii. Region
7. Licensing
8. Environmental conditions of service delivery
    i. Cost of malpractice insurance
    ii. Location of practice (rural, inner-city)
9. Economic indicators
10. Public perception of need for physicians and medical schools
11. Training opportunities for medical students
12. Generational changes

### B. Quality and Availability of the Data

Efforts to create a legislatively-mandated and funded physician workforce database failed this past session. Available data on physicians (through licensure data) is of questionable reliability, since it is provided on a voluntary basis and is riddled with duplication and inaccuracies.

The committee noted the following data elements that are currently available:

1. Population growth
2. Rough estimate of the number of physicians
3. Projections of the number of medical school graduates over the next few years
4. Data on the in-migration of physicians from other states

### C. Timeline of the Study

In light of the difficulty in collecting data, the complexity of the data, and the many interactions of factors that must be considered in assessing need, concern was raised over the likelihood of accurately completing this study in the short time frame proposed (4 months).

The committee viewed this study as a starting point with consensus reached on big-picture factors including the factors to consider when assessing need, as well as issues concerning:

1. Florida's dependence on International Medical Graduates (IMGs)
2. The increased likelihood of physicians to stay in Florida if they are trained in Florida, as opposed to those only educated in Florida.
3. Expansion of residency programs

The general consensus of the group was that it is not possible to develop a mathematical model in this time frame.

## II. Possible Alternatives to Address the Need for Additional Physicians

Four major alternatives were presented to address the need for additional physicians
1. Make the profession more attractive
2. Change Florida's licensing laws
3. Increase the number of residency slots
4. Increase the number of medical school slots

### A. Expansion of Residency Programs vs. New Medical Schools
Creating new medical schools will not increase the number of physicians if new residency slots are not created. Florida is currently 46th in the nation in residency positions, with 0% of the positions empty. Some of the members of the committee presented the benefits of having a medical school connected with a residency program (e.g., educational structure, proximity to faculty). Also, the high cost and difficult approval/accreditation process of establishing a new residency program were presented. Federal funding for residencies has been frozen since the Balanced Budget Act of 1997.

### B. Other Alternatives
In light of the high start-up costs of establishing new medical schools and new residency programs, other alternatives such as funding state scholarship and/or loan forgiveness programs and the Community Hospital Education Program (CHEP) were mentioned as cost-effective approaches to addressing the need for additional physicians.

## III. General Role and Responsibility of the Advisory Committee
The general role of the committee is to
1. Focus on the physician workforce
2. Identify key questions and answers

The following proposed tasks could be completed by the group in the study time frame provided:
1. Make a general statement that Florida needs more physicians, providing reasons, some of which can be quantified.
2. Examine the link that has been made between the need for more physicians and the need for more medical school slots.

**Meeting Detailed Summary**

## I. Establishing a Process for Measuring and Identifying Need

## A. <u>Factors to Consider</u>

Dr. Martini noted the great difficulty in predicting need long-term. It may be more realistic to focus on a shorter time frame (e.g., four or five years). He highlighted the following three reasons for why the long-term prediction of need is so difficult:

1. **Technology** – It is not possible to predict the technological advances of the next twenty years and how they will affect the delivery of health care.
2. **Growth in Other Health Professions** – There are various changes in the structure of health services, with a new role for ARNPs and PAs replacing work traditionally done by physicians.
3. **Poor Quality of Existing Data** – Data is especially poor in Florida, with as much as 20 percent of the data on physicians in duplicate. Most of the data on physicians is voluntarily provided by the physicians themselves, thus the reliability of the data is questionable.

Dr. Martini further mentioned that this study is not alone, as other national studies on assessing the need for the physicians are forthcoming (e.g., COGME, AAMC, and Carnegie Foundation).

In any attempt to assess need, Dr. Martini provided the following factors that must be accounted for:

1. **Age**
2. **Race**
3. **Place of training**
4. **Limit the investigation to active physicians (i.e., those involved in patient care)**
   a. Approximately 75% of licensed physicians in Florida are active
5. **Difficulty of investigating need by specialty**
   a. COGME concluded that it was too difficult to investigate need by specialty and is focusing its report solely on physicians as a whole.
6. **Quality of care and the safety of practice**
   a. The training and education of Florida physicians varies greatly (e.g., the high dependence on foreign-educated and trained physicians in Florida)

Any study must be population based with a special look at **population growth by (1) specific age categories; (2) specific ethnic groups; and (3) region**. **Issues of licensing must be addressed as well**. The requirements for licensing in Florida are less stringent than other states. One possible approach to increase the supply of physicians is to further lessen the licensing requirements.

Dr. Watson noted that the forthcoming COGME report will recommend a 15 percent increase in the number of medical students over the next several years. In Florida, the recent

opening of Lake Erie College of Osteopathic Medicine in Bradenton will increase the supply of medical students in Florida beyond that 15 percent (Lake Erie accepts its first class of 150 students this fall).

Dr. Watson added another factor that must be considered in assessing need—**gender**. The growth of women in the medical profession has some consequences. Namely, women practice 30 percent less than men. Although women practice at a lesser rate than men, younger male physicians are practicing at a lesser rate than their predecessors did. There are significant **lifestyle considerations of younger generations that need to be accounted for** (i.e., less likely to work long hours, more likely to change careers).

Dr. Fabri agreed that projecting need is a very difficult, near-impossible exercise. He also concurred that **gender must be taken into account**, noting a study of the medical workforce in Canada which showed that women practice at a lesser rate than men at younger ages (30 to 50). However, after age 50 women practice at a higher rate than male physicians.

Dr. Brooks mentioned a recently completed FSU statewide survey of rural physicians. Results from the survey show that the delivery of services is changing dramatically, due in large part to the high cost of medical malpractice insurance. The overall number of physicians leaving is not changing, however for some specialties the number of physicians practicing is changing dramatically. For example among OB/GYNs, for all those found delivering services the previous year, 50 percent of those physicians had stopped providing services the next year. **In assessing need, it is not simply the number of physicians, where they practice, and what specialty the practice, but rather are the physicians delivering the services under the environmental conditions they are in**.

Dr. O'Connell concurred with other participants that projecting need is a very difficult task, especially since the outcome is a moving target. He was persuaded by the work of Dr. Cooper which shows that demand for physicians rises with the growth of the economy (i.e., the growth in the gross domestic product). Therefore, for any model assessing need, **economic indicators need to be taken into account**.

Dr. Silvagni added the following factors that need to be accounted for:

1. **Public Perception of Need and Medical Schools** – One needs to recognize the perceived value a medical school has to the local community and institution. Once the public decides they need something, the Legislature generally moves.
2. **Training of Physicians** – Where are new students going to be trained if certain types of physicians are in short supply?
3. **High Cost of Malpractice Insurance** – For example, over 50 percent of OB/GYN physicians do not have malpractice insurance. Where will OB/GYN students be sent for training if so many are uninsured or no longer performing the procedures?
4. **Graduate Medical Education** – Florida is currently 45th or 46th in the nation in residency slots. Also there are currently no unfilled residency slots.

Dr. Ullman added that this group should investigate the work of health economists. The Health Manpower Policy Studies Group at the University of Michigan has done modeling of

how physicians locate, of need, and of how to collect the data.  The have done analyses for all fifty states.

Dr. Breslin noted that in assessing need, we must **look at Florida on a regional basis**.  Less than 4 percent of physicians in South Florida are UF or USF graduates.  About 50 percent are International Medical Graduates (IMGs).  One needs to account for the special needs of South Florida (e.g., the ethnic population).

Dr. Fabri added **the importance of accounting for generational changes**.  There are vast lifestyle changes between the younger generation and their predecessors.  Younger students/residents are less likely to work long hours and more likely to change careers.  When assessing need, we need to consider how long medical students are going to be practicing physicians before they decide to go into a different career.  Dr. Heinemann added that many of the applicants to MBA programs are physicians over the age of 50 looking for a lifestyle change.

## B.  Quality and Availability of the Data

Ms. Rackleff noted the failed attempt this past legislative session to establish a legislatively-mandated and funded Florida health care practitioner workforce database (HB 1075 and SB 1154).  In order to proceed with any analysis of need and projections, this data is necessary.

Dr. Brooks echoed the fact that research-level data is needed.  He noted that it is important to have the Board of Governors add their support to the creation of this data repository.

Dr. O'Connell agreed that there is a need to survey practitioners on a regular basis to uncover what drives physician decisions to practice where they do and to add services, for example.  Dr. Silvagni noted that such surveys were included in the proposed legislation for a central data repository on the health care workforce.

Dr. Heinemann noted that with the ever-changing modes of practice in the health care area (e.g., PAs and ARNPs performing roles traditionally done by physicians), the database should be linked to other health care professions.  The legislation indeed calls for a linkage to all health care professions; however data on physicians was the first step.

Dr. Silvagni noted the following data elements that are currently available:
1. **Population growth** – by various categories and region
2. **A rough estimate of the number of physicians** – Some on the committee doubted the availability of this data, but representatives from FIU asserted that they have cleaned the licensure data, a database that is riddled with duplicates and inaccurate information.
3. **Projections of the number of medical school graduates over the next few years** – These projections account for the existing medical schools increasing capacity 15 percent and the newly formed PIMS programs between (1) FAU and UM and (2) UCF and USF
4. **Change in reciprocity laws** (i.e., the in-migration of physicians from other states) – those reciprocity law changes have made it easier for physicians from other states to

get licenses in Florida; however, physicians are not flocking to Florida from other states (probably because of the high cost of malpractice insurance).

## C. <u>Timeline of the Study</u>

In light of the difficulty in collecting data, the complexity of the data, and the many interactions of factors that must be considered in assessing need, concern was raised over the likelihood of accurately completing this study in the short time frame proposed (4 months).

Dr. Watson concluded that it would be near-impossible to complete this study in four months without the data repository.

Dr. Fabri noted that this study can be viewed as a starting point. The role of this committee is to reach a consensus on the indisputable factors in this timeframe. In addition to the factors touched on earlier, the following need to be considered:

1. **Florida's dependence on International Medical Graduates (IMGs)** -- Tightening of immigration laws in a post-9/11 environment is likely to decrease the number of IMGs in the future.
2. **Physicians trained in the state are more likely to stay in the state than those educated in the state** – However, the difference is probably not as great as one may think; need data to answer this question.
3. **Expansion of residency programs** – How do you fund this expansion? The state could market residency programs in an attempt to get medical students from other states to come to Florida for training.

The answers to these big picture concerns can be refined over a long period of time as data becomes more available.

The general consensus of the group is that there is no way to develop a mathematical model within this time frame.

## II. Possible Alternatives to Address the Need for Additional Physicians

The group consensus is that a need for additional physicians in the future is clear. The approaches to meet that demand are varied.

Dr. Martini presented four major alternatives that can be pursued to deal with the need for additional physicians.

1. **Make the profession more attractive** – This can be done, for example, through tort reform and improving the Medicare reimbursement.
2. **Change the already loose Florida licensing laws** – This can increase the physician workforce, but questions of quality arise.
3. **Increase the number of residency slots** – This is critical issue, but funding is a problem

4. **Increase the number of medical school slots**

Dr. Martini added that assessing cost and quality of each alternative need not be done from the results of any mathematical model, but rather through discussions among a panel of experts, such as this committee.

Dr. Hickey asked whether the demand for additional physicians in the future can be met by simply increasing the state funding to existing colleges of medicine (up from the 4 to 5 percent UF, USF, and UM currently receive). In addition to that, there needs to be an expansion of residency programs and tort reform. Without those two key elements, medical students are going to have to go elsewhere for training, and if they leave, they are less likely to return to Florida.

Dr. Silvagni raised two questions that could lead this study in two fundamentally different directions:
1. Do we need more Florida medical students? If so, the response is more medical schools

   OR

2. Do we need more doctors? If so, we need to make the profession more attractive and/or increase graduate medical education. Both alternatives have a more immediate impact than building new medical schools.

Dr. Rosenberg added that if the concern is more doctors, there are two other questions—(1) What kind of doctors? and (2) Where are the doctors needed? Expanding capacity does not help answer the "where" and the "what kind" questions.

Dr. Romrell noted that it is easy to justify more medical schools, especially since compared to other states such as Texas and Ohio which have about 2,000 medical school slots, and Florida lags behind (approximately 600 slots). However, the question is what is the state willing to fund? State is currently not adequately funding existing medical schools.

Dr. Rosenberg focused on three issues regarding alternatives to deal with the need for additional physicians:
1. **Residencies** – what is the relationship between medical schools and residencies? What are the number of medical schools and the availability of residency slots?
2. **Diversity of practicing physicians** – is that an important consideration?
3. **Issues of pipeline** – what is the availability of qualified students to go to medical school? What should be done to address this far prior to when students take the MCAT.
4. **Foreign-trained physicians** – need projections on the number available in the future.

## A. <u>Expansion of Residency Programs vs. New Medical Schools</u>

Dr. Watson noted that there are 125 medical schools with residency programs nationwide. There are about 400 hospitals with residency programs. There is a loose link between medical schools and residency programs.

Dr. Fabri added that new medical schools will not increase the number of physicians. If medical schools increase capacity, without new residency programs, Florida will fail to produce more doctors practicing in Florida, because they are no opportunities for training in-state. Florida is currently 46th in the nation in residency positions.

Dr. Watson added that 0 percent of Florida's residency slots are empty. Nationally about 20 percent of residency slots are vacant. Political and social arguments can be made for new medical schools, but that doesn't address the physician deficit problem.

Dr. Breslin does not believe that it should be an either/or questions of medical schools vs. residency programs. Florida is 91 percent urban, and he asserts medical schools should be located where there are large population centers.

Dr. Watson countered that the teaching hospitals are largely located in urban sites (e.g., Shands Jacksonville, Jackson Memorial Hospital in Miami, and Orlando Regional Health Care – which has a residency program without a medical school).

Dr. Martini noted that residency training without a medical school can be problematic. The educational structure and proximity of faculty are useful benefits that a medical school provides to a residency program. Also, Dr. Martini notes that it is difficult to expand existing residency programs in South Florida.

Dr. Fabri added that the future training programs will be confined to large urban facilities that have the ability to sustain complex, advanced residencies. The trend is toward residencies in specialties, not family medicine.

Dr. Haynie added that the state no longer provides any Graduate Medical Education (GME) funding.

Dr. Fabri summarized the rules that govern the creation of residency programs.
1. Approval process – Has to be approved in an institution that sponsors GME. One cannot just start a residency program in any hospital.
2. Complex and difficult accreditation process – As difficult and complex as the accreditation process for a new medical school
3. Number of board certified physicians in that specialty must be specified in advance – How many physicians you must have per resident
4. Last step is funding – Funding is very difficult to come by. Since the Balanced Budget Act of 1997, federal funds for GME have been frozen.

Start-up costs for a new residency program are almost as much as starting a new medical school. However, the marginal cost of adding more residencies to an existing program is

less (about $70,000 per resident). The only way to get new money from the federal government is a brand new program in a brand new hospital (i.e., one that has never had a residency program).

## B. <u>Other Alternatives</u>

Dr. Brooks mentioned the use of scholarship and/or loan forgiveness programs to increase the number of specialists and doctors in certain practice locations through economic incentives. Given the cost of new medical schools, these are cost-effective approaches that are already in statute. They just have not been funded in recent years.

Dr. Silvagni mentioned once again providing support for the CHEP program (Community Hospital Education Program). This program formerly provided state support for GME positions, focusing on rural and primary care.

## III. General Role and Responsibility of the Advisory Committee

Dr. Haynie summed up the role of the committee as follows:
1.  **Focus on the physician workforce** – Are there enough doctors?
2.  **Identify questions and answers** – What are the correct questions to be asked?

Ms. Rackleff added that this group can complete the following tasks in the time frame provided:
1.  **Generally make a statement that we need more physicians in Florida** – provide some reasons, some of which can be quantified.
2.  **Examine the link that has been made between the need for more doctors and the need for more medical school slots either by expanding capacity or creating new medical schools** -- This relationship does not necessarily exist. The group needs to provide alternatives.

Dr. Hickey proposed using a production model to present this study to the Board of Governors. Conceptualize the relationship as a flowchart looking at the leakage points—inhibiting factors—that affect the production and retention of doctors in Florida.

Dr. Fabri questioned whether this model can be created since by looking at where medical students went to college and where residents went medical school, one would see that the relationship is a "random walk."

Dr. Rosenberg proposed that the information of this study can be presented under two main perspectives.

1.  Performance and Accountability
    a.  Investigate graduation rates of medical schools and other retention issues
2.  Return on Investment
    a.  Need to be clear on what the basis for cost efficiency is.

Dr. Romrell noted that this group can focus on the following:
1. Endorse the establishment of the data repository
2. Qualification of applicants to medical school
   a. The Association of American Medical Colleges found that the success in medical school can be predicted by performance on the MCAT
3. Expansion of residencies – 70 percent of resident completers establish practice within 200 miles of their residency program.