

NORTHROP GRUMMAN INFORMATION TECHNOLOGY

Moderator: Dianne Reynolds-Cane
September 16, 2010
12:00 p.m. CT

Operator: Good afternoon. My name is (Jessica) and I'll be your conference operator today. At this time, I'd like to welcome everyone to a press briefing on Virginia Physician workforce conference call.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there'll be a question-and-answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key.

Thank you. Dr. Dianne Reynolds-Cane, you may begin your conference.

Dianne Reynolds-Cane: Good afternoon. I am Dianne Reynolds-Cane, MD, director of the Virginia Department of Health Professions or DHP.

You have joined a 60-minute briefing regarding 2008 through 2030 DHP Healthcare Workforce Data Center survey findings of licensed Virginia physicians. Welcome to our esteemed panel – panelists and members of the media who are in attendance for today's release of the report from our Healthcare Workforce Data Center entitled "Forecasting Physician Supply and Demand in Virginia 2008 through 2030."

We look forward to taking your questions at the end of today's presentations. But first, let me share with you who is in the room and how we will spend our time together.

I am joined by the following esteemed guests and panelists, including the honorable William Hazel, MD, Virginia's Secretary of Health and Human Resources. Also, we are joined by Arthur "Tim" Garson, MD, University of Virginia Provost; William Harp, MD, Executor – Executive Director of Virginia's Board of Medicine; and the Director of the DHP Healthcare Workforce Data Center, Elizabeth Carter, PhD.

Additionally, we are honored to have as a guest with us today Jeff Cribbs, who's the Chair of DHP's Healthcare Workforce Data Center Advisory Council. The Advisory Council is the Data Center's governing body.

Dr. Hazel will highlight steps taken – pardon me – steps being given by Virginia to address the national shortage of physicians. You will then hear more details about the full reports and data cubes that detail findings from the voluntary 2007 to 2008 online survey of physicians renewing their licenses. Please note that physician surveys are ongoing.

As we talk, please feel free to go to www.dhp.virginia.gov/hwdc to access the full reports we will refer to, which includes forecasting physician supply and demand in Virginia 2008 through 2030; 2008 Virginia physician workforce survey findings and recommendations; DO and MD data cubes; and physician facts and truth.

Following Dr. Hazel's remarks, we will hear from our panelists, beginning with Dr. Elizabeth Carter, who will explain how the data was gathered, then walk you through top findings. She will then introduce Dr. Harp. Next Dr. William Harp will provide remarks from the perspective of the Virginia Board of Medicine.

He will then introduce our final (discussion), UVA's programs, Dr. Tim Garson, who will talk about what led him to (rally) the state government and Virginia medical schools, to work for solutions to meet an increase in the demand for physicians at a time when the state anticipates a decrease in the supply of medical doctors.

Following the panel discussion, telephone lines will be open for any questions. Call in instructions will be given.

With that said, please allow me to introduce the Honorable Dr. William Hazel, Secretary of Health and Human Services for the State of Virginia. Dr. Hazel is an orthopedic surgeon and is responsible for the 13 agencies that make up the health secretariat. Welcome, Dr. Hazel.

William Hazel: Thank you, Dr. Reynolds-Cane for the introduction. I'm happy to be here today. It allows me to wear most of my hat, as a physician practitioner and government servant.

The Commonwealth has a long tradition of making sound healthcare decisions based on the facts, and today we face a nationwide shortage of primary care physicians. (We know) that baby boomers are (inaudible) and they need increased medical services, and healthcare reform is also likely to increase the demand for physicians. Virginia is not exempt from this perfect storm. That's why it's important to use workforce data gathered directly from Virginia physicians to make strategic decisions regarding how best to meet the healthcare needs of the Commonwealth's more than eight million people.

These findings, gathered by the Department of Health Professions Healthcare Workforce Data Center under House Bill 2405 on the present and future workforce habits of Virginia's physicians are timely and important. The data was collected voluntarily from practicing physicians of osteopathic medicine and medical doctors. Department of Health Professions Healthcare Workforce Data Center among a growing repository of centrally located, state-specific survey findings.

Today's findings reflect input from 32,466 medical and surgical practitioners licensed by the Virginia Board of Medicine. You may recall earlier this year similar data was gathered regarding registered nurses. Additionally, this information is now available online and (for you are) formally informed to taking up constituents, legislative decision makers, economists, researchers, medical assistance and academic institutions.

The state encourages stakeholders to use content from the Department of Health Professions Healthcare Workforce Data Center to conduct their own analyses. The expectation is this will enable the medical community from

educators to those who provide medical care to place resources where they are most needed.

The Department of Health Professions Healthcare Workforce Data Center survey results from Virginia Physicians were gathered during the Board of Medicine's 2007 and 2008 license renewal process. And our one example of a proactive steps Virginia is taking to improve data collection on workforce habits from the Commonwealth Healthcare Workforce. I look forward to discussions with you today regarding the workforce trends of Virginia's physicians.

On behalf of the 13 state agencies that provide services for individuals with disabilities, seniors, low income working families, children, caregivers and providers, let me give you some perspective on what the state is already doing to address Virginia's supply of physicians.

Several weeks ago, the Virginia health reform initiative advisory council convened its first meeting in Roanoke, Virginia. Special attention is being paid to workforce issues and a sub-committee, a taskforce has been organized to look at workforce and capacity. Department of Health Professions survey data was presented that showed that despite an increase in the number of Virginia medical school graduates through 2014, the annual growth is declining. It's not welcome news considering the anticipated state national shortage of physicians and nurses by 2014.

On a brighter note, last month the new Virginia Tech Carilion School of Medicine and Research opened its doors to training 42 medical students. Last year, Eastern Virginia Medical School broke ground with a new facility. And Virginia Commonwealth University Medical College of Virginia begins construction of new buildings to (house) increased number of students. The goal is to assist state medical schools to achieve increases in class size to produce more medical school graduates.

As a result from the existing bond package for growth and expansion by 2015, Virginia's five medical schools will be in a position to train 786 students annually for careers in medicine and osteopathic medicine. This represents a

21 percent increase over the number of medical schools – medical students (to their) Virginia medical schools a year ago.

Virginia is now taking a hard look at how to encourage medical students trained here to work in the Commonwealth after they graduate. We are trying to identify medical residency programs for students train and remain as members of the local community.

The state's capital investment in medical schools will help meet future needs for healthcare professionals in the Commonwealth particularly in under serving rural areas and it will create jobs in these impacted areas.

As an orthopedic surgeon from a private group practice, I'm optimistic about the steps taken to date to improve forecast regarding Virginia's supply of physicians. (As the) Secretary of Health and Human Resources, I'm also very realistic about what it will take to balance this equation. Nothing short of the combined effort of government, private sector and informed citizens will do if we are to address the pressing healthcare needs of our time.

Together, using sound Virginia's specific findings from the Department of Health Professions Healthcare Workforce Data Center, we can lay the foundation to better meet the healthcare needs of Virginia's men, women, children and together families.

But that said, I turn the agenda back – back to Dr. Reynolds-Cane for an overview of what the state data actually show and the discussion about solutions underway of Virginia's medical schools to meet this ongoing demand. Dr. Reynolds-Cane?

Dianne Reynolds-Cane: Thank you very much for your comment, Secretary Hazel.

And now we will turn the meeting over to our panelist for their mini presentations. Our panel discussion will begin with Dr. Elizabeth Carter – Dr. Carter.

Elizabeth Carter: Thank you.

For those of you who are online right now, you actually have an advantage. You can look at the Web site as it's indicated earlier, www.dhp.virginia.gov/hwdc. Our four documents that you'll find posted there are the Physician Facts and Trends; our 2008 Virginia Physician and Workforce Survey Findings and Recommendations; our Physician Forecasting in Virginia 2008 to 2030; and our Data Cube, but not in exact order I think as we should have them.

But anyway, the key document I'd like you all to (put) all your greatest attention to at this time is the 2008 Virginia Physician and Workforce Survey Findings and Recommendations. Our Secretary Hazel indicated earlier the results that are included in this report come from a survey by the Board of Medicine that was about 2007 and 2008, and it's a two-year period because we have a biannual renewal for physicians and that's important for a number of reason.

But the data that you have there is, as you have been advanced a copy of the top messages from DHP 2008 to 2010 survey of the Commonwealth physicians in a document referred to as proposed concept for release of July – August 2010, the key messages are there. Basically, we are anticipating an increased demand for physician services at the time when there's a decrease in supply of medical doctors.

Some 39 percent of Virginia's physicians work in primary care specialties such as pediatrics, semi practice and internal medicine. Only 23 percent of Virginia's Physician Workforce graduated from Virginia medical schools and only 30 percent completed their residency in the state in accordance to the American Association of Medical Colleges. Virginia retains only 35 percent of its medical school graduate and 39 percent of its resident ranking at 31st and 29th respectively on the state.

We know that from the survey, approximately 85 percent of Virginia physicians are working full time. Almost 60 percent spend 40 or more hours per week on patient care activity. About one-third of survey respondents were age 55 or older, and it's pretty significant. And 10 percent were 65 or older.

By age 65, we know this, (a third) of respondents who are still in practice reported that they are only working part time. And by age 70, this figure jumped to over half. Although physicians intend to retain – remain in the workforce longer than other professionals, there is no doubt that a substantial (percent) of Virginia's (inaudible) physicians will be leaving the workforce or just will not involve in practice within the next decade, because (today – today's) physicians, again, they cut back their hours or retire after reaching age 55.

Meanwhile, persons age 65 to 75 in a population require twice as many physician services as a population in general. And those persons over age 75 require more than three times as much care.

We will be – in fact we are now as a result of the Healthcare Workforce Data Center Advisory Council's work and with the support of the – with the Physician's Advisory Committee changes to this 2007 – 2008 survey have been included and one of that has actually been launched in December of 2009.

Those changes reflect the need to get more demographic information. Currently we only have age. We'll be gathering race, ethnicity, and we'll also ask questions about when they intend to retire, and that's something that has not been asked for previously. And that survey is underway right now and we were able to have at least one year's worth of that two-year cycle by the end of December. And we intend to do an (annual) report on our findings in early 2011 and then the complete report we'll have in 2012. That's important to note.

The second that we have is referring to the Data Cube. What are they're interested in this is primarily folks that are really into research. The data cubes actually break down the findings in fine details. So for those of you that are really interested in that level of specificity, (these have it).

One key thing I need to say about our Physician Forecasting in Virginia this 2008 to 2030 is that forecasting supply and demand is in its infancy. It's in the national level as well as in Virginia. Currently there are also three models,

if you will, out there. There's one from the Health Resources and Services Administration, HRSA. There's one from the American Association of Medical Colleges. And based upon the methodology used in the AAMC model, Virginia attempted to pull together data that we have from our survey to predict what Virginia's forecast would be over the next 20 years.

I'm not so sure how – how successful we are at it. We're all beginning this process. I guess the basic message to take away, though, it doesn't matter what one model tells you, your six percent deficit and the other 38, regardless we are definitely high on the – one the verge of a tremendous gap in the supply and demand of physicians were only worsening over the next few years, so that we need to take that away as a very telling point.

Our focus for the Healthcare Workforce Data Center is not to do all those fancy analyses, if you will. Our primary mission is to ensure that we have the very best, empirically validated workforce data and that is our mission and we're here to provide that service for the Commonwealth.

We'll be gathering this data over time and that's when you really have a good opportunity with really good data that comes directly from the respondents be it the licensee themselves as part of their licensure renewal process. This allows us to – at this point we're actually getting a 90 percent response rate from those people who are renewing, which is excellent. We don't – we no longer really need to sample our physicians the way that we had to do in the past. We can actually pretty much get – get a 90 percent response rate. So that tells us much more than we had in the past.

In closing, there is a new Virginia Health Workforce Development Authority, which was created through legislation passed in 2009. It's currently being established and will serve as the coordinating agent for information affecting Virginia's Health Workforce through working with state agencies and other stakeholders. And the Healthcare Workforce Data Center stands ready to assist them by serving Virginia's source of empirically validated workforce obtained information. Again, not from selected sample, but from all licensees and we help only to improve this process from now on.

Also (inaudible) which is in your request sheet from yesterday, I'd like you all to please feel free to utilize the chart, the graph and any of the information that you see in our Web site document. That is open to the public domain, which, though, we ask that you acknowledge their source.

I thank you and I turn this over to Dr. William Harp. Thank you.

William Harp: Thank you, Liz, and good afternoon everyone.

Many of you may be familiar with the Virginia Board of Medicine and its role. But just as a quick review, the board is a state agency that licenses physicians and practitioners of 13 other healthcare professions. They regulate them, imposes discipline and requires a mediation when warranted in accordance with law and regulations.

The board currently licenses approximately 55,000 individuals and the work of the board is accomplished by its 18 gubernatorial appointees, the 40 members of the eight advisory boards and 16 board staff. The Board of Medicine is pleased to be able to assist the Department of Health Professions and the Healthcare Workforce Data Center in its initial efforts on the Physician Workforce.

The representative of the board serves on the Physician Advisory Committee of the Workforce Council as a resource to help with the development of survey instrument, identify sources of existing data, determine best approaches and data gathering, as well as the most accurate and user-friendly ways to present the data.

The board is first introduced for workforce issue in August of 2003 when Dr. Arthur Garson, then Dean of the University School of Medicine or University of Virginia School of Medicine, approached the board regarding any data it might have on physicians work activity. The answer was that no such data existed. And from that conversation grew an initiative to query all doctors of Medicine and Osteopathic Medicine about their current and projected work weeks as they renew their licenses.

Dr. Garson coordinated with deans of other medical schools. And with the help of Dr. Steve Mick of Virginia Commonwealth University, the surveys became a reality for the 2004 renewal cycle. The medical community enthusiastically embraced that first presentation of the survey and revised versions of the survey have been integrated into the renewal process for physicians in 2006, 2008 and 2010.

The ongoing and evermore refined collection of data by the Department of Health Professions all began with a vision of Dr. Garson. He is our next presenter and he is currently the Executive Vice President and Provost for the University of Virginia and he's also the Robert C. Taylor Professor of Health Science and Public Policy.

Dr. Garson's journey to his present post stretches from his undergraduate days at Princeton, the medical student with Duke, residency in Pediatrics at Duke, and fellowship in Pediatric Cardiology at Baylor where he subsequently became Chief of Pediatric Cardiology in 1988.

In 1992, he earned the Masters in Public Health from the University of Texas, Houston. And since that time, in addition to practice of Medicine, he has provided distinguished executive leadership in physicians with Baylor College of Medicine, Texas Children's Hospital, Texas State Department of Health, Duke University School of Medicine, North Carolina Vocational Rehab Commission, the American College of Cardiology Institute of Medicine, the Department of Health and Human Services on the White House. He served on the governors of Virginia Blue Ribbon Commission on health insurance and uninsured and he chaired the workforce committee for the Virginia's Healthcare Reform Commission.

His awards and honors are many. His passion for quality healthcare is unmatched. He teaches at graduate level health policy course at UVA, "Myths and Realities of American Healthcare." He's the author – or editor of more than 400 publications including eight books. His book, "Healthcare Half Truths: Too Many Myths, Not Enough Reality" was published in 2007.

Dr. Garson will help us understand from the medical education and policy perspectives how the Physician Workforce can be strengthened. Dr. Garson.

Arthur Garson: Dr. Harp, I appreciate you introducing my older brother. He thanks you.

One thing, of course, you could not say that I very much want to say is that entire effort would not have began or continued without Bill Harp, and that's the straight-out truth. So this really took a combination of two people with a small idea and a huge amount of implementation. So on behalf of all of us, I thank you.

Dr. Reynolds-Cane, I can tell you that when you used the word "rallying" and you refer to deans, these two words don't fit together, so you give me too much credit. The deans are phenomenal in this state. I know a lot around the country the deans are phenomenal here and they're rallying those to really do what they can to increase the workforce here.

I've got a fair amount of study on the (Leuven) methodology which is the one that was used here. And I have finally come to the conclusion in public that it's darn good. There's some things about it that we'd tweaked in looking at the Cardiology workforce nationally. But the basic premise is likely to be pretty accurate that somewhere between 2,000 – 2,500 and 3,000 physicians are going to be necessary to meet Virginia's need within the next 30 years.

That translates and interestingly that's the (Leuven) data. It's about 50 percent primary care according to them and nationally. And so we talk a lot about the need for primary care practitioners and we need primary care practitioners. We also need specialists. Even some orthopedic surgeons who might go back to practice.

Male: Be careful, (Dr. Garson).

Arthur Garson: Even some cardiologist.

The data – if you multiply it out, though – and Dr. Hazel talks about what the medical schools are currently can do, it looks like about 786, which is the number Dr. Hazel – Secretary Hazel gave us. If you then say 35 percent

remain in state, that adds 275 physicians per year, which would require a doubling from that, a doubling in the number of graduates of our medical schools for 10 years.

Now, that's not going to happen. All right. What you've seen is that the 786 is about what our schools, I believe, are capable of right about now. Now, I suspect – I really give the state tremendous credit. I give Carilion tremendous credit for starting a school. That is tough. But the combination between starting a school and increasing student numbers, as Secretary Hazel and I were talking about beforehand, one of the real issues here is how do we keep people here, because if you could double the number of people staying, you have that same kind of effect.

So I would think that there are a number of approaches that the medical schools are doing. Some of them are pretty standard, meaning you can increase the number of students, meaning you can have at least one new school. But I think we need to think beyond that. That's – that we know what we can do, that's going on right now.

When I had the opportunity to talk to some of the general assembly a couple of years ago, at least at the time they were surprised that graduate medical education slots were kept and could be increased.

And one of the things – and let me, as I now speak for another couple of minutes, let me remind myself and everybody else, I'm speaking on behalf of me, not the University of Virginia. I want to make that real clear because these are not proposals from the University of Virginia. I'm just putting out a few thoughts here.

The idea of having graduate medical education slots is important because you can go ahead and increase the number of medical students all you want. Graduate medical education, meaning residency slots are the responsibility of hospitals to pay for them any additional slots given the fact that Medicare capped a number that they were paying for.

The state could consider funding residency slots. As you heard, there is a slight differential in this state from 31 to 39 percent that there is a differential

in other states where even a greater percentage of people who finished their residencies stay in that state. So increasing the number of residency slots available in the state is one way of thinking about doing this.

But would you do it with no strings? I believe you would not. I believe the state could fund some GME slots but could say, by the way, if you get one of our slots, you stay for five years. You must be (able to stay).

You could also, given the fact that in current healthcare reform, if there is a 50 percent improvement in coverage, half of that coverage is going to be taken by Medicaid. The idea of giving some incentives to physicians in the state to see Medicaid patients is another thing that could be considered. Example, if you are going to take one of these state GME slots, you also have to see a certain number of Medicaid patients for a certain number of years.

You could do the same thing with loan repayment. Loan repayment became a pretty much rallying call for the state workforce working group that I chaired. But the question is, OK, how long – I think if the state is going to – is going to do loan repayment for somebody, you might want them to be here for five years. And, again, you could tie that to a certain amount of Medicaid, of seeing patients who are covered by Medicaid.

Paradoxically, the fourth – that's three. The fourth, you might not think that payment for quality is something that would be related to physician workforce. But in an estimate just done by the American College of Cardiology last month, that giving payment for quality, meaning incenting behavior that says, do exactly the right thing and more. There is a – at least a projection that less will be done giving physicians more time to see more patients.

So those – and that projection could be as much as 10 percent over the next 10 years. And it's not conscious. It's not physicians you've seen the data. In fact, there is a variation across the country of 400 percent in the rates of things like stents – putting stents into people or coronary bypass surgery with very similar results. And if there was a way that the state can develop to pay for quality, I believe that at least some of that at the margins might result in less

services, the appropriate services being done, perhaps some less service being done permitting physicians to have more time to seeing more patients.

The last is a little bit – it's not radical, it's just not about physicians. It's about non-physicians, which is to say can we develop a workforce model that says, all right, we're not going to get there. We're not going to produce enough physicians or nurses in the Commonwealth, and so we better get about (pushing it out) at the delivery systems.

One of those is to sort of obvious but not often talked about thought of including the public as part of work – as part of the healthcare workforce. And really rallying to say, all right, public, take care of ourselves. How can we educate the public to do better care of themselves and it's not just prevention. It is prevention, but it's follow the directions. It's come back to the doctor when you're told. It's take your medicines. Those are pretty simple things, but if you think about including the public as part of the workforce, that may in fact the reduce some of the needs of physicians to do as much work as we're doing.

We can leverage the public. We can leverage the non-physician providers and mid-level practitioners, (to be on the best) practice nurses, within the limits of what they are permitted to do by the state, and perhaps think a little bit out of the box of permitting them to do those things that are appropriate that the Board of Medicine, the Board of Nursing, the Department of Health Professionals would allow them to do.

One program that we're working on is – involves training laypeople to work with nurses as observers and to help them to do very simple primary care, using protocols developed by nurses and physicians to help people, for example, go home from the hospital. One could take a lay person who's trained and send them home from the hospital that day with somebody with heart failure and say, show me your medicine. Show me your scale. Show me how you're going to remember to take your medicine, (then) take a nurse to do that. I'll call you in six hours. I'll remind you to take your medicine. I'll be back tomorrow.

Those are the sorts of things that we want to be thinking about to leverage nurses and physicians to really allow physicians and nurses to do what only they can do, and allow others to do what they can do, certainly, only as allowed by law.

So, in summary, I guess our issue here is access. We're about to have twice as many – you know, the uninsured we hope are cut by half, which means we have to improve access. The four ways, I think, to put a rapid infusion into that, you've seen the medical schools are doing what they can. I do not believe they're going to be able to double their output.

And so graduate medical education slots, loan repayment, physician payment for quality, and some new programs, perhaps training lay people to be able to work with nurses and physicians in the appropriate way.

Thank you.

Dianne Reynolds-Cane: Thank you very much, Dr. Garson. And thanks – deepest thanks to all of today's panelists and members of the media who are with us for today's physician data launch.

We are not done. We will hear Dr. Hazel's closing remarks, and then we will open the phones for your questions. Dr. Hazel?

William Hazel: Thank you, Dr. Reynolds-Cane.

Well, Dr. Garson, we appreciate your leadership in this area and your thoughtful suggestions. The Virginia health reform initiative is obviously quite concerned that as we – as we expand the promise of care, the promise of insurance that we are actually able to meet those promises, and we know that if we were to do a number of things right away that are very expensive, that we still would be unable to continue to do business as usual in the commonwealth.

So, to that end, we have groups looking at how we will actually provide service, how we will pay for it. And we will look at our capacity, we'll look at the work and the usage of technology. We will look at insurance regulation

reform. We will look at how purchasers buy insurance, and then we will look to the Medicaid program itself to see if there are things that we can do to make our system more effective and efficient.

I appreciate the work here at the Data Workforce Center. I think this is very important in helping us get started, understanding where we are and what we need to do as a matter of public policy. I look forward to answering questions and thank all of the panelists in advance.

Dianne Reynolds-Cane: Thank you, Secretary Hazel.

And now we will open the phone line. This is an operator-assisted call. The operator will take questions in the order in which they are received, and we'll indicate which area you are calling from. Before you state your question, please tell us your name and news affiliation.

And now, I will ask the operator to provide you additional call in instructions. Is the operator there?

Operator: At this time, I'd like to remind everyone, in order to ask a question, please press star then the number one on your telephone keypad.

Your first question comes from the line of Veronica Chufo. Please state your geographic location. Your line is open.

Veronica Chufo: Hi. I'm with the Daily Press and Newport News. I'm calling – I was hoping to ask (that some of I've heard), the argument is that Medicaid reimbursing tier are so low compared to other states. Is that a factor in physicians leaving? And is there any effort afoot to change the Medicaid reimbursement rates?

Dianne Reynolds-Cane: (The answer), Dr. Garson or Dr. Hazel.

William Hazel: This is Dr. Hazel, Veronica.

The ability of the state as a pay provider is very much an issue in terms of access to care for the patients that we are responsible for in the state program of Medicaid. The – we have seen with the budget issues over the last few years some pressure to reduce costs in Medicaid. Medicaid is one of the

fastest growing areas of the budget, and those of us who are also concerned with such minor things as education and transportation do worry about that.

We are looking (as) part of Virginia health reform initiative, we have a group that will be looking at Medicaid, and specifically the way we hope to address that is to say, well, yes we have to pay for the services that are provided, but perhaps we could organize the services a little better. Perhaps we could get people to a more appropriate setting of care that's less expensive, say at home, with assistance as opposed to a nursing home, and so forth. So we will – as we go into this year's budget cycle, we will be looking at more of those opportunities to create some savings so that we can actually pay the providers adequately.

Dianne Reynolds-Cane: Thank you, Secretary Hazel. And the next question, please.

Operator: Again, if you would like to ask a question, press star one on your telephone keypad.

Your next question comes from the line of Amy Jeter. Please state your geographic location. Your line is open.

Amy Jeter: Hi. This is Amy Jeter. I'm with the Virginian-Pilot in Norfolk. And my question involves the retention statistics. I was wondering if you all could explain what is the significance of those statistics? Why is that important? And do you think that the problem with the (thinning) – the medical school graduates and residency here in Virginia, is that going to – I'm sorry. Is that going to influence the projected physician shortage? Is that going to contribute to it?

Dianne Reynolds-Cane: (All right). Dr. Garson?

Arthur Garson: The retention statistic means how many people who finish training stay here.

Amy Jeter: Right.

Arthur Garson: That's what that means. And Virginia, as you heard, is below the median by a fair amount in the country. That, to me, is actually good news because it gives

us opportunity. That's one of the relative – if you say would you rather be dealing with a low retention rate or a high retention rate, I would rather be dealing with a low retention rate. It's a lot – when I say easier, there are things that can be done in a commonwealth, whether it's loan repayment or anything else, whether it's telemedicine, whether it's the use of technology, whether it's state programs, as the secretary was talking about, like the one we're developing where we're using lay people to (provide here) at home and thereby reducing emergency room visits.

Some of these things are going to make life better for doctors in Virginia. And as you make life better for doctors in Virginia, they're going to stay here. And as you have them stay here the number of doctors therefore increases.

William Hazel: Amy, this is Dr. Hazel. To add on, the reason the residency slides where graduate medical education is important is when physicians leave medical school, they want to go get trainings that they want where they can get it. And to the extent that more physicians can train for their graduate medical education in Virginia, the likelihood that they will stay in Virginia increases.

Amy Jeter: To follow up, I guess what I'm wondering and having (inaudible) in focus beforehand is if we have enough – if we have physicians coming from other states that are practicing here, that – why does it matter whether they had their training here?

Dianne Reynolds-Cane: Dr. Garson?

Arthur Garson: If you can guarantee that somebody's going to come from another state here, can do things for people here, to keep them here, then you better believe that some of the things that I would – that we've all talked about, about keeping people here, we'll also track people here.

The issue here is we need about 3,000 more docs, and whether those – whether – there are probably five or six or seven different approaches to making that happen, some of which will also attract docs from other states.

William Hazel: Amy, as we look at the Virginia healthcare reform initiative, the Advisory Council is charged with looking at things that with the measures of what good

health reform in Virginia would do. And you think about the obvious things like access to care for people and cost of care and quality and safety and patient satisfaction, but provider satisfaction is one of the things that I suspect we will find ways to measure, because absent an environment in which physicians, nurses, dentists want to come work in the commonwealth, we will have trouble attracting people.

We are not the only ones in this position. This is a national problem, and we are competing to get these people to come in and to be there when we need them.

Amy Jeter: Thank you.

Dianne Reynolds-Cane: And thank you Dr. Hazel.

We have a question from – in the room. We have a number of the media here, Tommie McNeil from Public Radio here in – from here in the commonwealth, who has a question.

Tommie McNeil: All right. Although there's been an (inaudible) on the needs of specialists (inaudible). I'm sorry. There's been a – (it's a place) where they need (some specialists), and I was just wondering, would the training of more (physicians' assistants) help address the need with – more immediate needs for physicians in – primary care physicians in (inaudible)?

Arthur Garson: Let me be sure that I was clear. The data are pretty clear that we need both. We need both primary care practitioners and specialists. And if you think about it, it's – it is amazing to me that we go back 17 years and the data are similar, which is it's about 50-50 of what we need. Now, we don't have 50-50 (right now), but that's what we're talking about.

Now, your question about the non-physician, and there's a better way to say that, and it always – these are really important people, and so it's better to call them, I guess, physician assistants, advanced practice nurses and others. You bet that there is a need for those people as well who can, again, work within the limits of their licensure to do what they can do.

But, again, we've taken it one step down with our program called (Grand Age) where they're ultimately going to work with – this is lay people who will be trained for a year, who can then work as part of a team in a medical home, but help nurses dealing with colds, those kinds of things. Physician assistants and nurse practitioners can obviously do much more than that, and I think part of what the you know a commonwealth or any other state is going to want to do ultimately is really look at what should these people do, what is the limits of their licensure, and –

But the idea that this is now teamwork, these are people who can work together. We have not talked a lot about electronic medical records, but as electronic records come into more use, tying teams together like that, even with the patient, will improve things.

So that was a long way of saying, yes.

William Hazel: If I might add – this is Dr. Hazel. One of the issues that we face, quite honestly, is that the MD training is very expensive. It's – the four years of medical school costs \$450,000 to \$500,000 at the schools in Virginia. Now, student tuition pays for part of that, which means student loans for that, and we have some very high student loan debt in Virginia because the state budget does not pay for – pay very generously for medical education.

Now, at the – at basically at half a million dollars a pop for four years of medical school, then you have to have three or four more years of graduate medical education before these physicians are able to be really utilized and practiced. What we do know, I mean I think that Dr. Garson can say from UVA standpoint is to take a nurse and to make it – to get a graduate nurse, it probably costs about \$28,000.

Now, it is not – it is clear that a nurse practitioner and a physician with graduate training are not the same, but we do have to be very mindful of the things that people are trained to do, that they are able to do, because it is much more cost effective if it can be done properly and safely. And that's something that we will have to look at in the capacity part of the Virginia health reform initiative.

Dianne Reynolds-Cane: Thank you, Secretary Hazel and Dr. Garson.

And next question?

Operator: Your next question comes from the line of Chris Whitley. Please state your geographical location. Your line is open.

Chris Whitley: Yes. I'm in Roanoke, WSLS. I just wanted to – (I wondered if you) could maybe speak specifically to how important the new Carilion School of Medicine, West Virginia Tech, is in this whole process.

William Hazel: I'll take a shot at that. You know, being the thing that I'm supposedly the politician in the room and there's a vacancy or there's a void, no noise, I'll fill it. (I'll take it), Chris.

Chris Whitley: No problem. Who is this?

William Hazel: Who is this? Sorry. Art Garson, (G-A-R-S-O-N). Orthopedic surgeon Garson.

No, this is – this is Dr. Hazel. I'm the Secretary.

Chris Whitley: Oh, good.

William Hazel: You know, we welcome – we welcome the school, Carilion. I think that, clearly, there has been a really – a very strong community-based effort here to create a medical school. In fact, sort of a whole novel for Virginia, a novel (chair) system in Carilion, and I applaud their effort to do that. The graduates will be welcome, and I wish the – wish them great success.

Dianne Reynolds-Cane: Thank you, Secretary. Would anyone else like to add to the Secretary's comments?

Arthur Garson: Yes. I mean – this is Tim Garson. I couldn't be more supportive of this. We need more docs. Let's make more docs. Let's make more docs the most efficient and effective way that we can. There are wonderful people out there.

You know, one might wonder if you'd say well, OK, the other schools, can you double your output and therefore you know take an existing infrastructure and add that many more doctors? Terrific. But none of us can do that. And so, I think the answer is, at least one, it is not easy, as I will – I'm sure the people at Carilion will attest to, starting that kind of infrastructure is not only difficult, it's expensive.

And so, it doesn't seem that the best you know idea for any place is now let's create 15 new medical schools in the commonwealth. That's going to be expensive and inefficient. But I think that you know these are wonderful people out there and they're doing great work.

Dianne Reynolds-Cane: Thank you, Dr. Garson.

Next question.

Operator: Your next question comes from the line of Sarah Jones. Please state your geographic location. Your line is open.

Sarah Jones: Hi. I'm with the Roanoke Times in Roanoke. I...

William Hazel: Are you sure you're in Roanoke.

Sarah Jones: I am here in Roanoke.

William Hazel: OK. (Inaudible) Carilion?

Sarah Jones: No. I'm wondering about what kind of obstacles there are to increasing residency slots. I mean, it sounds like that's one area, and I've heard you know talk of wanting residency slots. But what are some of the specific obstacles there and have you measured that at all?

William Hazel: Sarah, this is Dr. Hazel. This conference is scheduled to be over in 20 minutes. We don't have time to read you the list.

But it is very complicated. The first, I think – well, there's several issues. Clearly, finding (inaudible) one, medical schools are expensive. That's one. It is very hard, as Dr. Garson said, to get it chartered. You have to have a

vision. You have to have financing. You have to go through accreditation processes to be accepted.

You then have to recruit capable students to come to your school. You have to train them, then you have to get them graduate training because we don't practice right out of medical school. There have to be slots. And, quite honestly, right now the graduate training, what you do after medical school, which is also expensive and competitive, is a – is a challenge (for a lot) as well.

So this is an enormously complicated issue, access to the patients that you would see is an issue. Access to the technologies now that we use in training to the simulations and things, it's very expensive. It's – so as Dr. Garson just passed me a note that said he's thinking about starting a new medical school, (inaudible) now, if you hear a – if you hear a report to back that, my deputy (inaudible) is Dr. Garson.

Arthur Garson: You know, this is – this is (DCT). OK, (here it is). An issue also, you asked about you know can you infinitely, with all the money in the world, could you increase residency slots? And the answer is of course not because you need a certain case load.

And so, the issue is not saying – you know, if now, magically, the commonwealth said, oh, terrific. Let's just you know pay hundreds of millions of dollars for more residents...

William Hazel: Let me interrupt. This is Dr. Hazel. I don't think we can do that.

Arthur Garson: I was – I was treating that as a given.

It is – you know, there are very strict – and are getting stricter – rules of competency that say you got to do this many hip replacements. You've got to – you know, under supervision. You've got to do this many different things. Even in the primary care practices, you've got to do a certain number of procedures, see certain numbers of patients.

So it is not simple. And – but I think we – everybody can do better, but it's going to take a combination – like I said, it's probably six or seven or 10 different things because pushing the pedal to the metal with any single one wouldn't work.

William Hazel: I would add one more thing to that Sarah, and that's faculty. You need teachers also, and not everyone has the disposition to understand the art and science of medicine and then train people and to give them just the right amount of responsibility and accountability at just the right time, it is very hard to train that population of people and insure that they have the teaching skills. And that's – that is no small part of this effort.

Sarah Jones: I guess what I'm a little bit lost is if one of the ideas is to encourage more doctors to stay in Virginia by creating more residency slots, do you have an idea of how many more residency slots could be created? Is there like a goal to shoot for, or...

William Hazel: I think that right now, the data that we're looking at is going to help us get to that goal.

Sarah Jones: OK.

William Hazel: That's the – that's the wonderful thing about this information, if we already knew that, we wouldn't need this. But this is a starting point and this is a step to trying to determine that.

Dianne Reynolds-Cane: Thank you, Sarah.

Next question?

Operator: Again, to ask a question, press star one on your telephone keypad.

Your next question comes from the line of Veronica Chufo. Please state your geographical location. Your line is open.

Veronica Chufo: It's Veronica from the Daily Press and Newport News again. I...

William Hazel: (Inaudible) again, Veronica?

Veronica Chufo: This is for Secretary Hazel. The suggestion.

William Hazel: He just left.

Veronica Chufo: Those suggestions that Dr. Garson brought up about loan repayment pay for residency, pay for quality, which I don't know if the states really can do anything about pay for quality, but what are the likelihood that those things would be – that the state could jump in on this thing?

William Hazel: Well, I think you've asked several questions all wrapped in one. And, in fact, this is part of the subject matter for the health reform initiative as we look at the delivery system reform and payment reform.

And I think that one of the – one of the interesting things that we have in Virginia, even today, most of us would suggest that if we keep doing things like we're doing, we don't actually have enough people to do it all today. And as we add maybe 600,000, 700,000 people as patients with insurance in 2014, we will certainly be struggling with our capacity. So we have a whole group looking at capacity.

I for one know – would say that the idea that we can continue to get more for less is probably unrealistic, unless we change the way we do things. And there is a – I will quote my father. My dad says it's a Wal-Mart world. Everybody wants more for less.

But the only way you got Wal-Mart was something called supply chain redesign. They went very – they go back all the way to the manufacturers and tell them what they want and how it's going to be packaged and how it's going to be delivered and how it's going to be paid for. And I think that if we really want to do reform in an economically responsible way, we're going to have to look at all of these elements.

So everything you've listed is on the table. Now, you have to balance that with the very hard economic reality. When I got the (keys far) from the governor in January, he said, Bill, you need to do health system reform. And, by the way, we need to have \$5 billion in budget cuts. And those two don't

necessarily go well together, so we have to be very careful that as we select and work through this that we get things that are likely to be most effective.

I think payment reforms are a given. There are models out there. I think that payment reforms are a given. I think that loan repayment is something that we need to – we need to think about. Funds have to come from somewhere for loan repayment, which makes that not an easy thing to do for a legislature that's already stretched thin with funding.

So we will – we will be presenting options to Virginia health reform initiative and discussion over time to address all of these.

Dianne Reynolds-Cane: Thank you, Secretary. And thank you Veronica.

And next question?

Operator: Again, to ask a question, press star one on your telephone keypad.

Your next question comes from the line of Bill Dubensky. Please state your geographic location. Your line is open.

Bill Dubensky: Hi. This is Bill Dubensky, WFLS in Fredericksburg.

Has this physician forecasting taken into account population growth? Because here in the greater Fredericksburg area, within the last year and a half, we've had two hospitals that never existed, open.

Elizabeth Carter: Absolutely. It's part of the analysis, (plus) (inaudible) basics certainly (puts this) into consideration there.

We're quite – we're quite well aware of the fact that Virginia is growing. As you indicated, in Northern Virginia, quiet a bit so, and it's – in the report, we indicate that one million more people will be here in 2020 than are out here today, so that's a significant growth.

I'm Elizabeth Carter, by the way. But thank you.

William Hazel: Bill, this is Dr. Hazel. I'd like to add to that.

It's one thing to try to predict how much the population is going to grow in the next year – next 10 years, but it's another thing to predict how the population is going to age in the next 10 years. And I think I can probably more reliably tell you that the population will age than I can how many people will come in, with the exception of Dr. Garson. He's ageless and timeless...

Arthur Garson: I was going to say all three (inaudible).

William Hazel: The issue is we believe right now that the Virginia population in 2020 will look like Florida does today. That's what our Virginia Department of Aging believe.

And when we look at an older population, we look at a population with people with multiple medical conditions, take – and many of them taking four or more medications. We look at – we look at the fact that a lot of that coverage comes from Medicare, a federal program that the state has nothing to do with, that typically underpays and transfers costs to other providers.

So it brings us an additional whole stack of regulations that come with that, too, so it is a challenge. And I was just in Fredericksburg I think, what, 10 days ago, or a week ago, speaking at Mary Washington and had the opportunity to visit there. But your community in Fredericksburg will be very much affected by this.

Bill Dubensky: OK. Thank you.

Dianne Reynolds-Cane: And thank you, Bill. Thank you Secretary Hazel and thank you Dr. Carter.

And next question.

Operator: We have no further questions at this time.

Dianne Reynolds-Cane: Thank you very much. Again, thanks to everyone who dialed in today to listen to our presentation. And thank you to all of the panelists who gave so much of their time and intellect and information today to make today's presentation run along wonderfully well.

And we are – we are done. Thank you very much.

Operator: This concludes today's conference call. You may now disconnect.

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