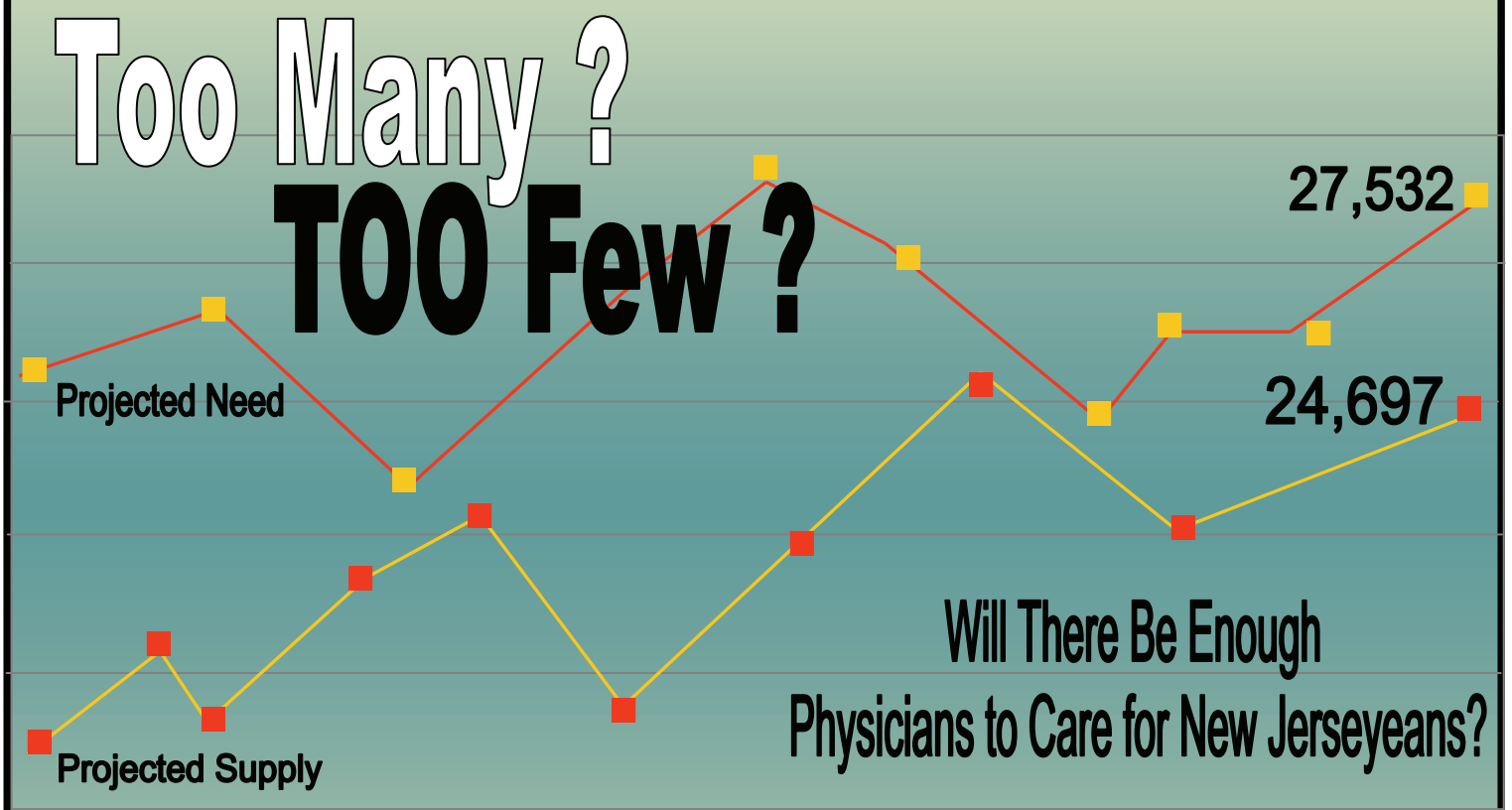
New Jersey Physician Workforce Task Force

Executive Summary



A Report by:

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EXECUTIVE SUMMARY

The New Jersey Council of Teaching Hospitals (Council), together with New Jersey's departments of Health and Senior Services (DHSS), Banking and Insurance (DOBI), Human Services (DHS), New Jersey Hospital Association, Medical Society of New Jersey, and numerous private organizations in 2007 established a Physician Workforce Policy Task Force (Task Force). The charge of the Task Force was:

- To undertake a needs assessment of current and future physician supply and demand, as well as distribution of physician practices across the state.
- To identify issues and barriers that impede the medical schools, teaching hospitals, state agencies, and "the market" at large in addressing physician shortages.
- To recommend specific strategies that address and correct health workforce shortfalls to ensure adequate access to health care services for New Jersey citizens for the next decade.

Findings

New Jersey is facing significant future shortages in both primary care and several specialty areas. In eleven years (2020), there is a projected shortfall of over 2,800 additional physicians beyond the current physician graduate medical education (GME) production pipeline representing a 12 percent gap in the physician supply versus the likely population demand for services. The shortage consists of approximately 1,000 primary care physicians and 1,800 specialists.

Based on existing publications from the Rutgers Center for State Health Policy on physician workforce supplies, the DHSS on prenatal services, the scrubbed American Medical Association (AMA) databases, national physician ratios by specialty, and numerous other data sources; the Task Force concluded that there is a current shortage within primary care specialties; including family medicine, geriatrics, general surgery, and obstetrics. Within non-primary care specialties, neurosurgery and pediatric sub-specialties are the most alarming. Over seventy percent of all pediatric sub-specialties have serious shortages.

To ensure New Jersey citizens have access to necessary physicians and clinical services in the future, the State of New Jersey, the medical schools and all the teaching hospitals will need to form a centralized strategic planning alliance to ensure policy, regulations, funding and recruitment/retention programs are put in place to manage the physician supply.

The Study Process

The Council retained the **Center for Health Workforce Studies of the University at Albany (CHWS),** who secured the forecast modeling expertise of the **Lewin Group** and **Altarum Institute**, to perform extensive review and modeling of the **AMA Masterfile of Physicians**, the **New Jersey Board of Medical Examiners database, the AMA Resident database, the New Jersey Department of Labor and Workforce Development data, and the New Jersey Resident Exit Survey** results. The Council embarked on parallel research of the **Association of American Medical Colleges (AAMC**) physician workforce data, other state health workforce activities, national physician to population ratios, and performed extensive literature searches to assess issues and proven solutions addressing physician shortages.

The Council's Physician Workforce Policy Task Force, which interfaced with the project consultants, refined the baseline supply model and then defined the "Most Likely Demand Scenario" from 2009 to

2020, weighing the most significant variables (health care reform, insuring the uninsured, New Jersey's economic growth, and increased efficiencies in the provision of medical care).

After months of deliberation the Task Force determined the following assumptions should be reflected in New Jersey's physician supply "most likely demand model:"

- Health care reform will begin by 2012, leading to major infrastructure, policy and funding reforms by 2020.
- The current 250,000 uninsured children will be reduced steadily between 2009 to less than 25,000 by 2020.
- Uninsured adults will be reduced from the current 1,150,000 adults in 2009 to approximately 345,000 by 2020. The remaining uninsured will include New Jersey's undocumented immigrants and individuals who choose not to participate in available insurance programs.
- New Jersey's economic growth will decline by 2 percent in 2009 and will remain negative until 2013; thereafter the economic growth incrementally improves reaching 2.5 percent economic growth by 2020.
- Clinical service efficiencies will occur, including the reduction of excess clinical tests and procedures; elimination of redundant diagnostic tests; enhanced communication through the use of information technology; and implementation of electronic health records. Together these reforms will improve efficiencies by 2.5 percent by 2020.

This "Most Likely Demand Scenario" was then modeled against the baseline.

Table 1: Most Likely Demand Scenario		2008 Current Supply	2020 Projected Supply	Projected Shortage By 2020
Baseline Supply **Physician production, practice patterns, rates of separation from workforce, and migration patterns remain constant**	TOTAL	22,410	24,697	**-2835**
	PRIMARY CARE	8,233	9,020	**-1006**
	SPECIALISTS	14,177	15,697	**-1829**
	Anesthesiology	1,406	1,612	**-188**
	Cardiovascular Diseases	1,013	1,269	**-118**
	Emergency Medicine	780	897	**36**
	General Internal Medicine	3,825	4,424	**-526**
	General Pediatrics	2,539	2,944	**-67**
	General Surgery	620	999	**-181**
	General/Family Medicine	1,869	2,228	**-412**
	Obstetrics & Gynecology	1,353	1,528	**-43**
	Ophthalmology	614	693	**-66**
	Orthopedic Surgery	685	770	**-105**
	Other Int. Med. Subspecialties	2,007	3,179	**-720**
	Pediatric Subspecialties *	536		
	Other Specialties	1,170	1,428	**-16**
	Other Surgical Specialties	784	576	**-70**
	Otolaryngology	259	274	**-35**
	Pathology	341	440	**-57**
	Psychiatry	1,302	1,532	**-56**
	Radiology	961	1,110	**-139**
	Urology	346	373	**-70**

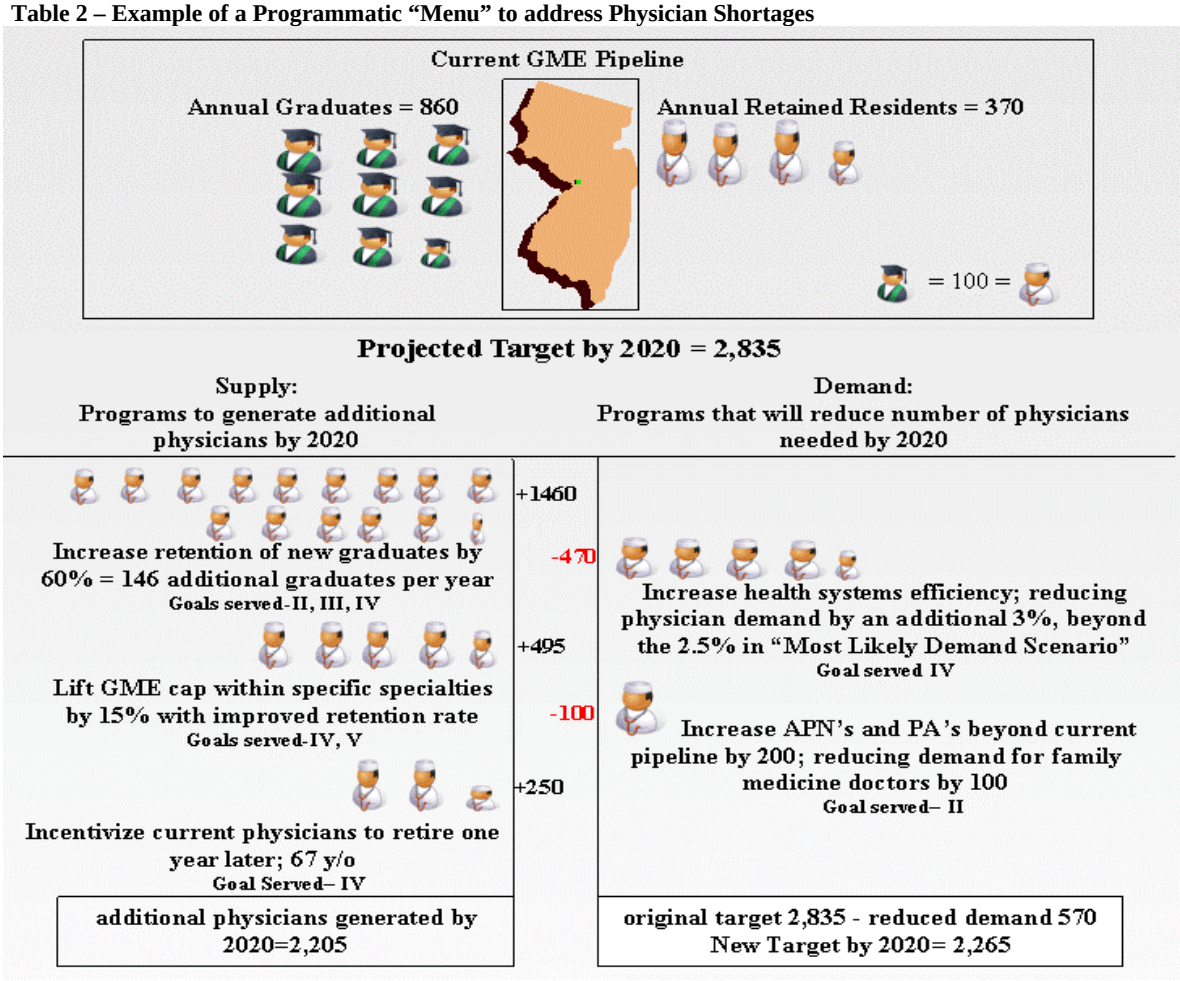
*** Pediatric Sub-specialists supply and demand data can be found on separate exhibit.**

Insights Regarding Physician Data and the Determination of Supply and Demand

The Task Force became frustrated with the absence of data to provide critical information which would clarify specific physician shortages, such as whether the practicing OB/GYN physicians in the state are actually performing deliveries. This lack of data created other negative consequences relating to qualifying for J-1 visa positions and federal loan repayment funding that the Task Force believed could be rectified if New Jersey instituted a mandatory re-licensure survey. This survey would provide vital data that could guide policy and funding decisions impacting future physician supply.

Our goal was to identify the needed supply of primary care and specialty physicians over the next twelve years. The sophisticated forecasting models utilizing the CHWS and the Lewin Group provided baseline targets, but it was soon realized it is impossible to mathematically calculate several "unknowns" that will impact physician supply and demand in the future. These include the outcomes derived by federal and state health reform initiatives, the success of the Obama administration in restoring economic growth through the federal stimulus package, the impact of deploying IT integration and electronic medical record's, the success of increasing the health care workforce through educational grants, and the ability to improve cost efficiency and clinical effectiveness through these broad based reforms. Nonetheless, New Jersey's need is daunting, with deficits in the best case scenario being a shortfall of 2,500 primary care and specialty physicians, beyond the current pipeline. The worst case scenario demonstrates the need of more than 3,100 physicians, by 2020. With this variable target, the Task Force prioritized as the most important action, the creation of a central entity within the state to continually monitor and forecast supply and demand, as well as to manage and refine policy, programs and strategies. A very deliberate, multi-faceted strategic action plan must to be implemented expeditiously. Figure 1 provides an example of a multi-faceted policy and programmatic approach that could significantly address New Jersey's impending physician shortage.

Table 2 – Example of a Programmatic "Menu" to address Physician Shortages



The Task Force's Recommendations

Goal I – Pursue federal reforms that focus on expanding GME resident positions to address workforce shortages, as well as systemic problems in GME funding mechanisms, administrative processes, and regulatory oversight.

Medical education and healthcare workforce needs have changed over the past 15 years, while regulations and funding have not. For example, more training takes place in an outpatient setting however, Medicare reimbursement for GME is primarily inpatient driven. As the training model changes, the reimbursement methodology must be reformed. Additionally, the oversight system is over-complicated with costly rules and regulations that thwart logic and stifle innovation. GME resident position expansion, administrative and funding systems must be addressed as national health system reform is being contemplated in Washington, D.C.

- Integrate GME reform into current health care reform initiatives to ensure newly insured citizens have access to physicians,
- Preserve existing resident slots assigned within New Jersey when a teaching hospital closes,
- Remove regulatory and funding barriers that limit executing flexible GME training venues beyond traditional sites,
- Revise current administrative guidelines to ensure clear, consistent administrative requirements and auditing standards across and between all Medicare's Fiscal Intermediaries. Center for Medicare and Medicaid Services (CMS) will publish administrative requirements and auditing standards in advance of implementation. Auditing rules will not be applied retrospectively.
- Increase caps for GME positions for states who have documented a ten percent or greater shortage in their physician workforce by 2020. An increase in physician resident positions will be allowed within primary care residencies and other specialties where shortages have been identified by HRSA utilized forecasting models.

Goal II - Create or designate an organization, the "Center for Medical and Health Workforce Planning," to continuously monitor, forecast, predict, and refine recommendations to ensure an adequate and well-dispersed supply of physicians and advanced practice practitioners for New Jersey.

The Center will be responsible to perform (or subcontract with an entity to perform) the collection, analysis of multiple data sources and comprehensive reporting on health workforce supply and demand trends. With this information the Center will guide the allocation of resources based on workforce needs, track physician and advanced practice providers shortages to determine graduate medical education (GME) and other funding priorities, manage "vacant" resident positions, direct funds to the individual programs with greatest impact on workforce needs, and provide incentives for teaching programs to retain graduates to practice in New Jersey.

- Establish the infrastructure, professional personnel and necessary resources to facilitate the operations of the "Center for Medical and Health Workforce Planning."
- Establish overall statewide policies and procedures for physician and advanced practice providers to reinforce and direct workforce planning.
- Establish a New Jersey "Office of Recruitment" within the Center for Medical and Health Workforce Planning.

- Create a process to gather and maintain adequate data to guide interventions and policy recommendations.
- Implement policies and programs to ensure the diversity of the physician workforce supports the ethnic and cultural demographics within New Jersey.
- Interface with the National Health Workforce Advisory Council to submit data and obtain federal grants that support New Jersey's health workforce initiatives.
- Oversee data collection and annual reporting that updates the supply and distribution of the physician and advanced practice provider workforce, as well as the in-state retention rates.

  › Mandate data collection through physician re-licensure surveys, consumer health attitude surveys, state epidemiology data, utilization by ethnicity, etc., to ensure comprehensive, credible data is available to analyze trends and refine Task Force recommendations.
  › Ensure necessary data is collected and collated to increase the number of Health Professional Shortage Area (HPSA) designated underserved areas in New Jersey. Use data to expand the Conrad State 30 (J-1 Visa) Program and federal loan repayment funds.
  › Improve data collection specific to international medical graduates (IMGs) by requiring respondents to identify citizenship status.
  › Use a unique identifier, such as the DEA number, to provide better data and tracking of New Jersey physicians and residents within and outside of New Jersey (to support recruitment/retention initiatives).
  › Expand data sources through surveys, state, and private data sources to track: demographics, health attitude/utilization by ethnicity, practice patterns, practice components, medical school application data, graduate tracking, etc.

Goal III – Align goals and incentives between the medical education stakeholders: medical schools, teaching hospitals and the State of New Jersey.

Reforms should focus on establishing a strategic planning processes between the state, teaching institutions, and medical education leadership. Using forecasting models and data driven reports created by "the Center", all stakeholders should work to ensure the medical education system, the physician specialty training programs and residency counts are adjusted to address future physician workforce shortages by specialties and will collaborate on strategies to increase in-state retention.

- Identify, target, and enroll students in medical school who will more likely practice in New Jersey.
- Establish "incentive grants" for medical schools and teaching hospitals that encourage them to retain graduates post graduation.
- Develop curriculum to reinforce team-based care models that will ultimately promote multi-disciplinary care processes and the medical home model. This curriculum will allow New Jersey to qualify for federal grants and potential resident cap expansion via the proposed health reform initiatives.
- Create an "Office of Recruitment" within the Center for Medical and Health Workforce Planning to promote the job, fellowship, and resident position opportunities for New Jersey graduates and out of state physician residents. This Office can also serve as a resource to identify partnerships between hospitals for new fellowships, research grant opportunities, etc.

Goal IV – Enhance state funding for physicians, medical education and post graduate physician residency programs.

Graduate medical education in New Jersey cost $765M in 2007. Of this, state Medicaid GME funding is only $60M (including the federal matching dollars). Medicare funds approximately $340M, leaving the balance is paid by hospitals from foundation funds and operational margins. Goal #IV focuses on identifying sources of adequate funding that will allow New Jersey to be more competitive. New Jersey must attract more students by increasing medical school capacity, it must adequately fund graduate medical training positions, it must address medical education debt levels through viable programs and finally, the practice environment must be improved to retain or attract physicians seeking to establish their medical practice in this or another state.

- Increase state funding for medical education.
- Increase Medicaid GME funding, maximizing upper payment limit (UPL) federal match, and tie increases to Task Force goals.
- Increase Medicaid fee for service and Medicaid HMO physician services payments to minimally 80 percent of Medicare payments.
- Establish the New Jersey Medical Education Foundation, funded from the Horizon BC/BS for-profit conversion (if the conversion proceeds), or other foundation grants, to create a financial infrastructure that funds the variety of initiatives outlined in the Task Force recommendations.
- Establish a commercial insurer covered lives tax; direct funds to address physician shortages and support operational expenses of the Center for Medical and Health Workforce Planning.
- Direct a portion of the Board of Medical Examiner's licensure and re-licensure fees to fund the Center for Medical and Health Workforce Planning.
- Institute off-shore clerkship fees that will assist in the funding of the retention and recruitment programs outlined in Goal II.
- Ensure the State of New Jersey has adopted a "State Workforce Plan" and identifies the entity to request grants and funding, to optimize the health and education programs and related recommendations and initiatives identified by the Task Force. Funding and grants will soon be available through the federal stimulus package.

Goal V – Expand retention and recruitment initiatives to encourage physicians to enter, remain in, or return to practice in New Jersey.

New Jersey is competing with forty nine states to recruit new physicians, as they address their state's physician workforce shortages. New Jersey must expand current workforce programs, improve New Jersey's practice environment, and establish financial incentives which offset the high cost-of-living and small business barriers inherent to the state, to be competitive. Our goal must be to foster innovation within existing programs and make sure we maximize federal programs and fund to ensure New Jersey is a viable state to practice medicine.

- Expand the current **loan redemption program** to target specialties with the most significant shortages.

  › State-only program – expands beyond primary care to include specialties with significant projected shortages by 2020; including pediatric sub-specialties.
  › Federal-state loan repayment program – improve data collection and analysis to re-qualify for federal HPSA designation and improve federal funding for loan repayment. Work with federal legislators to update Section 332 of the Public Health Service Act recognizing New Jersey's unique demographics and underserved areas.

- Create a **recruitment Internet site** run by the "Office of Recruitment," under the Center for Medical and Health Workforce Planning (see Goal #3), to serve as a comprehensive resource center for job and resident/fellowship position opportunities.
- Identify residents leaving the state to pursue fellowship training and create a **fellowship**
- **training fund** to support their educational expenses, with the guarantee they will return to the state to establish clinical practice post graduation.
- Establish a three-year state **tax forgiveness program, practice subsidy fund,** and a **mortgage assistance program** for new physicians establishing clinical practice in New Jersey.
- Identify **educational and professional incentives**, such as IT technology grants.
- **Target pre-med students** to direct mindset towards specialties of greatest needs.
- Consider **expanding pipeline programs** (K-12) that motivate and prepare New Jersey residents for medical careers.
- Improve New Jersey's **physician practice environment** and job satisfaction by raising Medicaid reimbursement rates to nationally competitive levels; improving the insurance environment by enhancing transparency and consistency in insurers' claims processing rules; and promoting a less malignant medical malpractice environment that results in sustained lowered premiums and the fairer administration of justice.
- Identify and secure research grant opportunities to enhance fellowships positions within the state.

Conclusion

Ensuring that New Jersey has an adequate physician supply will not be easy. The physician shortage is a national problem, albeit less so in states that have established policies and programs to address their physician training ad practice environment. Utah, Georgia and other states have implemented state-financed physician retention and recruitment programs with documented success. New Jersey has several retention programs, but these initiatives function autonomously and are poorly funded.

Meeting the five goals will require state and federal commitment, public and private partnerships, as well as significant "political will" and health leadership engagement, to address system improvements, identify funding sources, and establish recruitment and retention programs. Medical schools, teaching hospitals and academic medical centers, and state agencies must be willing to embrace change, reject traditional thinking and participate in on-going give and take in reform discussions. If these parties are successful, we can be assured that New Jersey's future physician and health care workforce will be able to meet the clinical and health care needs for all New Jersey citizens.