Indiana Graduate Medical Education Board

Business Meeting Minutes

January 19, 2016

1:00 p.m. (EDT)

101 West Ohio Street

7th Floor Conference Room

Indianapolis, IN 46204

Board Members Present: Tim Putnam (Chair), Steven Becker, MD, James Buchanan, MD, Mark Cantieri, DO, Paul Evans, DO, Paul Haut, MD, Tricia Hern, MD, Bryan Mills, Peter Nalin, MD, Beth Wrobel

Commission Staff Present: Eugene Johnson, Dominick Chase

CALL TO ORDER

The meeting was called to order by Tim Putnam. The roll call counted 10 members present. Bryan Mills participated by phone.

BUSINESS ITEMS

The Chair welcomed the Board, thanked everyone for attending and ensured everyone had a meeting agenda.

Peter Nalin stated that Dean Jay Hess of the IU School of Medicine would like to address the Board at its first meeting and would like to come around 2pm to make some welcoming remarks. Tim Putnam, moved to amend the agenda to allow Dean Hess to address and was seconded by Steven Becker. Motion passed 10 – 0.

ADOPTION OF PARALIMENTARY PROCEDURES

Tim Putnam went over requirements for convening of meetings, stating six members in-person or participating electronically are required for the Board to convene a meeting as well as six votes being required to move on any action. Commission staff stated that a quorum required six members to be physically present for a meeting, however votes from Board members attending by phone were valid for any action the Board voted to take. Tim Putnam asked the Board if anyone objected to the use of Roberts Rules of Orders and stated that he wanted to keep a good flow of information going. He asked if there was any objection or discussion on how the Board would get things done; no objection was voiced.

REVIEW OF 2015 HOUSE ENROLLED ACT 1323

Commission staff reviewed 2015 House Enrolled Act 1323. Staff discussed the terms of service of Board members and clarified that the Commission for Higher Education is the fiscal entity for the fund and that the fund is non-reverting. Staff stated that HEA 1323's Fiscal Impact Statement projected costs out for

eight years and that current funding is $3 million for fiscal years (FY) 2016 and 2017. Staff stated that funding beyond FY 2017 would be based on the decisions of the State Legislature and the Board.

Staff discussed the requirement of matching funds and questions from the Board about what would constitute the 25% match required for award recipients. Staff informed the Board that they would make the decision on how the match would be met by recipients (in-kind donations, cash, etc.).

The Board was informed of their requirement to provide a report on the expansion of medical education in Indiana to the General Assembly by November 1, 2016 and what the reporting requirements are.

Tim Putnam called for questions and there were none.

Tim Putnam stated one of his questions for the Board as a whole is what result the group wanted to produce for the Legislature by November, questions that need to be addressed, and what does the Board want researched. He stated his goal for the meeting is to get a list of questions and determine who to engage.

Beth Wrobel suggested starting with questions that Board has to answer to see what they have and don't have. Tim Putnam stated that the broadness of legislation left many open-ended questions which needed to be answered. Bryan Mills asked if the Board could entertain the idea of having residency opportunities for all physicians graduating in Indiana and if that is the concept that gives Board aspiration.

Beth Wrobel asked if the thought was to start matching projections of graduates to opportunities. Bryan Mills cautioned against a "bottom-up" approach as the Board might not get close fulfilling the opportunity they have. Steven Becker stated that his consultants' analysis said the state of Indiana is 500 down in number of physicians training and that's about the max the state could support looking at current sites that could train peripherally; there is a number that can't be exceeded to offer reasonable training to residents.

Tim Putnam asked how many medical students are in Indiana today. Steven Becker stated there are 1,700 training. Paul Evans stated there are 400 PGY1 spots in the state; a year ago it was around 397; he stated that there are two questions needing to be answered; 1) Do we have enough PGY1 spots to cover graduates of both medical schools? 2) What are the graduating physicians looking like and how does that relate to the needs of the state? He stated that to reach that primary care number you have to ask how many are practicing in primary care location and that that's a tough answer to get to.

Tricia Hern asked what percentage of the 397 are primary care; Paul Evans stated he didn't have that percentage but he could get those numbers.

Steven Becker commented more internal residency programs are at larger academic centers; internal medical programs regionally would lead to higher regional outcomes; the HEA 1323 number of $22.5 million by year eight, that number was developed using 500 times $45,000 per resident; hospital task force felt there was $45,000 deficit per resident; the data came from residency programs in state of Indiana.

Tricia Hern stated her best analysis as a Program Director showed it's more costly in primary care as opposed to highly specialized fields as there's less procedural revenue; their deficit is about $100,000

per resident per year shortfall after accounting for any revenue; that is the cost bring in a family medicine resident.

Steven Becker stated his consultants nationally have $135,000 per resident average cost and doesn't think they are including direct cost. Grand Rapids Medical Education Partners had it at $107,000 3.5 to 4 years ago across the board; he thinks they brought it down to the absolute minimum.

Beth Wrobel stated that Board likely needed a consultant on this.

Tim Putnam stated part of goal of this group is to educate the Legislature and get everyone on the same page as to what costs are included for a resident; group is looking at the cost to add a residency slot, be it at a virgin hospital or one that already exists.

Jeb Buchanan stated that triple six is sweet spot; above is ok, under and costs increase; this is another piece to get guidance on.

Tim Putnam asked group about the question of economic impact on community.

Steven Becker stated his consultants calculated indirect/direct economic impact of a resident at $200,000 per year in your region; a physician practicing in the region has about $1.25 to $1.5 million economic impact with 5-6 jobs created; both Steven Becker and Beth Wrobel agreed on the numbers; Beth Wrobel stated she had $1.5 million as the number; they also have data that physicians in severely underserved areas could have impact of up to $3 million per year.

Additional discussion occurred about additional community infrastructure that hospitals and healthcare facilities provided including pharmacies. Paul Evans stated that in many rural communities 50% of gross business product is related to healthcare; he stated there are two things employers ask for in the Midwest when looking at a community; they don't worry about workers because the Midwest working mentality has proven to be reliably good, they look at schools and healthcare in communities; if you have good schools and good healthcare you are a desirable community. Tim Putnam stated he doesn't know that Honda goes into Greensburg or Toyota goes into Princeton if there's not a viable healthcare delivery system. Other Board members agreed with each members' comments.

Steven Becker stated that this kind of economic data was provided to Dr. Brown and the Governor when the conversations about graduate medical funding started.

Peter Nalin stated there are data on the economic impact of residency programs on urban communities that he can share with the group.

Jeb Buchanan stated that it almost looks like what the Board will do for the first year or two is to get more provisional data/literature; then switch to direct impact data once physicians get in to residency/practice.

Steven Becker stated he thinks case has been made with the Legislature; it's up to the Board to figure out what's the best way to implement and study afterwards; need to have public health schools involved in measuring outcomes.

Beth Wrobel stated she's heard numbers on how many are coming out of medical school but not how many we need.

Tim Putnam stated that we have such a good opportunity; the largest medical school in country; new medical school adding graduates within 18 months; goes to Bryan Mills question "do we have slot for every student" and the answer is "no".

Beth Wrobel asked if there's data on graduates who stay or leave; Peter Nalin stated they (IU School of Medicine) have that data.

Steven Becker said 50% of IUSM graduates practice in Indiana; if they do both medical school and residency in Indiana that number is about 78%; last year 38% to 39% did their first year in Indiana.

Beth Wrobel asked if the ones that didn't stay left was because there was not a slot; Steven Becker stated he's more worried about having students not match; with medical schools being added and growing it will become more of a problem.

Tim Putnam stated it would be good to say to someone thinking about Indiana medical schools that there are enough slots for graduates; no guarantee of one but there are enough available

Peter Nalin asked the Board to also consider there will be shortages of physicians in general; the best way to position state of Indiana and all its entities is to beef up medical schools and hospital systems. It comes back full circle as needing more GME training slots; not enough residency programs means IN would keep having the same pipeline problem it already has.

Tim Putnam discussed questions three and four; where do they need to be and what specialty do they need to be in.

Steven Becker stated that if you push out to regions; regions will know their needs. Tim Putnam asked Paul Haut what was his perspective on highest level of need.

Paul Haut said there's a mix; rarest pediatric subspecialties will always get their training in tertiary and quaternary care; there are a couple of areas where opportunities for better sharing of training across areas; shared training sites allow boarder understanding and networking to provide better coordinated care; one of the highest needs is mental health; it is hard to find psychologist in communities who can deal with child health issues; child psychiatry is rare; things like pediatric dermatology are supported; they are hard to recruit. More than ½ of kids in Indiana are seen by family medicine doctors for their primary care; one thing lacking that maybe we could do a better job with is linking family and pediatric training in the care of children.

Paul Haut referenced discussion in Muncie from the past Friday including how to support the level of care needed in neo-natal intensive care units across state; how to recruit those correct personal to live in a community that's not the size on Indianapolis; one strategy is to provide care that crosses both those entities so they understand the challenges of working in that community; not only creating programs in underserved areas but who are you linking; make it well-rounded training program; having balanced approach is meaningful.

Tim Putnam called for a break.

PUBLIC TESTIMONY

Peter Nalin introduced Dr. Jay Hess, Dean of the IU School of Medicine

Jay Hess thanked the Board for the opportunity to speak and for its work. He stated he feels the Board has the chance to do something special and address healthcare needs in Indiana. He reviewed a PowerPoint that was provided to the Board and meeting attendees. He outlined the mission of the IU School of Medicine and stated it's also a mission of Dr. Evans' school; he stated the only thing that matters is what impact is had on the health of people in Indiana. He stated we all have a lot of work to do; Indiana ranks poorly in areas like suicide, smoking, diabetes; there is a lot of ownership of these issues beyond healthcare. We (medical community) have important role in the kind of residency we create how we do this in way to effectively engage everyone in community; rural, urban, every demographic. He discussed what the IU School of Medicine has done to address Indiana's workforce need; the undersupply of physicians in Indiana, particularly in primary care and that it all becomes concerning when you consider Indiana is aging population-wise and you're seeing epidemics in chronic diseases; demand for physicians will increase exponentially.

He stated that more than 50% of IU School of Medicine graduates practice in Indiana and the School has expanded its class size by 30%; this was done by expanding to 4-year programs across all nine IU School of Medicine campuses; he stated it's important to note that when people do residencies in state they often stay; 70% of IUSM grads who do their residency in-state stay. 40% of graduates enter primary care; think primary care physicians are big part of solution of healthcare challenges we face and they will provide a lot of the care that will have the biggest impact on healthcare outcomes. Finally he reviewed the current revised curriculum of the School and its impact on students.

Tim Putnam called for questions. He asked about the 40% of graduates going into primary care and number was developed.

Jay Hess said that number is based on where people match; could include some specialists; family medicine, OBGYN, pediatrics; internal medical makes up that number; no way to know for sure once beyond match to get data on what is considered primary care but 40% is a high percentage as far as medical schools go.

Beth Wrobel asked can anything be done in medical school to improve the numbers who are going into primary care; Jay Hess stated all recognize there's an important impact of reimbursement; stated he feels in long run market forces will prevail; if there's need for primary care physicians and increasing move to health plans salaries for those physicians will go up and put pressure on subspecialty salaries and they eventually will reset. He stated that, from his seat, the first priority is to create a culture where primary care physicians are highly valued, train them well, have them in the regional campus system, expose students to high quality primary care and, to the extent that health system can, look at creative arrangements to attract people to primary care.

Tim Putnam called for more discussion on questions asked in the Legislature; could be a simple needs assessment; Board may have differing perspectives; stated certainly we want to have specialties needed in state but also ones that students are willing to fill; asked for opinions of the Board.

Paul Evans suggested that Dr. Brown come and talk to Board about his thoughts on the bill; heard him present it in the Senate and the emphasis was on primary care with attention to geographic shortage specific areas of the state. He stated the next question is "how do you define primary care?". He mentioned that Marian University College of Osteopathic Medicine has a scholarship bill thru CHE that

defined primary care and it was a broad definition; it could be put to the Board and see if Board agrees with that definition. Thinks part of work of Board is to find that definition.

Jeb Buchanan stated his concern is going down those avenues; get away from purview of the committee; must stay focused on the point of the bill; how do we get locations into the various parts of state and get physicians there; need to look geographically at were shortage are; where will triple six mantra work? Those hospital wills say these are the kinds of doctors we need and "we'll buy in if you get us the residents."

Peter Nalin stated example might be disparate need across state; perhaps relatively rural area might be able to sustain psychiatrist program; perhaps bigger city could be hub of those programs.

Beth Wrobel said maybe options like telehealth could be looked at; Tim Putnam felt that this likely needs to be put off the table in the interest of other things.

Jeb Buchanan stated that there is now a full body of information about the benefits of psychiatry co-located with primary care. He questions if residency can be interpreted as being a fellowship in the Bill; can fellowship training be a component or not. His feedback from ACGME conference, RC breakout session was that most say it's a 3 to 5 year process to get a residency program up and started; 4 or 5 years is not unusual; need to set the expectation so that the Legislature is not frustrated with amount of time needed to establish new residency slots.

Paul Haut stated that with limited resources, looking for the biggest impact, what types of approaches should we think about supporting; may be a mix that could be weighted one way versus the other.

Tim Putnam stated it might be getting back to Paul Evans point about inviting Dr. Brown to tell the Board what success is, what failure looks like, what he has to take back to the legislative body; what do we need to have to be successful and to prove to the Legislature this is a worthy investment; may take 2-3 years to before first dollar flows to residency programs but here's option to get dollars flowing today that would have impact; think clarifying that would be important and getting from source (Dr. Brown) would help.

Eugene Johnson stated he spoke with Dr. Brown this past Tuesday and the feedback was for the Board to "get it right"; it's up to Board to decided what it meant to "get it right"; there have been concerns expressed on funding beyond the $6 million; Dr. Brown said he wanted to work on sustaining funding this session but other things sidetracked that; goal going into next budget session is to get dedicated funding source for GME.

Steven Becker stated that the HRSA grant and other grants haven't been tapped into enough because they knew in five years they might not have continued funding; it would be good to get idea from Dr. Brown about the solidity of the revenue stream for the GME funding.

Tim Putnam stated that in talking to his Board the first question will be about funding and if we make a promise to students and community how will funds sustain beyond existing funds.

Steven Becker stated that he was not sure that, looking at gaps in state, you'll get gaps filled

Beth Wrobel mentioned that in Northwest Indiana, hospitals, federally qualified health centers, and mental health centers have stepped up to form a consortium; phase one study is on-going.

Tim Putnam mentioned to the Board that one issue is gaining support is turnover of hospital CEOs.

Tricia Hern stated that it's worth seeing what other states have done, implementing a plan, maybe worth a call.

Paul Evans said Washington has supported multiple family medicine programs in a multi-state area and the Washington State Legislature put aside money to support family medical residency programs.

Tim Putnam stated that Georgia also has a program similar to Indiana's; 4-5 medical schools; nowhere near enough residency slots.

Paul Evans stated that Georgia was one of first states in the country to put together money for residency programs; the other piece is that the Board can define areas in that state that are geographically deficient; hard for areas around state to be able to be put money on the table to start a residency program

Tim Putnam asked if the Board has the ability to gather the information necessary or should a consultant be leveraged?

Beth Wrobel stated the scope may be above what staff is supposed to do; thing Board will need to hire consultant. Jeb Buchanan agreed and stated the Board should utilize a consultant unless they can leverage IU or other available data.

Tim Putnam said in his experience, you write and RFP, committee or board review the proposals, create scope, and knows what will be paid for. Paul Haut then asked if the Board is looking for someone gather a lot of info and board collectively do analysis and do recommendation or board hiring a consultant to do detailed analysis and make recommendations?

Tim Putnam stated he thinks we have right talent in room to put it all together; how many hours of work it would take from each member is it the right use of time and are there enough time

Beth Wrobel asked if Board could do an RFP with these questions.

Tim Putnam said he thinks it needs to be boarder than just the question in the bill; RFP would be clarity on the questions and synthesize that information

Jeb Buchanan asked CHE Staff "when you look at these things are they things you can do?"

Eugene Johnson stated that its data that could be gathered; the process of analyzing data in form palatable to needs of board and taxpayers, he would be more comfortable working with entity that has done this type of work and worked with multiple parties impacted by the bills. He felt after conversations around state leading up to the meeting that there was strong sentiment for use of a consultant and he thinks it's important for the Board as body of partners reflecting entire state, important for Board-unified document/study to show statewide need and how they can be best addressed.

Paul Evans stated that it's not just Indiana issue, but a national issue; Steven Becker concept good to apply for when final decisions are made for the state of Indiana;

Peter Nalin stated that the Board may not have to look far for Commission supporting expertise; it's a matter of figuring out how to access it. He stated the Board should be cautious to not lose the "Indiana

specific" texture to an informed plan and introduced a stakeholder physician analysis plan from 2008 as a reference document.

Tim Putnam asked for volunteers to work with CHE staff on committee to develop the RFP. Beth Wrobel, Peter Nalin and Paul Haut agreed to participate on the RFP committee. Tim Putnam asked Peter Nalin to head this Committee and he volunteered to do so.

Eugene Johnson then introduced state and CHE standards for RFP review and asked for Dominick Chase to explain how CHE handles RFP process. Dominick Chase explained the RFP scoring process and that CHE selects minimum of three vendors and will post RFP to CHE website.ds

Tim Putnam asked the Board about thoughts on meeting times and frequencies. Differing opinions on times and dates were given. Tim gave his appreciation for everyone time and schedules and stated the next meeting would be scheduled and a list of future meetings will be provided shortly.

Tim Putnam motioned to adjourn the meeting and was seconded by Jeb Buchanan. Vote to adjourn; YAY – 10, NAY – 0. The meeting adjourned at 4:00pm.