WEBVTT

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00:00:49.090 --> 00:01:04.160
Anthony M Wallace: Alrighty. We can go ahead and get started. So good morning, everyone, and welcome to another installment of the Dean's lecture series. My name is Anthony Wallace. I'm a learning and development manager in the office of diversity, equity and inclusion. And we're really excited to have you all here today.

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00:01:04.160 --> 00:01:19.850
Anthony M Wallace: So just so, you know, this session will be recorded and shared out within 2 days to all of those who registered for the event. Otherwise you can find the recording for this lecture, and all of our previous lectures under the education and training tab of the Odei website

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00:01:20.220 --> 00:01:26.660
Anthony M Wallace: live transcription has been enabled. But please note that this live transcript is not perfect, as it is an auto transcript.

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Anthony M Wallace: We invite you to take care of yourself as necessary throughout today's session as we will not be taking any breaks.

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Anthony M Wallace: Any feedback or questions about accessibility can be directed to us directly at Dls dash Odei at Umnedu

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00:01:43.240 --> 00:02:06.450
Anthony M Wallace: we ask that all participants use the Q. And a function instead of the chat in order to ask questions for Dr. Foster during the Q. And a part of today's lecture, we will do our best to respond. But please understand that we're working with a set window of time. Should we not get to your question, we will pass along the unanswered questions to Dr. Foster, and then get those answers posted for you all on the Dean's lecture series. Web page.

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00:02:06.560 --> 00:02:14.700
Anthony M Wallace: Paste it in the chat you will find links to the Dean's lecture series website, the slides to today's lecture and the Dls email address.

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00:02:15.110 --> 00:02:21.129
Anthony M Wallace: So without further ado, I'm going to pass it over to Dr. Nunez, who will introduce our lecturer for today.

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Ana Nunez MD: Good morning, everybody. You know there is a phrase we live in interesting times, and we certainly do in terms of all of the things that are happening as we move forward in terms of sort of trying to make sense of some of these things. You know, we start with our values. We

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00:02:39.230 --> 00:03:03.899
Ana Nunez MD: dig in in terms of our mission in terms of moving forward to do what we do best in terms of education, research, and clinical care for everybody. It's important in terms of sort of moving our work forward, which our talk here today on a really important topic about sort of workforce is exactly that we will, as an office, make available in terms of some training sessions for

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00:03:03.900 --> 00:03:27.949
Ana Nunez MD: and Anthony to come and visit and have sort of conversations with you about some of the challenging things that are happening, and I'm certainly happy to sort of come and chat with you as well. If that is helpful as we sort of stay the course moving through things, but focusing on sort of getting the job done. We have an important question to talk about, and we've heard a bit about it in terms of the physician workforce. So I am delighted today

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00:03:28.450 --> 00:03:52.919
Ana Nunez MD: to introduce Dr. Jill Foster. She's going to solve all the problems in workforce for us in a short period of time, but certainly take questions and hear from your perspectives as well. Let me introduce Dr. Foster. Dr. Foster is a professor of Pediatrics, Division of infectious diseases in the office of Medical Education's Assistant Dean of Pipelines and Pathways. She received her medical degree at the Medical College of Pennsylvania, and was a resident at

13
00:03:52.920 --> 00:04:16.329
Ana Nunez MD: Saint Christopher's Hospital for Children. She received her fellowship training from the Children's Hospital of Pennsylvania Infectious disease, immunology and public health promotion. She's been here at the University of Minnesota's Medical School, Twin City Campus for 4 years, focusing her efforts on integrative best practices and development of physician pipelines. She's also heavily related in Covid, related issues, especially in the area of vaccine hesitancy

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00:04:16.329 --> 00:04:39.410
Ana Nunez MD: prior to coming to Minnesota. She was Drexel University College of Medicine, as the founding director of the Dorothy Mann Center for pediatric and adolescent HIV. And in medical education worked in terms of sort of contributing, so far as care of students. She took a 5 year interval, detour from academic medicine into an industry, sponsored philanthropic public health initiative

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00:04:39.410 --> 00:04:49.660
Ana Nunez MD: around blood-borne viral diseases. And she's here today to talk to us about the physician. Workforce challenges ahead. Welcome, Dr. Foster.

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00:04:50.270 --> 00:04:52.010
Dr. Jill Foster: Thank you, Dr. Nunez.

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00:04:52.380 --> 00:04:54.740
Dr. Jill Foster: I was start sharing.

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00:05:02.660 --> 00:05:04.370
Dr. Jill Foster: See? My title slide.

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00:05:05.830 --> 00:05:06.510
Dr. Jill Foster: Okay.

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00:05:06.510 --> 00:05:07.090
Ana Nunez MD: Yes.

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00:05:07.670 --> 00:05:17.009
Dr. Jill Foster: All right. So challenges ahead. Put your seat belts on. We have a rather challenging road ahead of us.

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00:05:17.730 --> 00:05:35.149
Dr. Jill Foster: So today's questions, do we have enough doctors? Do we have the right kind of doctors? Meaning really not? Do we have good doctors? Because, of course, we have good doctors? Do we have the right distribution of different specialties, and then our doctors in the places we need them. And if not, what are we going to do about it?

23
00:05:36.040 --> 00:05:59.540
Dr. Jill Foster: So let's sort of imagine this scenario so chatting with an aunt who lives in blue earth. She says she's kind of down in the dumps. Her neighbor's nephew is driving his tractor, and it rolled on him, and he didn't make it. The 1 h ambulance ride to the nearest hospital just was too much, and they couldn't save him. Another neighbor just got back home after her baby's 2 month. Nicu stay in a Twin Cities hospital.

24
00:05:59.540 --> 00:06:10.289
Dr. Jill Foster: The closest labor and delivery room just closed. So they had to travel further and had complications. And there's no closer Nicu. And she's really worried about what will happen if she has a serious health issue.

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Dr. Jill Foster: So

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00:06:11.950 --> 00:06:26.729
Dr. Jill Foster: so, being people who do and people who collect numbers, we decide to do research, to see, to see if we can get a better picture of what is the physician workforce needs in the Southwest. Pick the Southwest for a couple reasons. I think it's it's it.

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00:06:26.730 --> 00:06:51.729
Dr. Jill Foster: It kind of is emblematic of areas outside of the twin cities. And then we want to view this kind of as a supply and demand equation. Do we have enough supply. And what's the demand? And most of this I got from the Minnesota Department of Health did an overview of the Physician workforce back in 2019. And I'm going to focus because these 2 scenarios, where we really kind of had a shortage of surgeons.

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Dr. Jill Foster: pediatricians. I'm going to use surgeons and pediatricians as kind of the models of what we're talking about here. But we'll also talk about physicians in general.

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Dr. Jill Foster: So supply issues southwest Minnesota. That sort of left lower left hand corner of the State. It's about 7% of the population pretty rural, mostly. So

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Dr. Jill Foster: in total. For the for Minnesota, we have 27,500 doctors in Minnesota, 550 of them are general surgeons.

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Dr. Jill Foster: and down in the southwest we have 24, so that left hand lower left hand corner of the population, which is 7% of the Minnesota population, has only 4% of the surgeons which already those 550 general surgeons weren't really enough for the whole State, and now we have disproportionately even fewer. So we got 24 surgeons for that whole area, and this pretty much tracks for almost every specialty you look

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00:07:51.330 --> 00:08:08.440
Dr. Jill Foster: pediatricians, internists, family medicine, primary care, everything. There's a shortage of physicians down there or around surgeons. We have one surgeon for every 16,000 people which that's way. Too many people, according to the benchmarks or way too few surgeons.

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00:08:09.800 --> 00:08:34.789
Dr. Jill Foster: In addition, on the supply issue, we have an aging population of Minnesota physicians. The Median age of physicians in Minnesota is 59, 16% of Minnesota physicians are already 65, and older and so kind of already working past the end date, and 22% are 55 to 64, or getting very close to retirement. And so there's a cliff approaching.

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00:08:34.789 --> 00:08:49.049
Dr. Jill Foster: Physicians. Retiring physicians tend to hang on working longer than most occupations, as you can see there from the table, but there is only so long that people can can keep practicing.

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00:08:49.440 --> 00:08:50.530
Dr. Jill Foster: This is

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00:08:50.690 --> 00:09:03.870
Dr. Jill Foster: also this is exacerbated because the whole population of of the country is getting older. The green line. There is the percent change in population of those over 75.

37
00:09:03.870 --> 00:09:28.859
Dr. Jill Foster: And the lowest line is the percent change in population of under 18. So not getting all, you know, just sort of the population just sort of perking along in these lower ages. But the number of older people in the population, you know, like the physicians, is getting older. Minnesota numbers where again, you see a big jump, you know, back in 2013 we had

38
00:09:28.860 --> 00:09:46.509
Dr. Jill Foster: 756,000 folks, 65 and older. And by the mid 2035, 2040, we're going to have 1.3,000,001.4 million, almost older people and older people come with more health challenges.

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00:09:47.750 --> 00:10:09.880
Dr. Jill Foster: So this is this, I apologize. This is my wonkiest slide. This is taken from a study by the Aamc of the complexities of physician supply and demand projections of where are we going with supply and demand? So demand is amount of physicians we need. So we have a growing population. We have an aging population.

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00:10:09.880 --> 00:10:34.469
Dr. Jill Foster: Medicine is getting more and more complex. We have a geographic maldistribution which nobody's expecting is really going to get much better. We have an equity gap. The population of physicians and the skills of physicians have don't really match the demographics of our population. And then there's the who knows what effect pandemics, disasters, changes in federal funding.

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00:10:34.470 --> 00:10:39.970
Dr. Jill Foster: things like that happen, and it it changes the need for the number of physicians we have

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Dr. Jill Foster: on the supply side. We have a few pluses there. There are new doctors. There are some improved technologies, but mostly we are on the negative side. There in the supply side, we have retiring or otherwise leaving doctors. We have. People aren't willing to work 80 h

weeks back in the day of sort of the family physician who, you know, in a horse and buggy, would come out at 3 o'clock in the morning.

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Dr. Jill Foster: That people just aren't doing that anymore. Expected that the specialty specific maldistribution is going to get worse.

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Dr. Jill Foster: And I'll talk about that in a little bit. And then there's the Covid quitters, that the people who are retiring or otherwise leaving has accelerated since 2020, that more people are retiring than predicted to be, and a lot of it is, is viewed that it just the toll that Covid took on physicians.

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00:11:33.140 --> 00:11:58.120
Dr. Jill Foster: So where does that leave us that leave us with a gap across all specialties that by the year 2034, which isn't really that far off, it seems far off. We're going to have a gap of about 100,000 physicians in the United States, and the chart down below is the projected supply and demand for primary care. Physicians. Any field that this article goes through. You know, surgeons, family

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00:11:58.120 --> 00:12:00.360
Dr. Jill Foster: medicine, pediatrics.

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00:12:00.360 --> 00:12:22.819
Dr. Jill Foster: Every one of the charts looks this way. The solid lines are demand for physicians, and the dotted lines are the supply. So, no matter what specialty or you look at the in total, we are. The demand for number of physicians is going to be much more than the supply. These also account for the supply and demand of

48
00:12:22.820 --> 00:12:41.069
Dr. Jill Foster: advanced practice. The line in there, the blue lines, the orange line for demand, and the blue line for advanced practice. Physicians, assistants, and nurse practitioners is also factored into this, and yet we still have a deficit.

49
00:12:42.400 --> 00:13:06.969
Dr. Jill Foster: This is a chart. This is a map that shows the distribution problems. You can see that Minnesota. So the way it is is that gray is that there is no shortage of physicians. All of the green is that there's a shortage of it's actually goes beyond physicians. And it's it's but this particular one is the physician workforce.

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00:13:07.370 --> 00:13:30.110
Dr. Jill Foster: The green is the shortage, and the darker the green, the more the shortage. And that's talking about using these predictions forward, you can see that Minnesota is not as bad

as the southeast. The southeast is really in trouble. The reason I showed this is that we're going to talk about like, well, where can we get more physicians.

51
00:13:30.110 --> 00:13:47.689
Dr. Jill Foster: and there's not a lot of areas that we can pull physicians from. You could say, one is, we're going to get new physicians here and train our own, but the other is well, maybe we can pull them from other places. But there's not really a lot of other places that we can pull them from, unless you're going to look at the northeast us

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00:13:48.620 --> 00:14:03.220
Dr. Jill Foster: tracking with us from the same publication. This is life expectancy at birth, and you see that it tracks all. You could almost superimpose them. The the red is areas that are has low low

53
00:14:03.220 --> 00:14:28.189
Dr. Jill Foster: life expectancy at birth. And the blue areas are areas that have a high life expectancy, the darker the blue, the higher the life expectancy, the darker the red, the lower life expectancy. And they track where you have a good healthcare workforce, you're going to have a longer life expectancy in general. And so this is why we care. This isn't just a numbers game of do we have the right

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00:14:28.190 --> 00:14:33.469
Dr. Jill Foster: numbers matching some number that was arbitrarily thought up. It's that these 2 track together.

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00:14:34.500 --> 00:14:52.719
Dr. Jill Foster: So let's try to increase increase our supply side. The ways we can do this, we can try to grow more. We can try to attract more. But talk to that. There's not a lot to attract elsewhere. That aren't where they need to be. But we also talk about retaining the runs we have. So I'm going to talk about sort of these 3 domains.

56
00:14:53.770 --> 00:15:23.600
Dr. Jill Foster: So where do we get our doctors from? And where do the people that we train? We're training institution with medical school and Residency and fellowships. So our current physician workforce in Minnesota is about 40% are kind of what I call local. 28% came from Minnesota medical schools and 13% came from neighboring states, medical schools, and Canada there, that we propose that will make Canada a Us. State rather than making the Us. Part of making Canada part of the Us.

57
00:15:23.600 --> 00:15:45.700
Dr. Jill Foster: So, looking at our medical school, looking at match data from 2011 to 2022, you can see there. Minnesota is in the dark. Minnesota gets about 40% of our graduates. People stay and do training here. There's pretty good data nationally, that where you do. Your training is, you have a better chance.

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00:15:45.700 --> 00:15:53.949
Dr. Jill Foster: There's a better chance than not of if you've trained there that you'll probably stay there so important important to retain

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00:15:54.780 --> 00:16:19.749
Dr. Jill Foster: from our residencies and fellowships residencies, we capture 67% of those graduating from our residency. So again, you know, pretty good numbers of that. You're going to stay in Minnesota if you've done a Minnesota Residency, and that's everybody that's not just the folks that graduated from University of Minnesota Medical School. A little less good for our fellowships, only 44.9% stay

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00:16:19.750 --> 00:16:25.619
Dr. Jill Foster: of those that finish our fellowships. So both of these sort of areas that we have room to grow in.

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Dr. Jill Foster: So thinking about this as that staying in Minnesota is the top of the pinnacles. The goal is, you reach the top of the pinnacle is that everybody who starts to climb up the pinnacle ends up at the top of the pinnacle which is practicing in Minnesota, which is what we need. So down at the bottom is those people who apply to medical school, which there's a lot of them, and then up at the top is graduating fellows and graduating

62
00:16:52.000 --> 00:16:59.860
Dr. Jill Foster: residences where there is opportunity to capture those folks, to get them to the pinnacle and to keep them on the pinnacle.

63
00:17:00.540 --> 00:17:26.440
Dr. Jill Foster: So how are we going to do this? What are we going to do? So how do we impact the supply of new doctors? How soon if we do something today for kids that are in high school, for instance, to try to influence them, to stay here as physicians, that we're going to have between 11 and 22 years to really have that be fruitful, and it's good because we should do long-term thinking we were talking about. You know, the mid 2,030 s.

64
00:17:26.560 --> 00:17:51.550
Dr. Jill Foster: Is when we were going to have this. But it's not going to be that all of a sudden, in 2030, we're going to have this shortage of 100,000 physicians. Nationally, it's that we will grow into that. So there's all these other places that we can impact. We can impact people that are applying to medical school, the ones that have gotten into medical school, the ones that have survived medical school and successfully matched to a Residency.

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Dr. Jill Foster: Those that have finished Residency are in our fellowships, and then those that are finishing their fellowship training. These are all points of impact where, through our pipelines, pathways, whatever we're going to call them, that we can have influence on having people want to practice in Minnesota. And so we have to be thinking about all of those different areas of who is in them, how we're going to influence them at all of these places

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00:18:16.540 --> 00:18:29.060
Dr. Jill Foster: we don't want to look only at the end with kind of the people that we ended up with, and then with the people that we ended up with, how are we going to get them to stay. We want to think of this as very longitudinal and holistically

67
00:18:30.120 --> 00:18:54.779
Dr. Jill Foster: so can we put more people into the pipeline that feels kind of the easiest thing. Every year 50,000 applications to medical school, and only half of them. 25,000 are going to result in a new medical student here at the University of Minnesota. We have about 5,000 applications. We start with about 250 new medical students every year. We just, you know, it's very exciting. We have campuses in Duluth.

68
00:18:54.830 --> 00:19:19.820
Dr. Jill Foster: and we have campuses in twin cities, and now we have a campus in St. Cloud, where we are able to add 24 additional spots for the fall of 2025. So that that's really exciting, and a nice jump for us in the number of physicians that we'll be producing, and with a real expectation that those folks in the South St. Cloud campus there's been a lot of thought going into both in Duluth and St. Cloud of impacting the population

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Dr. Jill Foster: of applicants who will likely want to stay in Minnesota and applicants who will also want to work in rural areas.

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Dr. Jill Foster: So how about all those other folks? And you know, 25,000 people who want to go to medical school is a lot a lot of people. So about half of them will try to get in. We'll apply again, or we'll go to international schools.

71
00:19:41.440 --> 00:20:06.420
Dr. Jill Foster: probably half of those rejected. We have all these different ways that we can predict. Success in medical school, and probably about half of those people we rejected would have been just fine medical students would have been, would have gotten through. Medical school, would have gotten through. Residency would have been just fine doctors, but we turn them away every year, so imagine somebody would have a magic wand, and we could increase our, you know, across the United States and increase

72
00:20:06.420 --> 00:20:30.049

Dr. Jill Foster: medical school admissions by 25%, say and take in half of those who didn't get in. Well, we don't have Residency slots for them, so we could put them through medical school. We would already have insufficient number of Residency slots, for if you add together the Us. Graduates and those Us. Students who graduated from schools outside the Us. We don't have enough Residency slots for them. So we're already

73
00:20:30.050 --> 00:20:50.769
Dr. Jill Foster: having looking at sort of Americans who are graduating from a medical school. We don't have enough residency slots for them. And it's really those slots are decided by the Federal Government and Congress, and there's been very little movement over the years, probably even, for, like the last 34 years of increasing those number of slots. So we're a little bit of a stalemate there

74
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Dr. Jill Foster: who's in the pipeline.

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Dr. Jill Foster: So the total number of students. Medical students is inching up this last year it inched up by 0 point 8%. We have more 1st time applicants, more black Latino and Asian applicants, and the only demographic, however, that has shifted is, we've had more Asian students by 8 percentage points.

76
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Dr. Jill Foster: Declining is the total number of applicants has declined

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Dr. Jill Foster: 1st generation. College students have declined, white students have declined, and American Indian, native Alaskan, has had a huge decline of number of native American applicants to medical school has fallen by 15 percentage points in the last year, entering students. Despite having more black Latino medical students or applying

78
00:21:47.040 --> 00:22:11.940
Dr. Jill Foster: to medical school, we're having fewer that are entering medical school, so 22 percentage points different for American Indian, 11.6 for black, 10.8 for Hispanic, 1st Gen. 2.1 and white 0 point 3. So very little change and military veterans is also so the students that are sort of viewed as most of these fall into a category of already

79
00:22:11.940 --> 00:22:29.040
Dr. Jill Foster: underrepresented in medicine, as in you know, we have fewer. 1st Gen. We have fewer black than the population that matches that fell over the last year. And this is all since the Supreme Court decision that made admissions race blind.

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00:22:30.640 --> 00:22:48.810

Dr. Jill Foster: So we imagine we have all these folks graduating from medical school. So most people are taking out loans to go to medical school, put a lot of work into medical school, so there's not really any system where we tell them we can make them go into certain things we can't say. Well, we have a shortage of physicians in Southwest

81
00:22:48.810 --> 00:23:13.609
Dr. Jill Foster: Minnesota, and so we're going to make you become a surgeon, or we're going to make you become a new obgyn. Students. Get to choose where they're going to go. But we have some information to let us know how they're making these choices. So number one thing is fit with personality skills and interests, along with the specialty content of what people are interested in. Most of the folks by this point are pretty internally motivated.

82
00:23:13.610 --> 00:23:38.530
Dr. Jill Foster: Who are, you know, find some a passion for medicine, and so they're following their passion for what they do, things that we can influence is we can influence the work-life balance, not make it be that if you're going to work 80 HA week in this specialty, and you're going to work 40 HA week in another specialty role model influence is still incredibly important. We have to make sure that our folks that are entering the pipeline

83
00:23:38.550 --> 00:24:03.399
Dr. Jill Foster: have had the good role models and had a variety of role models so that they can see what the different fields are. Future family plans, location of residency, income, expectations, length of residency. All of these things are important. Start falling off. And it's interesting because education debt ends up falling right to the very bottom. But this is what medical students graduating medical students

84
00:24:03.450 --> 00:24:11.509
Dr. Jill Foster: tell you. Which may be that it's not actually what comes up. And I'll show you some further information on this.

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00:24:12.580 --> 00:24:35.610
Dr. Jill Foster: So where are our what kind of specialties are our graduates choosing so primary care family medicine, we're ranked very high in the country for our family medicine programs. 19.2% of our graduates have gone into primary care. Family medicine, primary care. Ish, I list as internal medicine, pediatrics, and med peds, because

86
00:24:35.620 --> 00:24:58.189
Dr. Jill Foster: actually, from our training programs about 2 thirds of our medicine and pediatric residents actually go into subspecialties, and they're needed in those subspecialties, but they get counted as being primary care doctors. But the majority of them are actually not working in primary care. They're working in subspecialties of things like cardiology, infectious disease, things like that, general surgery only 4.6%

87
00:24:58.190 --> 00:25:13.780

Dr. Jill Foster: in 10 years we produced 127 new general surgeons out of 22,700 graduates. Not all of them stayed in Minnesota, and I don't know how many ended up in Southwest Minnesota.

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00:25:14.320 --> 00:25:38.229
Dr. Jill Foster: Surgical subspecialties is about twice that. Those are the things like, you know, ear, nose, and throat, ophthalmology. Things like that. Obgyn 4.8, and then something else is the biggest category, actually, which is a whole bunch of different things. You know, things like orthopedic surgery, neurosurgery, and anesthesia. And so you know, this is just an example of we produced more anesthesiologists than we did surgeons.

89
00:25:38.230 --> 00:25:53.909
Dr. Jill Foster: And if people know how ors work. You can have, you know, one anesthesiologist and 5 nurse anesthetists running, you know, an operating room, but you know each 3, rd each operating room requires a surgeon. So this is just a place where there's, you know, a little bit of an imbalance.

90
00:25:55.430 --> 00:26:24.100
Dr. Jill Foster: So interest in general surgery training are people, you know, are there spots for the surgeons? So there's more interest than fills. We have a lot more people applying for general surgery to get into general surgery. General surgery has increased its number of spots incrementally, but not by a huge amount. So our demand for residency slots is much greater than the slots that we have. So a lot of people that want to be surgeons, but not as many spots that need to

91
00:26:24.100 --> 00:26:53.840
Dr. Jill Foster: state by state Minnesota is, you know, we have the big states like New York and California, which disproportionately have a lot more surgery slots than they do people. Minnesota. By my best calculations we have about 25 slots every year to produce new surgeons, and which, if we were going to look proportionally to the populations of New York and California, New York and California are producing a lot more surgeons per population than we are here in Minnesota.

92
00:26:56.590 --> 00:27:10.070
Dr. Jill Foster: Pediatrics is another story. Though so pediatrics we have fewer and fewer people applying for pediatrics. So back, and even in 2019, we had 6,100 people applying. And now we only have 4,500 in the most recent match.

93
00:27:10.070 --> 00:27:36.269
Dr. Jill Foster: the number. It's very consistently gone down of us graduates, and that we would probably not be filling the number of pediatric spots we have at all. If we didn't use international medical graduates. And those are both international medical graduates that are Americans that went to the international schools and international people that went to the international schools. So we have a real problem in pediatrics that we don't have people applying for pediatrics and going into pediatrics

94
00:27:37.280 --> 00:28:01.770
Dr. Jill Foster: if you look at the. So this graph is very busy, but at least colorful, that we these are the subspecialties that people that go into medicine and pediatrics goes into. So up at the top, you know. Really, really good. You know, you have fellowships, and people want them, and people go into them. So you have things like cardiology, Hemont, gi rheumatology.

95
00:28:01.770 --> 00:28:25.640
Dr. Jill Foster: allergy, immunology, and then down at the bottom you have all the pediatric subspecialties. So 8 of the 10 lowest fill rates are in pediatrics. The only thing in those other 10 that didn't, that don't have good fill rates that aren't pediatrics are geriatrics and addiction medicine. And then, even when you look at the pediatric subspecialties.

96
00:28:25.640 --> 00:28:45.929
Dr. Jill Foster: you have some decent ones with decent fill rates of things like pediatric cardiology, pediatric gastroenterology, it tends to be in this, that the ones that fill the best are the ones that make the most money. So here is an average annual physician compensation, and this is beyond just medicine and pediatrics.

97
00:28:45.930 --> 00:29:11.630
Dr. Jill Foster: but plastic surgery, orthopedics. And then we way way way down at the bottom we have pediatrics and geriatrics the 2 that are in the lowest fill rate. So our graduates will tell you that their future earnings don't really have that much impact, and we were not able to divide that out, that well, between the ones that have a lot of student loans and the ones that do have a lot of student loans, but those that are going into pediatrics

98
00:29:11.630 --> 00:29:19.509
Dr. Jill Foster: and the the low paying specialties are declining and the ones going into the highest paying specialties are increasing

99
00:29:19.960 --> 00:29:42.560
Dr. Jill Foster: and just sorry just to put that in a little bit of a perspective, because these numbers sort of start blurring together a little after a while. If you're going to be a pediatrician over 30 years. You'll make 7 million dollars, which sounds like a lot of money and is a lot of money, and I'm very glad, as a pediatrician to have made that amount of money. Well, if I have.

100
00:29:42.560 --> 00:30:07.549
Dr. Jill Foster: however, if I had chosen to be a plastic surgeon or a dermatologist. I would have made 17 million or 13 million, and if I had even chosen to be an internist and take care of big people instead of little people over my lifetime earnings. I would have made a million dollars more by being an internist. So it would be nice as we're thinking about these pipelines and pathways and areas where we have shortages

101

00:30:07.550 --> 00:30:11.069
Dr. Jill Foster: to not have it. Be that the physician salaries.

102
00:30:11.070 --> 00:30:28.899
Dr. Jill Foster: There's 1 way in pediatrics. You can make more money than an internist, and that's to become a neonatologist. So what gets paid is people that do rather than people that think. People that take care of big people get paid more than people that take care of little people or old people.

103
00:30:30.020 --> 00:30:58.850
Dr. Jill Foster: I can't believe that it doesn't impact that the Median average the average debt for medical students. Graduating is 200,003 quarters of the medical students graduating have educational debt with that average debt being 200,000, which means that there's a lot also that have debt of more than 200,000. So what that translates into sort of comparing it to lifetime earnings is you could have bought 2 houses instead of one house.

104
00:30:58.850 --> 00:31:07.079
Dr. Jill Foster: that the amount of of student loan payment ends up being about like a paying mortgage on 2 regular houses.

105
00:31:08.270 --> 00:31:33.239
Dr. Jill Foster: women, physicians, it's even worse. Women. Physicians make 66 to 75%, 75 cents on every dollar that male physicians make. They tried looking at. Well, you know, it's kind of makes sense. A lot more women go into pediatrics than women go into orthopedic surgery, even equalized for number of hours worked specialty gone into. Women still make 66 to 75 cents on the dollar.

106
00:31:33.240 --> 00:31:41.589
Dr. Jill Foster: So another barrier for women that are choosing specialties is they're going to be paid less and then go into specialties that pay less.

107
00:31:42.780 --> 00:32:09.919
Dr. Jill Foster: So easy solution is, let's just pay everybody more, or let's take from the high paying specialties and pay it to the low paying specialty, you know, that's not going to work. But so where does physician compensation come from? So people that work for a hospital system. Most of it's going to come from the clinical revenue. Some other things that physicians do for the system. Some other revenue academic physicians which most of us are. It comes from Grant, funding

108
00:32:09.920 --> 00:32:16.069
Dr. Jill Foster: some from the clinical revenue, from the tuition that the people pay so that they end up with all of this educational debt.

109

00:32:16.070 --> 00:32:43.400
Dr. Jill Foster: So I you know, I dug a little bit deeper into this, because I'm like, where do those numbers? We're all used to Rvus. We get assigned Rvus. When we, you know, you see a patient and you spend an hour with them, or you spend 10 min with them. You're given this thing called a relative value unit, where somebody, it seemed like it came from God and was, you know, Moses, on a tablet, figured out these numbers of what it's worth to see a pediatric well, visit versus what it's worth to see

110
00:32:43.400 --> 00:32:56.879
Dr. Jill Foster: an adult well, visit versus what it's worth to spend an hour in the or, you know, doing plastic surgery on somebody with a facelift. And so what it is is. There's actually a committee called the Ruck.

111
00:32:56.880 --> 00:33:21.859
Dr. Jill Foster: which is an Ama. Committee that sets these Rvus to determine the amount of clinical revenue. So they meet, and they said, probably on zoom now, and they talk about how much worth it's worth for each of these procedures. Well, there's 31 physicians on this who are predominantly subspecialists. There's only one pediatrician on this of the entire 31 and only 4 of them are women. And so this is basically

112
00:33:21.860 --> 00:33:32.289
Dr. Jill Foster: sub specialists, like orthopedics gets a spot. And you know, internal medicine gets a spot, and anesthesia gets a spot, and ophthalmology gets a spot, and then pediatrics gets a spot.

113
00:33:32.760 --> 00:33:51.990
Dr. Jill Foster: and that's how this is all set. And so it's not working. It hasn't been working. And there's a lot of there's a lot of innovation, that is, there's opportunity for a lot of innovation in this especially something called, you know, value-based care. But you know that's another whole deed seminar in itself.

114
00:33:51.990 --> 00:34:04.480
Dr. Jill Foster: So the quick fix for this is, or even the long term fix, for this is not to be able to fix the gaps, the equity gaps in salary. And so we're going to have to be imaginative and come up with some other things.

115
00:34:05.220 --> 00:34:18.619
Dr. Jill Foster: So advocacy and action. There's things that we can do through national and state legislatures and with our policymakers. So we need to push for reform of our view and Cpt calculations.

116
00:34:18.620 --> 00:34:43.609
Dr. Jill Foster: We need to fund student loan repayment and Health Service Corps having worked for I won't say how many years with medical students, residents, pre-meds. It's hard for

me to believe that the amount of student loan debt that people are coming out with? Does it influence both their specialty choice and where they're going to practice practicing in an area where they're going to get high compensation

117
00:34:43.610 --> 00:35:07.999
Dr. Jill Foster: versus perhaps maybe Southwest Minnesota, which may not have as high. We need Nih set asides for the folks that are. We need Nih just to pay the money that they said they were going to pay. But we need Nih set asides for people who want to do research, especially in one of the areas where there's a real shortages in pediatric subspecialties. There needs to be funding there to make

118
00:35:08.020 --> 00:35:13.430
Dr. Jill Foster: bring us to equity even not even be sort of a bonus position.

119
00:35:13.600 --> 00:35:37.510
Dr. Jill Foster: There's things we can do through our professional societies and boards. Where this is. Maybe we have even a little bit more control over. I think the National and State legislatures and policymakers. It's harder. There's opportunities to do that kind of advocacy, but I think that that's the harder stuff for us to do at our level. But professional societies and boards. Most of us are on, you know, member of some professional society.

120
00:35:37.510 --> 00:36:02.489
Dr. Jill Foster: and it's really time to get moving with that policy statements. We can do changes in specialty training and recertification requirements. There's a lot of people looking at, you know, a lot of pediatric subspecialties are 3 year fellowships where a matching internal medicine fellowship would only be 2 years. And so, you know, why are we asking people to do that extra year when they're not paying off student loans and not getting the low income that pediatricians get.

121
00:36:02.490 --> 00:36:25.059
Dr. Jill Foster: We need to do data collection and publishing about the state of the field. We need to be able to say this is why there's value, you know. We need to say, hey, look at southwest Minnesota. Our mortality rate's higher there, and we don't have enough doctors there. We can't prove necessarily causation, but there's a pretty clear link here, at least.

122
00:36:25.060 --> 00:36:54.549
Dr. Jill Foster: and so we need to be able to do this, and we need to create messages that the public understands. The public right now is hearing that, you know Nih is throwing away all this money, giving money to universities, you know, as indirects that is just wasted money rather than what universities are using this money for. And so we need to be able to have clear messages to the general public, because the general public are the ones who vote and are making decisions about these things.

123
00:36:55.540 --> 00:37:23.740

Dr. Jill Foster: recruitment and retention strategies. So if we lose a position, it costs about a million dollars to replace them. There's the amount of lost income that they had while they were gone before we get somebody. New recruitment costs getting somebody settled in their new position. It costs about a million dollars. So a lot of times people end up thinking about. Well, you know, how do we keep the people we have, and that there's an incremental cost to making these changes to keep the people that we have

124
00:37:24.001 --> 00:37:31.309
Dr. Jill Foster: but you really have to look at it that we're really trying to save a million dollars rather than we're spending 200,000, or whatever it is.

125
00:37:31.310 --> 00:37:58.559
Dr. Jill Foster: So one of the big areas is student loan payback. Yes, it would be nice to have Federal programs that do that. It would be nice to have federal programs that if you go into an area of medicine and work in an area of the country where there are shortages and gaps that the Federal Government would do it well. The Federal Government sometimes does it. I suspect that that may change in the near future, but institutions themselves can have student loan payback

126
00:37:58.810 --> 00:38:12.509
Dr. Jill Foster: creating a positive. And these are the, you know, evidence-based domains that have been decided by, you know, the business people of what helps with recruitment and retention. So creating a positive environment that's really difficult

127
00:38:12.510 --> 00:38:37.350
Dr. Jill Foster: and that has to come from both the leadership and from the folks that work there but creating a positive environment. And one of the biggest reasons people leave is they don't like where they're working, and there's some other place that it may be, grass always seems greener on the other side, but there may be other place where the grass really is greener, and so you need to be looking at? What is our grass, provide development and leadership opportunities?

128
00:38:37.350 --> 00:39:02.300
Dr. Jill Foster: How many years it takes to make a physician? Folks that go into medical school and go into medicine are people that have a growth mindset. People are always wanting to learn more, do more, gain new skills. And so institutions need to be able to provide those opportunities for them so that they can. They can grow and not feel like they're stagnant in their field. Some people are happy enough with learning new

129
00:39:02.300 --> 00:39:12.389
Dr. Jill Foster: things about. You know the better way to do a hip replacement or something like that. But a lot of people they want to grow as a person, and they grow in their skills. And so institutions need to be able to provide those

130

00:39:12.780 --> 00:39:41.840
Dr. Jill Foster: we have to be attentive to. Burnout burnout is something where, where, you know expectations for how something is going to be are different than what they are, and there's only so long you could live with that I think we've become a lot more attentive to burnout because of the pandemic, but it feels to me that we're already losing some of those lessons now that it's more the height of the pandemic has. And before the next pandemic has been, you know, alleviated a little bit.

131
00:39:41.840 --> 00:40:06.819
Dr. Jill Foster: Technology technology can be your best friend, you know. Emrs, I think a lot of people don't understand that Emrs were really built to be really good and efficient billing mechanisms. I think most of the physicians that are using emrs understand that this wasn't built for us. So we have to be better about how using technology. If we're going to use advanced technologies. We have to make sure that they're physician friendly. It's all about.

132
00:40:06.820 --> 00:40:31.419
Dr. Jill Foster: They're creating that positive environment. And it has to come from leadership and has to come from people at the top that they care about how we use our technology. So all of these things are really important, so that we retain the people we have. I've talked about how we don't have enough supply. To begin with, we are at risk for losing people that don't make it to the top of that pinnacle. And so we need to be very attentive to

133
00:40:31.480 --> 00:40:36.229
Dr. Jill Foster: keeping the people that we have, and viewing the people that we have is a valuable resource.

134
00:40:37.460 --> 00:41:02.419
Dr. Jill Foster: We can use a lot of creativity in the early recruitment and retention. I mean, this is and planning for retention, planning, for we're getting people into fields that they want to be in, and that they're going to stay in. And we can think about that from the very beginning. So nontraditional students. We have one of the programs we're working with and pathways. It's a new one is looking at medics, medics to medical school. And I think there's a few listening in

135
00:41:02.420 --> 00:41:27.320
Dr. Jill Foster: today that we take folks that have had all these incredible skills that they have learned by being medics in the field, and then they will bring them to medical school with them, and I think be much more likely to be committed to Minnesota because we have this program and committed to doing things that are, you know, out in the field and working and doing very hands on field

136
00:41:27.710 --> 00:41:51.959
Dr. Jill Foster: other than traditional students, I guess kind of probably non-traditional isn't even the word to use for it. It's students who aren't the, you know, 4.0 grade point. Average student whose parent is a doctor, who, you know, goes to an Ivy League institution and looks perfect on paper, is, I think, we have to be able to look at the students that aren't that.

137
00:41:51.960 --> 00:42:16.779
Dr. Jill Foster: And think of them that they're going to be great doctors, and that they're going to be great doctors, potentially willing to go to the Southwest. So we have a holistic admissions process where we look at the whole person and what their potential is for, how they're going to go, where they're going to be. And part of that is we think about, you know, especially with the St. Cloud and Duluth campuses of people who are going to want to

138
00:42:16.780 --> 00:42:21.479
Dr. Jill Foster: work in a rural area, not just people who will be willing to work in a rural area.

139
00:42:21.980 --> 00:42:46.370
Dr. Jill Foster: and then that we have to look at minimizing the barriers to the success programs, things that look at the folks to bridge these gaps between somebody who's coming in who may not in the beginning have as many of the qualities and numbers as somebody else might have, but with very little work will get to the place where that they are exactly the same

140
00:42:46.627 --> 00:42:54.080
Dr. Jill Foster: and so, taking down the barriers, i 1 of the things that I do with the work that I do is I have so many folks that we have

141
00:42:54.080 --> 00:43:18.620
Dr. Jill Foster: inched along in this this pipeline, who then become, you know, who like through like really really good programs and like high schools and elementary schools to convince kids to go into medicine, and then they get into pre-med, and they get a C in organic chemistry, and someone says, Well, you'll never be a doctor, and whereas, you know, maybe they needed a tutor, and maybe they didn't have in their high school as much as somebody else had.

142
00:43:18.620 --> 00:43:32.160
Dr. Jill Foster: but with a little bit of tutoring. They're going to have the same capacity and skills and knowledge that somebody else that didn't have that. So just really, this is about trying to take down some of the barriers to success that are out there.

143
00:43:33.910 --> 00:43:55.959
Dr. Jill Foster: Telehealth. I want to spend a minute on telehealth because telehealth is one of those things that it's not just supply and demand, it becomes for the supply that we have. How can we use the supply better? And it's about having the technology, but having the technology back to that place where I said that the technology works for the people that we have

144
00:43:55.960 --> 00:44:20.929
Dr. Jill Foster: so something called an echo model which has worked incredibly well, especially in areas with physician shortages around hepatitis C, which is a project that I worked on for a little bit in one of my previous roles which we had these center of excellence physicians, we

had these gi folks at these hub institutions. Who then we would have these folks going out and training primary care providers to increase their ability because there was actually some insurance companies even had

145
00:44:20.930 --> 00:44:44.320
Dr. Jill Foster: role that the drugs for hepatitis could only be prescribed by gastroenterologists, and so we increased the capacity of people to do something that was highly technological, that they hadn't done before, that they could now do with just a little bit of help. And this wasn't a patient in the room. This was like a training session that they would bring cases in and they would do it.

146
00:44:44.540 --> 00:45:04.180
Dr. Jill Foster: The second kind of telehealth is individuals or groups of physicians interacting directly with a patient and technology. This isn't very efficient, but it is efficient for the patient who doesn't have to drive 3 h to get in to be seen in an office. And so it's a way that we could extend our services to areas with health profession shortages.

147
00:45:04.930 --> 00:45:28.480
Dr. Jill Foster: The 3rd one is one that I'm really excited about, which is physicians providing advice, real time. So the 1st one was sort of like, let us teach you the second one requires sort of a patient right in front of you, with a direct physician. So this 3rd one is our center for resuscitative trauma has a grant to go to southwest Minnesota and work with Ems providers

148
00:45:28.480 --> 00:45:53.479
Dr. Jill Foster: to actually do a telehealth solution that involves ipads. So that guy that rolled on his tractor when the paramedics or emts or basic 1st Aid people even get to him. They can have the expertise of a trauma surgeon sitting, you know, someplace else directly on the ipad. Real time to be able to help them through that patient's care, so that before they even get the patient

149
00:45:53.480 --> 00:46:02.060
Dr. Jill Foster: to a hospital they've had the expertise of somebody in one of these other hubs which may alleviate some of that. The shortages.

150
00:46:03.250 --> 00:46:25.350
Dr. Jill Foster: All right. So let's get back to blue Earth whoops. Sorry. Let's get back to Blue Earth here. So what are we doing to help those folks in blue Earth? So we're increasing the number of graduates from the region through St. Cloud. We have another program, a pipeline program called Minnesota Future Doctors, which is working with pre-meds who were in these areas to try to

151
00:46:25.350 --> 00:46:54.569
Dr. Jill Foster: help them a little bit, become better. Better applicants enhance familiarity with rural medicine through the rpap program that the medical school has. We extend our Hub

expertise through programs like the center for resuscitative trauma program. We have the holistic admissions review process, and then we continually partner with our other stakeholders, statewide, so that we hear from them. What do they need? What are their perceptions of what they need. How is what we're doing, working for them?

152
00:46:54.795 --> 00:46:59.310
Dr. Jill Foster: Rather than us, just sitting in an ivory tower and thinking up what we think will be better for them.

153
00:46:59.970 --> 00:47:21.099
Dr. Jill Foster: So the questions are today, do we have enough doctors? No. Do we have the right kind of doctors? No, our doctors in the places we need them. No, but yes, we're working on it, and there's still work to be done. I think that there's a lot of exciting stuff that's going on here at the U. And I think that I look forward to seeing the other exciting stuff that we will be doing.

154
00:47:24.870 --> 00:47:27.659
Dr. Jill Foster: and I will now go back to the group.

155
00:47:29.550 --> 00:47:31.400
Ana Nunez MD: Excellent, all right. Well, we have

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00:47:31.890 --> 00:47:43.279
Ana Nunez MD: a number of questions. If it's okay with you, I'm going to answer sort of our live first, st and then we'll get to the ones that were sort of invited, and I'll try to kind of bundle them together, since I want to

157
00:47:43.310 --> 00:47:49.630
Ana Nunez MD: make the best use of our time. Thank you very much for this presentation, you know. I think there's a couple things that sort of

158
00:47:49.630 --> 00:48:14.569
Ana Nunez MD: I had heard. If you lose a doctor in terms of retiring or stepping away, it takes 2 at least to replace, and so that when we look at our numbers those numbers may be half there in terms of what we're doing. You mentioned about the National Health Service Corps. That's a program funded from the Department of Health and human services, and I'll share with folks. There are some opportunities for advocacy. If there

159
00:48:14.570 --> 00:48:37.919
Ana Nunez MD: folks here who want to gather to talk about sort of advocacy opportunities, we can have a conversation about that in terms of how to reach out to Congress and Senate, to sort of give examples of how these workforce shortages are going to hurt people, if not sort of

attended to. There's a Residency Workforce Shortage Act that we want to try to get reintroduced in terms of the current Congress.

160
00:48:37.920 --> 00:48:47.189
Ana Nunez MD: which only looks to increase the Residency slots by 14,000 over 7 years. That's actually not that much based on the numbers that you shared us.

161
00:48:47.360 --> 00:49:11.910
Ana Nunez MD: But if people do want to sort of continue the conversation about, how can we have sort of advocacy with some of these things? Hhs training programs, etc, happy to talk to folks in terms of sort of doing that. But the National Health Service Corps had been a tool that was funded, not funded was funded sort of a boomerang kind of thing late. Do you know, lately, in terms of

162
00:49:12.020 --> 00:49:14.360
Ana Nunez MD: the status of that

163
00:49:14.910 --> 00:49:30.290
Ana Nunez MD: about sort of as an opportunity, and that was an opportunity for people to go to medically underserved sites which aren't necessarily only rural, by the way, and be able to get some loan repayment, so that they can decrease of their educational debt any any thoughts about that.

164
00:49:30.990 --> 00:49:46.860
Dr. Jill Foster: I mean, I grew up in a rural area, not Minnesota, but I grew up in a rural area where we had a National Health service, Doc, that came every year, and I don't know what we would have done without that National Health service, Doc. The numbers are have been decreased.

165
00:49:47.010 --> 00:50:11.569
Dr. Jill Foster: There's a lot of the. There's proposals to just get rid of the program. The view is that medical schools and residency should do it on their own, and that the view is all doctors make all this extra money, you should just on your own self, select for it another requirement for it is that you work full time in a clinical setting. And so, if you're talking to somebody who's a subspecialist.

166
00:50:11.600 --> 00:50:36.489
Dr. Jill Foster: especially in pediatrics, all the subspecialists in pediatrics are at an institution. And so, you know you can't. You know you have academic responsibilities, teaching things like that outside of your, you know, seeing patients 40, 50 HA week. And so it's not really available for people. It's great, and we need more of it. And there's certainly a lot of people going into primary care. It is only for primary care, for a lot of people going into primary

167

00:50:36.490 --> 00:50:55.010
Dr. Jill Foster: care to do it. Another area which I'm afraid will go on. This chopping block is. Nih has also had a loan repayment program for people going into research careers. There's a lot of stuff going on there now, all of these things at this point are about trying to at least keep what we have.

168
00:50:56.800 --> 00:51:05.759
Ana Nunez MD: Yeah. And one of the questions was, you know, sort of a tough question in terms of will the recent Nih budget cut affect next year's medical student enrollment.

169
00:51:06.240 --> 00:51:06.990
Ana Nunez MD: So this is.

170
00:51:06.990 --> 00:51:09.990
Dr. Jill Foster: That's so far above my pay grade.

171
00:51:10.626 --> 00:51:11.900
Ana Nunez MD: I mean.

172
00:51:11.900 --> 00:51:18.499
Dr. Jill Foster: Our needs certainly aren't changing but that's so far above my pay grade. I'm continued to do my work.

173
00:51:18.730 --> 00:51:43.669
Ana Nunez MD: Well, I mean, you know, medical students are sort of paying attention, and I think our advocacy towards them is really important in terms of how we move forward, you know, and letting folks know again what are the real world consequences for your loved ones, for people that you care about, what you know will not happen if we don't have support in terms of the work. Chris Van Breck, Brenk says, assuming you cannot

174
00:51:43.670 --> 00:51:54.369
Ana Nunez MD: all specialties in rural areas. Do you think there's specialties that rural areas should prioritize over others, ie. Especially retention programs for geriatrics, since most rural are generally older than

175
00:51:54.370 --> 00:51:55.070
Ana Nunez MD: urban.

176
00:51:55.810 --> 00:52:20.770
Dr. Jill Foster: I think that we especially need to prioritize things that require in person. So if you have appendicitis, part of the reason I chose surgeons is. I like surgeons, but the other part is that you know, if you have appendicitis, you need a surgeon to take out your appendix.

If you roll over your tractor. You need a trauma surgeon to take care of you. The more thinking specialties of you know I

177
00:52:20.770 --> 00:52:45.590
Dr. Jill Foster: I can recommend an antibiotic regimen to somebody by looking at their chart and doing telehealth with them. So I don't necessarily need to be in blue earth. But we need to have the people that do procedures that can't wait for a delay. So we need things like obgyn. You know, you have a difficult delivery. You need family medicine people, and you need obgyns who do the

178
00:52:45.590 --> 00:53:10.580
Dr. Jill Foster: you know the high, level, maternal fetal medicine stuff in blue earth because you put somebody in an ambulance to the twin cities. There's going to be problems. There's going to be complications with that. I think geriatrics is much better. I mean, all of these things are much better done when you can, especially with senior citizens, when you can sit right across from someone rather than asking somebody who's 75. I'm trying to picture my my mother, who's 90, being on a zoom

179
00:53:10.580 --> 00:53:26.079
Dr. Jill Foster: screen, trying to, you know. Talk with her, doctor. It's going to be a lot more difficult, and I think you know, geriatrics is a perfect example of where you have to kind of make an exception for maybe technology and distance work is not going to be as as good and as efficient.

180
00:53:26.880 --> 00:53:50.260
Ana Nunez MD: And that brings to sort of a number of questions that we had in terms of geriatrics about, how can we increase knowledge about sort of gerontologic knowledge about the physicians. How do we increase programming in lots of our different programs? Our rural physicians associate programs, geriatric workforce memory keepers, discovery team, Duluth and St. Cloud campuses, and so on and so forth.

181
00:53:50.260 --> 00:54:03.559
Ana Nunez MD: as well as you know. How do we make geriatrics more appealing in terms of students? Right any thoughts there, I mean, I apologize. If we're asking a pediatrician how to make geriatrics sexy.

182
00:54:03.560 --> 00:54:27.110
Dr. Jill Foster: Both ends of the spectrum are similar. I think that geriatrics is one of those things that can the echo model of having the hub expertise. I mean, there's certain things of, you know, there's a lot of things in geriatric population that are skills and knowledge base about different pharmacokinetics, polypharmacy, different illnesses that present different ways in geriatrics that just.

183
00:54:27.160 --> 00:54:32.880

Dr. Jill Foster: you know, increasing the knowledge and skills of people that are already in the area will help.

184
00:54:32.880 --> 00:54:57.810
Dr. Jill Foster: And so you can do things like that, but that, you know, that's going to require some Federal funding or state funding, because, you know, I showed those models of where does reimbursement come from? You know. Nowhere in that. Did you see that you know somebody sitting on a camera for an hour training people in blue earth. How to be better at doing something was reimbursable. You're not going to generate Rvus from it. You have to have grant funding for it.

185
00:54:57.810 --> 00:55:08.619
Dr. Jill Foster: and so somebody has to provide the money to do that sort of thing because it's come to a place where, you know we can't just do work that does. There doesn't come a place

186
00:55:08.620 --> 00:55:25.609
Dr. Jill Foster: that there's income or recognition toward your income that comes from it. And so then things end up getting prioritized, and little people and old people are never at the beginning of the priority line. And so we need to do a lot of education and advocacy about that.

187
00:55:26.630 --> 00:55:26.990
Ana Nunez MD: Good morning!

188
00:55:26.990 --> 00:55:28.749
Dr. Jill Foster: Are great programs here already.

189
00:55:29.160 --> 00:55:45.069
Ana Nunez MD: Mark Slice says, thanks for the great talk, Dr. Foster. Is there any evidence that the falling birth rate, both in Minnesota and nationally, is impacting career choice vis-a-vis choice whether to go into pediatrics. If birth rate continues to fall at this current rate, we just won't need the same number of pediatricians in the past right.

190
00:55:47.480 --> 00:55:56.299
Dr. Jill Foster: Well, we already have an undersupply. So we're making up from a deficit. I think that you know I mean being. I don't.

191
00:55:56.350 --> 00:56:23.200
Dr. Jill Foster: I think if you ask the average medical student whether they could understand about the birth rate and how that's going to impact their future practice. I don't think most of them. That wasn't 1 of the things that fell into that choice of thing of I'm worried about the cliff of. And these things fluctuate, too. So no, I'm not going to start laying crepe over the death of the pediatrics field. Yet.

192
00:56:23.930 --> 00:56:47.369
Ana Nunez MD: You know, I actually wonder if the flip side is that if we see that people are waiting longer to have children, then the risk potentially in terms of complications fall within that graph that you showed about sort of lack of payment in terms of pediatric subspecialists. So we may need more people to work in Nicus, and more people to understand about complications, because that might be who sort of tomorrow's infants are.

193
00:56:47.370 --> 00:57:06.349
Ana Nunez MD: But figuring out how we can have people be born, be healthy, be productive, and sort of contribute is really, you know, I mean, people would say, that's important for our national security, because it is in terms of taking care of people so interesting things. And then Barbara Port asks what are the chances? Residency slots can be increased.

194
00:57:08.450 --> 00:57:27.179
Dr. Jill Foster: You know it's all political, so I mean it. There has to be a will, and there has to be a politic. I mean, there was a little bit of a movement toward this in the last Congress, and with the last administration. I'm not seeing that happen right now, though

195
00:57:27.290 --> 00:57:51.270
Dr. Jill Foster: I mean there have to be Federal incentives right now. It's a game of chicken of the Federal Government is saying, oh, you hospitals! You've got all this money, you know you should be paying your residents and just increase nobody's telling you. You can't increase your residency slots. It's just the Federal Government's not going to reimburse you for the extra effort you have to do to train a resident. So it's been a game of chicken, and I certainly don't see that

196
00:57:51.270 --> 00:57:58.050
Dr. Jill Foster: happening anytime in the near future. But I'm actually being fairly pessimistic right now on Federal funding. So.

197
00:57:58.550 --> 00:58:12.100
Ana Nunez MD: Well, this is an opportunity in terms, you know. Elected representatives are exactly that we elect them, and the folks that sort of may be like-minded. That's great. And the people who aren't, we need to sort of chat with in terms of sort of saying, How

198
00:58:12.100 --> 00:58:31.510
Ana Nunez MD: how do the stories that you all have in terms of if we don't have more residents. If we don't have people going into these fields, how is that affecting your loved ones? Your ability to get seen by a doctor, so there are opportunities to be sort of advocates to sort of let folks know in terms of at both of the State and Federal level

199
00:58:31.510 --> 00:58:56.080

Ana Nunez MD: as a citizen in terms of sort of understanding how the implications here and some of the things that we're hearing can hurt folks, so I would encourage you. If folks are interested in terms of having more conversations about advocacy, please reach out to us, and we're happy to sort of talk about sort of various things that may be an opportunity to whether it's in an app or in a phone call. Let your elected representative know how academic medicine and how

200
00:58:56.080 --> 00:59:12.059
Ana Nunez MD: we care for people and care for Minnesotans makes a difference in terms of our lives. I would like to thank Dr. Foster for her time. This is a great talk, all right. You didn't solve everything. But next time, okay, but appreciate sort of your insights, and I'll turn it back over to Anthony.

201
00:59:12.060 --> 00:59:14.609
Dr. Jill Foster: I'll just say 2 final words, go, birds.

202
00:59:17.630 --> 00:59:43.940
Anthony M Wallace: No words, indeed! Alrighty! Thank you, everybody for joining us this morning. On your way out. a 1 question survey will appear in your web, Browser, immediately after you end this session. Please take the time just to complete this survey. We love to hear your feedback, and we would love for you to give us some ideas on future presentation topics you'd be interested in. And just again, as I said at the top of the session, you know this session will be recorded, and it is going to be shared out to everyone who registered for the event within 2 days.

203
00:59:44.366 --> 00:59:51.620
Anthony M Wallace: Otherwise recordings can always be found on the education and training tab of our Ode Odei website.

204
00:59:51.710 --> 01:00:06.240
Anthony M Wallace: And then finally, just as a plug looking ahead to next month, we want you to save the date. The next Dean's lecture series will be on Wednesday, March 12, th 2025, with Doctors Mary Owen and Rahel Kempra. So thank you all again for joining us, and have a great rest of your day.

205
01:00:06.570 --> 01:00:08.190
Ana Nunez MD: Take care, everybody stay strong.