May 15, 2016

1:00-4:30 PM

Florida Physician Workforce Advisory Council
**Meeting Minutes**

Council Members Present:

- Celeste Philip, MD, MPH, Surgeon General and Secretary of Health, Chair
- Amy Beaven
- Thesla Berne-Anderson, MS
- Michael Curtis, MBA
- Linda Delo, DO
- Michael Gervasi, DO
- Gary Goforth, MD
- Jim Howell, MD
- Alma Littles, MD
- Ralph Nobo, MD
- James O'Leary, MD
- Dennis Saver, MD
- Paul Seltzer, DO
- Sergio Seoane, MD
- Kevin Sherin, MD, MPH, MBA, FACPM, FAAFP

DOH Staff Present:

- Steven F. Chapman, PhD, Division Director, Public Health Statistics and Performance Management
- Duane Ashe, Health Resources and Access Administrator
- Debbie Reich, State Primary Care Office Supervisor

Interested Parties Present:

- Diane Davey, MD, University of Central Florida
- Chuck Paides, MD, MBA, University of South Florida
- Tom Wallace, Bureau Chief of Medicaid Program Finance, Agency for Health Care Administration (AHCA)

A quorum was present. Three Board members participated via conference call and could actively and equally participate in the discussion.

## I. Welcome and Roll

Dr. Philip thanked everyone for taking out time to meet in person on a Sunday to reset some of the previous discussions to focus on alignment. She encouraged discussion regarding existing resources the Council could leverage and plans already in place that need additional attention and support.

This conversation will allow progress to be made within the context of the existing strategic plan and the charge of the Council.

## II. Minutes from December Meeting

December 2015 meeting minutes were approved on a motion from Dr. Delo, and seconded by Dr. Seoane.

Dr. Seltzer mentioned that the minutes stated a GME disbursements spreadsheet would be provided. Tom Wallace supplied a link to the information which was posted to the PWAC website, but some council members were not aware of the link, and no attachment was provided. Staff said a link to the AHCA website is on the PWAC webpage, and the link information was sent out to members. One of the members confirmed this. The spreadsheets from Mr. Wallace will, however, be provided to Council members by staff, in addition to the link.

## III. Opening Comments

The Department is tasked with leveraging existing partnerships. There is a section in the PWAC strategic plan that looks at creating a pipeline for how we can engage elementary, middle, and high school students to think about a career in medicine. She feels that is an area of huge potential.

Dr. Littles mentioned the Department having survey results. Staff confirmed we do have 2014 responses collected from Colleges of Medicine about their pipeline programs. Dr. Sherin commented AMA singled out Florida as a good state for Hispanic medical students and FSU provided leadership with its SSTRIDE (Science Students Together Reaching Instructional Diversity and Excellence) Program. Dr. Seltzer sees quite a bit of diversity in terms of culture, but not diversity in terms of what socioeconomic class they come from. Several of the pipeline programs address this. Dr. Gervasi mentioned this being an opportunity for FQHCs to have a role in economic diversity disparity. Dr. Sherin shared how physicians go into the schools and become mentors and role models getting the students interested in careers in medicine. Ms. Berne-Anderson spoke about the FSU pipeline program which starts at 8$^{th}$ grade; SSTRIDE has elective courses in middle/high schools and leadership development. The program is working with these students every day and has been for 22 years. Dr. Nobo reinforced the importance of starting at that age to give the students hope.

Ms. Berne-Anderson stated that it is not an easy task in trying to secure funding and resources for these programs. Dr. O'Leary mentioned the problem of medical school debt which averages $180,000 and could reach as high as $220,000-$250,000. And there is not enough scholarship money to go around. Dr. Philip asked if SSTRIDE or any existing programs for the state have data, and the answer is yes. Dr. Littles feels it is important to review the pipeline information received in 2014 and go from there. Dr. Howell mentioned in years past the AHEC program used to fund some of this, but is now dedicated totally to tobacco cessation programs, so the resources are really not there. He read an article where a number of minority groups are avoiding medical school, because of debt potential, but feels the FSU program is a wonderful model.

Dr. Philip requested staff to revisit the 2014 pipeline survey data and would like the responses to be summarized and given to the group. Since that information did not include outcomes, this could be the next step. Finding a way to collect this data may be difficult, but she senses being able to track the data to show it is worth the investment might be a way to look at more stable funding. It is very important to think about how the Council can do that. If there is an interest in getting the schools together who have these programs, maybe the Council could look at standardizing how the students are tracked.

Dr. Delo commented that nationwide a lot of people are not going into family medicine because of huge student debt, and everyone is trying to find a solution. She recommends the loan pay-back programs be considered for physicians in underserved areas. Unfortunately, that kind of program, and state funding for it was stopped. Dr. Saver does not believe 8$^{th}$ and 10$^{th}$ graders are at a point to think about debt, but agrees there are no good programs to reduce debt, and opportunities for

loan repayment are limited. Dr. Gervasi responded to a comment over the phone from Dr. Howell that using National Health Service Corps (NHSC) as a recruiting tool has been very successful. Dr. Sherin suggested the Council begin to investigate social/capital bonds where investors finance bonds, even to include scholarships. Dr. Littles said a number of hospital systems have funded parts of students' medical education. Ms. Beaven can compare pipeline data to their surveys to see if she has more to contribute.

The number of students graduating is not the problem; instead it is retaining physicians in Florida and the lack of federal funding for GME. Dr. Nobo sees the need to have more GME to retain students. Tom Wallace (AHCA) recapped state/federal GME funding and stated that Florida is approaching the federal cap for funding through its Medicaid program. State funding for GME is considered part of Medicaid reimbursement. To receive more federal share, we need state match. Dr. Littles explained the history of the Medicare medical resident cap issue based on the Balanced Budget Act of 1997. Another option for creating ways to fund GME is partnerships between city, county, state and federal governments.

Dr. Delo said confirmed that this is a big problem and asked how the Council may come up with other ways to fund GME by other state incentives or private sector involvement to help hospitals and communities? Dr. O'Leary suggested an initiative to reach out to Humana, for instance, to fund programs. He stated that GME, not the pipeline, is the most critical thing the Council can address for impact.

**IV. Update and Discussion of Board of Governors Physician Workforce and GME Activities – Amy Beaven**

Amy Beaven works with the Board of Governors (BOG) for the State University System (SUS) and spoke about the background of BOG for new members. Six of the nine medical schools are under the SUS. She staffs a special committee created in late 2013, the Health Initiatives Committee, tasked with a data-driven environmental scan looking at three areas of health (health care workforce, health care delivery, and health-related research). From their findings, three extensive reports and a 10-page summary were generated. At the end of last year, they put together a strategic plan to see if there was anything the SUS could do to make an impact. They focused on two main goals:

1. Building workforce in areas of identified need
    a. Physician shortage
    b. Nurses with advanced degrees
2. Health-related research

The number one barrier is GME. Florida has sufficient medical students, but GME is needed to keep them in Florida and recruit others to Florida. Last February the committee held a workshop, and Dean Michael Good from UF, speaking on behalf of the Council of Florida Medical School Deans gave a presentation which included numbers, suggestions, and recommendations. Florida needs about 3,400 additional physicians to come up to the national average. They are putting together a grant program to start up/expand residency GME programs with an initial legislative budget request for $10-15 million. They are also drafting a RFP using recommendations from a report done by IHS, Inc. last year. The timeline is to have these approved at the BOG's September board meeting. Ms. Beaven will check with Dean Good about circulating his presentation to the council.

The reports Ms. Beaven mentioned are all online on the Board of Governors site. The IHS Global Report is on the AHCA website, because AHCA links to that for their GME start-up bonus program. The Council requested that the links be sent to the group.

Dr. Saver asked if the grant program would only be for medical schools, not hospitals or FQHCs. Ms. Beaven responded that medical schools would assume the leadership role to work on

program start-up or expansion with the partners of GME providers in that phase before accreditation. Once the programs are accredited, they can go after other sources of funding. The BOG recognizes a gap in funding in the early start-up phase. Medical schools do not currently receive direct GME funding, as it goes to hospitals, primarily.

Dr. Seltzer asked if there is data to show from the monies provided by the state budget for GME, how many new residency spots were created in the last 2 years, and how much money was given to existing spots? Tom Wallace said the state GME program has been around for 3 years with $80 million to fund the current residency slots. There is a new program, the GME start-up bonus program, for new programs that were starting with 66 new FTEs being funded effective this year. The data is available on AHCAs website, and Mr. Wallace can provide the information to the Department to get it to the Council members.

Ms. Beaven said the grant program was not designed to pay for salary and fringe. Mr. Wallace was asked if the start-up funding would be recurring. He said yes, but it is contingent on local intergovernmental transfers which are used to draw down the federal funds. These local transfer sources must be public funds. Jackson Memorial and UF Health - Gainesville provide the state's share to fund the start-up bonus program.

Dr. Sherin asked Ms. Beaven out of the $10-15 million, how many grants would be put out per year. Right now there are 4-6 grants they have in mind.

Staff reiterated that the GME funding AHCA handles is all part of the Medicaid program. The state match portion cannot be derived from private sources.

**V. Presentation: Health Professional Shortage Areas (HPSAs) – Debbie Reich**

Ms. Reich presented a slide show to provide an overview of what HPSAs are and how they are determined. The primary purpose and use is for the federal National Health Service Corps (NHSC) program site determinations where clinicians can apply for scholarships or loan repayment if they agree to work in a NHSC site. It is a very competitive program, and NHSC sites receive a score based on need and poverty rates. The higher the score, the better chance a clinician has to receive a scholarship or loan repayment. HPSAs are also used for the federal foreign physician waiver programs: the State Conrad 30, National interest waiver, and Health and Human Services waiver. Rural health clinics in HPSAs (currently 58 facilities) can receive increased Medicare reimbursement rates, and FQHCs in HPSAs (currently 150 facilities) also get a comprehensive health center score which they use for NHSC. HPSAs are also used in determining area of critical need facility designations in Florida which enables the facility to employ limited-license and temporary certificate licensed physicians.

Out of 625 Florida HPSAs, 252 are primary care. Population HPSAs are primarily comprised of groupings of census tracts. HRSA defines primary care doctors as: Family medicine, OBGYN, internal medicine, and pediatrics. Florida mainly has low-income population HPSAs. Geographic HPSAs include the whole county. Only Baker and Monroe counties do not have any HPSAs. HRSA has to approve all HPSAs. The Primary Care Office is working in HRSA's new software system and trying to add more census tracts, as the system allows. Ms. Reich spoke about providers being "usable", meaning they accept Medicaid and a sliding fee scale, and "non-usable" if they don't. The HRSA HPSAs are focused on providing services to the low-income population.

Dr. Delo had a question about expanding NHSC to private practices. Ms. Reich said as long as private practices are in HPSAs and have been accepting Medicaid and a sliding fee scale for 12 months, they can apply to become a NHSC site. This does not give them funding, but it allows them to use NHSC to recruit clinicians and those hired can use loan repayment. The owner of the business can receive loan repayment, but cannot also be the NHSC site administrator. An office assistant could fill that role, though.

Is this information out there for new physicians to be aware? This could be a way to retain physicians. It may take community support to open a clinic for this to really work, because many practices do not want to accept Medicaid. Dr. Saver felt this could be an opportunity to provide state support for new solo practitioners to become NHSC providers. It was asked if hospitals could take advantage of this, but Ms. Reich said only critical access hospitals can become NHSC sites.

Dr. Philip asked Dr. Gervasi if the FQHCs are tracking how many sites have physicians utilizing loan repayment. To his knowledge that is not currently being tracked, but they could use a survey to get that information. Dr. Philip feels getting the message out to better utilize this program could be one way to address retaining physicians.

Are there any incentives available for large employers who are opening their own clinics? Perhaps that is a resource to make sure those kinds of places are aware of this.

A comment at the end of the call by Dr. Gervasi regarding ACNs was that an unintended consequence of Medicaid patients being enrolled in managed care plans, is managed care plans will not credential doctors with limited licenses. If there was a way to tell the managed care plans that Medicaid approves them, so you have to approve them; that would open up a world of opportunities.

## VI. Review: Physician Licensure Survey

Dr. Seoane said the FMA is very interested in capturing practice arrangements data to be able to compare Florida with the rest of the country, and suggested adding or changing questions to the survey to accomplish this. He feels it would be extremely valuable to have this data in Florida.

Dr. Seltzer asked if the AMA survey includes all physicians or just AMA members. He said the idea is to have the most accurate Florida data, not just to compare it with the US or other states. He agrees the questions need to be more specific, though.

Dr. Delo thinks it is a good idea to look at the AMA questionnaire and use that as a template to determine what questions we use for Florida.

Dr. Philip reviewed statutory requirements and how the current survey addresses these, but the rest is up for discussion. Dr. Littles recapped how the survey came about and expressed it was good to know change is possible. Dr. Sherin thought there is room to have some of the elements in the AMA survey. Dr. Howell had concerns about not getting too proprietary, as far as employment arrangements, when it comes to sharing this information. Mr. Ashe said it was protected data by statute. Dr. Littles had a concern to not make the survey too long for physicians to complete it.

Dr. Saver asked who had the final authority to approve this questionnaire. Dr. Philip responded that the council advises but that the Department is responsible for finalizing the survey, Mr. Ashe mentioned that any changes in the survey would need to go through the administrative rule process.

Can staff help create a timeline and work plan? Dr. Philip thought that was a great suggestion.

## VII. Strategic Plan Discussion

Dr. Philip proposed to divide up the council in groups to work with staff on various areas – Strategic plan, physician survey review, and HPSAs. No one was opposed and felt it was an excellent idea.

There was a lengthy discussion on the accuracy of the IHS report.

## VIII. Next Steps

Outline the groups in more detail, talk about the expectations and identify staff leading it. A survey will be sent out to determine this. Efforts are ongoing to fill the remaining Council vacancies.

Items to be sent out to the council members: 2014 pipeline programs survey results, 10-page summary of report and longer document, the IHS Report, Dean Good's PowerPoint, Tom Wallace's spreadsheet of 66 new GME positions created under new program, OPPAGA Report, user guide or overview of the Council website. Dr. Philip suggested that it will be helpful to place statutory language in one place for the Council members.

## IX. Public Comment

Dr. Diane Davey said they have had new programs recently approved at hospitals that are separately funded. HCA hospitals are expanding a lot.

## X. Future Meeting Schedule

Looking at the last weekend in July at the Disney Yacht and Beach Club in Orlando in coordination with FMA's annual meeting. Anyone attending needs to get the FMA code to get discounted hotel rates.