BRIAN SANDOVAL
GOVERNOR

STATE OF NEVADA
Office of the Governor
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PUBLIC MEETING NOTICE AND AGENDA

Name of Organization: Graduate Medical Education (GME) Task Force

Date and Time of Meeting: September 13, 2016, 9:00 AM

Place of Meeting Legislative Counsel Bureau
401 South Carson Street
Room 2135
Carson City, NV 89701

This meeting will be videoconferenced to the following location:

Nevada System of Higher Education, South
4300 S. Maryland Parkway
Conference Room 101
Las Vegas, NV 89119

MINUTES

I. Call to Order/Roll Call
Vance Farrow, Chair

Chair Farrow called the meeting to order at 9:10 am.

Members Present: Vance Farrow, Bill Welch, John Dougherty, Dr. Thomas Schwenk, Laura Hale, Gregory Boyer, Dr. Barbara Atkinson, Sam Kaufman, Mark Penn, Ramu Komanduri

Members Excused: Stephen Altoff

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Guests Present: Gerald Ackerman, Dr. Daniel Spogen, Dr. Catherine Goring, Julie Clyde, Paula Guzman, Dr. Neila Shumaker, Stanley Shumaker, John Packham, Aurelio Muyot, Mahender Solanki, Daisy Rosado, Benjamin Baumann, Dr. Andrew Eisen, Julie Zacharias-Simpson, Dr. Vick Gill, Mimi Burn, Shelley Berkley

Staff Members Present: Brian Mitchell, Dale Ann Luzzi, Elyse Monroy, Jodi Bass

II. Public Comment (No action may be taken upon a matter raised under public comment period unless the matter itself has been specifically included on an agenda as an action item.)

There were no public comments.

III. Approval of the Minutes From the May 10, 2016, meeting **(For possible action)**
Vance Farrow, Chair

Chair Farrow was provided the following corrects to the minutes: Some doctors were not referred to or noted with the title of Doctor before their name. Chair Farrow said it is noted. Chair Farrow made a motion to approve the minutes with the corrections noted. The motion was seconded. The motion passed unanimously.

IV. Welcoming Remarks
Vance Farrow, Chair

Chair Farrow said we are very proud to get this far and welcomed everyone to round two of this GME journey. He stated that with the success so far, we can have equal success today in getting another round of funding so we can expand the opportunity to attract more specialties, which will ultimately be left to the decision of the Legislature. Chair Farrow added that hopefully we will be doing this again next spring or summer and be able to move forward with this initial effort to increase slots in healthcare and behavioral health to be successful. He said he certainly believes the Governor feels the same way and hopefully so does the Legislature so we can build on that with another round of funding. He stated how really impactful this will be on the healthcare system in Nevada.

Dr. Schwenk asked Chair Farrow to comment on the committee's role, if any, as we go into the legislative session. He stated that other members of the task force share his views to some extent, saying that we have tapped out the primary care and mental health capacity and yet there are still huge needs and other specialties we need to be lobbying for, not only the extension of the funding but expansion of the criteria and what role this task force has or how that process would go. Chair Farrow replied that after recommendations of this round of GME, there should be a conversation with the Governor's Chief of Staff, Mike Willden to express that exact point and determine at what point during the session we should introduce that conversation. He further stated

that notification of dates for that conversation will be sent out alerting interested parties and members of this task force who are willing to testify on behalf of GME will be welcome. We will be presenting on every funded program and what their projections are and certainly any of the approved programs that would like to come forward and testify on behalf of the project would be welcomed. At this time we do not have any dates, but welcome the opportunity for anyone to come forward and testify in favor of GME expansion throughout Nevada.

Chair Farrow stated that for today's meeting each of the applications submitted will be presented and representatives of the programs will be asked to answer questions from members of the committee. After the question and answer period we will proceed through each of the applications and consider each of the applications as they are ranked.

V. Discussion and Possible Vote on Scoring and Making Recommendation to the Governor

Vance Farrow, Chair

Chair Farrow opened the discussion, he asked Brian Mitchell whether he had received all members scoring matrixes. Mr. Mitchell responded that he had received them. Chair Farrow asked for a summary of the scoring as presented on PowerPoint. Mr. Mitchell responded that Touro University scored the highest, followed by the Unsom FM Program, then Mountain View, followed by the Unsom Geriatric Program and Valley Health. Chair Farrow asked whether that was an 86 for Touro. Mr. Mitchell replied yes.

Applicant:
Touro University Nevada
Representative: Aurelio Muyot, Program Director of Geriatrician, Julie Zacharias-Simpson, Assistant Professor, Shelley Berkley, CEO Sr. Provost
Chair Farrow: Thank you and congratulations on the high score today.
Mr. Muyot: Thank you for allowing our institution to participate in this grant application.
Dr. Schwenk: My main question has to do with ACGME accreditation. It was referenced in the application as something that would come along in 2018. I wonder if it is possible that it is moved up or if you could clarify how that would proceed? While I was generally favorable about the application, it would strengthen it even more if there was dual accreditation and you could incorporate both DO and MD graduates.
Mr. Muyot: For the ACGNE, there are two requirements. We already have our neurology program, which is one of those affiliated sub-specialties that every training institution should have, and is already initially accredited. Our internal medicine program at Valley Hospital has already submitted their applications and we are awaiting word from the ACGME as far as their accreditations status.

Once that goes through, we then should be able to fulfil the requirements in order to proceed with the ACGME accreditation for our program.

Ramu Komanduri: There is a tremendous need for geriatrics programs which traditionally they have a tuff time filling. Across the country they struggle. What are your thoughts and how Touro would approach getting a new program filled due to the fact that established programs even struggle.

Mr. Muyot: In order to address your question, we start at the student level, I happen to be the advisor of our student geriatric interest group. We start with our first year and second years, several of them have actually gone through their clinicals and approach me about doing a rotation in geriatrics, as a student. Some of the students have expressed, when they ask for their Dean's Letter about a career in geriatrics, anything is also highly associated with some local training programs through Valley Hospital, I have a one third-year resident who expressed interest and we are trying to get our forms together for him to start his application process. So we have ties locally. I have also had another resident who is training in Pennsylvania in his second year in internal medicine, and actually made a site visit looking at the succeeding year of our geriatric training program.

Julie Zacharias-Simpson: Let me just add that we have multiple educational partners who are sponsoring the institution and a strong network of many core programs in family medicine and internal medicine.

Shelley Berkley: With an aging population in this country and certainly in this state, the need for this program becomes more acute with every passing year and the sooner we can start the program, I think the better off the people of the State of Nevada are going to be. We have tremendous interest within our student body for a geriatric program and I am sure it would be filled rapidly and be very successful.

Mark Penn: The impact analysis reached referred to the number of trainees practicing in Nevada after one year, how realistic is it to have four? It seems like that is a high number because it is almost one hundred percent return.

Mr. Muyot: The Nevada Physicians Workforce report indicated seventy seven percent of physicians who take undergraduate medical education stay within the state.

Mark Penn: My follow up question for that is whether four is an accurate number when you say seventy seven percent?

Mr. Muyot: That is probably taken into account those two years, we got two and four on the second one.

Dr. Schwenk: I would like to highlight his comment about recruitment and appreciate the sentiment about student interest and general statements, but this is a huge issue and for a fellowship of this size that has yet to have a track record, I think that anything thing that can be done to create more explicit pipelines or special attractions or loan repayment or other things because it is as Shelley Berkley pointed out it is extremely a great need but recruitment is an issue.

Ramu Komanduri: In regards to budget issues, the cost per resident I have trouble understanding. For instance $532,000 dollars which seems expensive.

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The other thing is that towards the end the facility rent of $48,000 a year to train two residents, I am just trying to figure out the cost. I am having trouble understanding that.

Mr. Muyot: The amount is actually split between Touro University and through the grant, so it is not actually shouldered completely per trainee. The actual number is probably closer to $200,000 plus per trainee, which we are asking through the grant and asking half of that or a little more than half of that will be funded through the university.

Julie Zacharias-Simpson: We are looking to cover about 10% of our contribution and those numbers are all supported by Touro in the clinic for that amount.

Mr. Muyot: So those facilities, I believe that is the $48,000 you are referring to, part is actually figuring the cost if you were to put a practice in there, but that is still shouldered by Touro University because we got a clinic actually located within our campus.

Dr. Atkinson: Because I do not know enough about AOA, Accreditation and the system that I am interested in who is actually sponsoring the programs. Is it actually Valley Hospital or is it Touro? I am assuming that Touro put the proposal in because you are supporting so much money in this and in the future. How does that work between you and the residencies at Valley and the rest of the Valley Health?

Julie Zacharias-Simpson: As a part of the sponsoring institution, that is a contortion with multiple education partners. We were actually one of their sole sponsor years ago and basically it is a sponsored institution with partners in several states so we would be applying through the single accreditation system.

Mr. Muyot: To elaborate further, it is a little different organized AOA versus the ACGME. AOA breaks it into regions, they are a sponsoring institution, and they work with institutions such as hospitals and universities and bring out their GME programs. We report to them but we are also our own institution as sponsored. We have to work under that umbrella as part of the AOA setup.

Mark Penn: I'm still having difficulty understanding the financing. If you look under 2-Traning (C) estimated total cost to train each resident for the two year term of the grant is $532,000 and down below as I'm looking at the table, you have number of trainees, two in the first year, four in the second year and at the bottom it says total for trainee is $532,000. I heard what you said earlier, but I'm still struggling with that number, because that is a high number even if you split it in half, you are talking about $200,000 plus per trainee. So if you could please let me understand those numbers again. It seems to me that those numbers are not a per trainee dollar, it could very well be per three or four trainees, so I just need to get more clarification.

Mr. Muyot: The cost of training is including the continuity care clinic which is a component of the requirements for ACGMA and AOA to accomplish the training program, which shoulders the financial burden associated with the continuity care total. When you include that continuity care it bumps up the total cost per trainee.

Mark Penn: Thank you.

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Ramu Komanduri: I'm trying to figure the same cost issue. Most places estimate approximately $150,000 per resident, which is the typical price. I'm just trying to see why these trainees are far more expansive than other ones.
Mr. Muyot: For the cost of trainees, aside from salaries and benefits, there is also, especially for our first year, the need to build infrastructure to be able to accommodate, because we need office space for our trainees too. Part of that would be some of the other associate costs to include malpractice to training resources that will be necessary in order to fulfil the requirements. So as we go into the second year the cost actually goes down, because some of those initial built-out costs will already be taken care of the first year. To train in a range of services that need to be available from the salaries themselves, the benefits, the training facilities and the training material that they will need. Faculty is needed depending on the size of the program. So these are all incorporated. The clinical piece of it, since we are working with the Touro Health Center are able to absorb some for that training expense. That is why the cost has gone down. If you take out some of the initial costs in the second year per trainee, it does go down. I believe that looking at the others and factoring in all the other costs, they are fairly comparable.
Ramu Komanduri: If the program is not fully funded would it still be established and go forward?
Shelley Berkley: It would be extremely difficult to go forward if this proposal is not fully funded.
Gregory Boyer: In the other applications, we found the highest cost to be about $159,000 per resident, which varied within that range. I'm concerned that this cost which is in excess of $200,000, well in excess for the residents. I would think in terms of approving funding more in the range of $159,000 or so. Would you be able to fund your program with that type of support?
Shelley Berkley: This program is very important to the people of the State of Nevada. I think the proposal as submitted is an accurate reflection of the costs of the geriatric program and putting it together for the first time. There are costs associated with the first year startup that do not exist as the program gets under way. But if you could move forward with this fellowship, we would not only being producing geriatric specialists in a state, as I mentioned earlier, that has a significant aging population but also a tremendous need for this type of fellowship and as I did mention, it would be extremely difficult for Touro to absorb the additional costs if the entire program is not funded. Now our proposal is not funded. We believe in this. I believe we have the staff, faculty and administration fully capable of doing this and bringing on day one to get this program started, but we are here today to request the help of the GME Committee for the allocation of the desperately needed resources in order to perform our obligation to the people of the State of Nevada.
Laura Hale: The cost I think across all of these applications, when you look at that per resident cost, perhaps there was not clarity about what to include in that, so those applications that include build-out or construction of some kind are going to have a higher cost per resident. There are some applications here have that build-out cost but did not necessarily include that in their cost per

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resident, so we are not necessarily looking at apples to apples comparison. There are some applications that do not include significant build-out, so they are able to achieve that low rate, but then again there are some that did have significant build-out cost, but does not appear that they included that in cost per resident.

Shelley Berkley: We believe this proposal accurately reflects the cost of putting this program together and getting it started, and consequently that is the cost. We didn't try to over-sell or under-sell, we are presenting to the committee what we believe is the accurate cost for starting this desperately needed program in the State of Nevada.

Gregory Boyer: I would note that on their anticipated statement of operations, Touro is supporting, as laid out, the construction of the facilities. You don't seem to be adding the cost of construction of your facilities into your proposal if I understand this schedule accurately. The grant request applies to salaries, it applies to program directors, etc. and Touro is supplying the facilities build-out. No, I have that wrong, sorry. Thank you.

John Dougherty: Just to illustrate the point made earlier, when I made my calculations, some programs have over $400,000 per trainee in their budget.

Mark Penn: I appreciate the earlier comments, I'm very supportive of this proposal, but for clarification it is important to know, and as we move forward I appreciate Laura's comments about defining the criteria within each of these categories, so that was the part that was not clear, but now it is clear, thank you.

Ramu Komanduri: As we go forward in the future I believe we should go with two different paths of approach, one is infrastructure approach and one is trainee approach. That way you could really compare fairly to all the programs.

Shelley Berkley: I agree with you on that. This is an amazing thing you are doing. We have created, among all of us, a GME program that previously did not exist in the state of Nevada. The Governor fully appreciates the fact that we have a physician shortage that is critical in the State of Nevada and the only way to insure that we have an adequate supply of doctors for the future, this state is to create GME programs in order to retain medical school graduates and future doctors to keep them here in the State. As we all know, seventy percent of doctors end up practicing where they do their residency. If we don't provide these residencies here in Nevada then we will never ever have an opportunity to expand our specialists programs and insure we have an adequate supply of doctors. What this committee has done in the last year and a half is nothing short of extraordinary. There are bumps we have not worked out, including the best way to present these proposals, and I think this is a good example of how we are learning as we go along and I quite agree with you I am sure the proposals are presented in different ways because the guidelines are not fully flushed out, but I suspect that by this time next year when you are allocating money coming from the legislature, we will all have a much clearer understanding of how these proposals should be worded and presented. I am very enthusiastic about it, and I believe that this committee has done a remarkable job creating something that did not exist a year ago.

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Dr. Schwenk: Just one more run at this funding issue, I would like the Touro folks relative to Greg Boyer's question. Whether it is difficult to impossible to consider this proposal at a somewhat reduced startup budget, can the comment on the sustainability issue, you got fellow salaries, six FTE's total over the two years, substantial program director, core faculty and administrative support staff salaries that will come to an end after the two years. How is that going to be handled in the terms of long-term commitment?
Mr. Muyot: As far as the long-term commitment and assuming there is funding for the first two years, depending on the budget that we will be working with Touro University as far as for continuing the program, this will probably determine the size of the program after the funding runs out. We are still committed and Touro has made it clear to me they are committed to sustaining this program but we may see some changes that may happen as a result of what the budget allows.
Shelley Berkley: As the CEO of Touro, I can assure you we will sustain this program.
Dr. Schwenk: There are no more questions in Las Vegas.
Brian Mitchell: There appears to be no more questions in Carson City.

Applicant:
University of Nevada School of Medicine (UNSOM) - University of Nevada Reno (UNR) - Family Medicine Practice
Representative: Dan Spogen, Chairman, Gerald Ackerman, Assistant Dean of Rural Programs, Mimi Burn, Associate Dean for Graduate Medical Education
Laura Hale: I really like this application the components of public health and partnering with community health centers, the outreach and the process you went through as well as working with State Medicaid to support some of your costs. However, I did not see a support letter from State Medicaid. Did I miss that?
Dr. Spogen: It was received after we submitted our application and we do have it today.
Bill Welch: I also like this application, and back to the letters of support, I did think you did a great job on the application, where it talks about significant financial support from a number of entities; the county, the state and others. As I read the support letters which are from all the departments which includes a generic letter from Medicaid included in the application, but as I read any of the letters I do not see the commitment to the financial points that you represent in the letter. The hospital letter talks about what it has done, and it supports the program but I do not see the commitment of financial as represented in the application. Similarly from Elko County. Medicaid is a very important letter, so if you have it, I believe it will be critical because you are heavily dependent on Medicaid to match Elko County's financial commitment. You are also dependent upon Medicaid paying a significantly higher rate for the services provided for these residents. Again, you have letters of support from all of your

partners. I think the letters are not as strong in representing the financial commitment indicated in the application. I need to understand this better.
Gerald Ackerman: This is my fault. We wrote the letter and sent it out to our partners. I believe there was an email attached or some reference behind those reference letters that did get further commitment in salary support for physicians from Nevada health centers and residency salary support from the hospital and in building support from the county. Those are all committed to support those costs moving forward.
Bill Welch: In the letter you have for Medicaid, it does indicate they will match the county contribution and they are committed to the 136 percent.
Gerald Ackerman: So we invited them from the beginning of this planning process when we brought our consultant out and they are committed to develop a rural GME program and we have had two conference calls with them and what that will look like. They had two models. They are doing some exploration with some states that are around us that have a more robust Medicaid GME program, but yes they have committed to that program.
Dr. Atkinson: I was interested in the timing as to when you would actually start residence by this next summer. It seems to me like it is a one plus two program and you have not yet submitted for accreditation for it. I think they usually come and do a site visit for a program like that. I just don't understand the timing you have planned.
Dan Spoken: We have had a rural consultant come in and talk with us about the best way to form our program and per their suggestion was to do it as an expansion program of our current program. Basically the program is already approved we have had discussion with ACGME about expanding the two slots starting next year. The first year will be at our current program and the major affiliation with Renown Medical Center, which is already in progress and we have our residents and interns already in rotation with Renown. With the commitment from Renown we look forward to that. We have been told that July 2018 to get the rural site up and going in Elko and there will be a site visit sometime before that time.
Dr. Atkinson: Have you submitted a letter requesting an expansion already?
Gerald Ackerman: We have. We have not received a letter of commitment from ACGME at this point yet.
Dr. Atkinson: Related to that, were the faculty members in Elko, which I am particularly concerned about. I see you are going to add one in Reno but three in Elko and you were going to start a search committee. Are those all three going to be hired from the outside and do you have community physicians in Elko who are going to be part of the program?
Gerald Ackerman: We will have community physicians in our part of the program. We actually have one community physician who has expressed interest in becoming more affiliated with that program. We will have to do a search for one or two of these spots. Community physicians have been involved from the beginning. For training they were all invited, whatever sub-specialist we have including hospice, they have all given support to this program.

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Dr. Atkinson: It sounds like it is really good to have community physicians involved. You've made it so clear how hard it is to recruit to Elko, I couldn't imagine if you had to recruit three people that you would be able to do it and I certainly not that quickly.

Gerald Ackerman: The nice thing about this two of the family physicians in the community are graduates that have given us a commitment to work with us so we are ready to go forward.

John Dougherty: So to clarify, your initial plan is to subtract FTE's from your current approved Board that exists in Reno as it stands?

Gerald Ackerman: No. Our plan is actually to expand our program. Currently we are eight per year in the current residency program so we will add two interns in our current program and their second and third year they will go to the Elko site for their further training.

John Dougherty: So for a rural training track, that is a separate ACGME application. It is not a program expansion, have you begun the process for a rural training track application ACGME?

Dr. Spogen: Correct. We have had a consultation that we have secured for that. We are moving forward with that expansion. We are given the option per that consultation to work as an expansion of our current program versus a standalone rural training track. There are two different models. The big advantage of working as an expansion is we are able to get our residents going quickly and that allows us to start our program next year. My understanding according to the consultant is that we can move to a fully independent rural training track at any time we can get that going. They didn't think that was a problem working with that type of expansion system.

John Dougherty: Unfortunately I think your consultant is wrong. Rural training track is a separate application process, am I correct Dr. Atkinson on that?

Mimi Burn: There are two methods of doing this. The method with the family medicine department as chosen, based on the recommendations of their consultant, has actually been done in Montana. Some of the smaller programs have used this model to, as Dr. Spogen said, start up a rural training program rapidly and also capitalize on the track record of recruitment of the primary training program at the mother ship. The new requirements approved within the last year or so in family medicine allow for using a secondary family medicine practice to facilitate obtaining the 1650 number of patients that are required to be seen in the outpatient and can be used as a facility to implement a project like this. Whether it remains as an expansion versus a separate one plus two, which you are absolutely correct is a separate ACGME program number. What this requires is that the paperwork goes in to ask for a permanent increase in complement from twenty four to thrity.

John Dougherty: With all due respect, as a member of the ASGME, it can take you 18 months for that paperwork to go through.

Mimi Burn: Actually it usually occurs within two to three weeks

John Dougherty: The meeting is twice a year. I just got back from Chicago last weekend. I do not go back again until the fall.

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Mimi Burn: Yes, but a permanent expansion in complement is done by the executive committee of the review committee and is done within a couple of weeks.
John Dougherty: I am a member of the executive committee of NRC.
Mimi Burn: Well I can just tell you my last four programs I have asked for permanent increases.
John Dougherty: I think there may be some confusion relative to your consultant's recommendations and what is actually happening. I do not know how quickly you are going to be able to ramp this up. My other question is whether you will have core faculty at the Elko site?
Dr. Spogen: Correct. There is a requirement to have core faculty on site at the training site for the residents.
John Dougherty: Do they meet the criteria for core faculty?
Dr. Spogen: That is correct.
Ramu Komanduri: I have a couple of questions. Is there any local community support within the outside of the healthcare environment in Elko to support this program? How do you attract and keep physicians to go to any rural area? It is a great idea but it is a challenge to keep them there.
Gerald Ackerman: We talk about that exposure early on in medical school, one of the unique things in Elko is that we have medical students come and spend about 16 to 17 weeks of their medical education in their third year in Elko, so we are exposing those students already to Elko from the School of Medicine, which is about 4 to 5 students per year. Secondly, with the experience with the current RTT in Winnemucca, they have been fairly successful in recruitment to that program and we would continue to look at following their model and their success.
Dr. Spogen: As a supplement to that, this is one of the real beautiful things about doing a rural training track type of training, you train those physicians in the rural area and get to know that culture of that rural area and how to practice rural medicine so it will serve itself as a recruitment for physicians in that area.
Dr. Atkinson: In reference to the Winnemucca program, it was a new one and last year it didn't fill its two spots in Nevada. I think you have to be very careful. I will say they did was get hundreds of applications and scramble and were able to interview and get good people, then scramble again. I think it was very much a fact they did not have time to advertise the way it needed to be done in order to really make people understand it was really available and going to be a good program. I am a little concerned about this one because you cannot exactly advertise it as a rural track program, if you did not have rural track accreditation.
Gerald Ackerman: I can get back with you on the numbers. Dr. David Schmidt was our consultant. He received a federal grant with rural training programs to do consulting for development of rural training opportunities which was an 8 year program. There are more than just one in Bozeman, Montana. They are called rural training track look-alikes. If I remember correctly, the number five to eight stands out in my mind and they include them in their numbers of rural training opportunities, however they are not true rural training tracks, they are sponsored programs like what Dr. Spogen has talked about. So there are

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models around the country that we are following and we felt pretty confident in what he has encouraged us to do.

Mark Penn: I have a question about page 25. You have the program director, site director and the Elko faculty all with the same base salary. Is that realistic?

Dr. Spogen: Yes, these are largely guestimates of what we expect in the future. This is based on the current data that we have received.

Mark Penn: It would seem that program directors now require more than the base that you give to a faculty member, however that is widely known across the country.

Dr. Spogen: Yes, right now our program directors are given protected time to be a program director.

John Dougherty: It looks like you are asking for $1.6 million and over the two year period of the grant would be two residents per year, with four residents in training. Is it $400,000 per trainee you are asking for in grant money?

Dr. Spogen: Correct.

Ramu Komanduri: Is there any support locally beyond the health system to build this program, since there is mining and other opportunities that might be willing to fund as a portion of this?

Gerald Ackerman: The County has building space that they are providing and we have the hospital providing support. Currently, the county and the hospital do provide some funds that we will use through that Medicaid match process in supporting some internal medicine residents who also train in Elko and do month long rotations. There is strong community support on that aspect. They do already provide support for training in the community.

Dr. Spogen: My understanding in Elko is there are basically two populations; those patients who are covered under the mining industries who have pretty decent primary care coverage and the other half of the population really does not have any coverage. That is one of the main focuses of this program is to give that other half of the Elko population primary care coverage.

Gerald Ackerman: One of the other tasks that I do is serve on the Board of Nevada Health Centers who will be our partner, and I actually chair that board this year. The county actually provides over $300,000 per year to help support that community health center. There is some general support there going into the medical community, which these residents would receive benefits from.

Dr. Atkinson: I am wondering about the faculty and whether you need to add a faculty in Reno to add two residents per year?

Dr. Spogen: Currently we have enough faculty to cover the residents that we have, however we do not have additional faculty to cover additional residents to come in. We are required to have faculty for every three to four residents that we have in our program. It will require extra faculty time to include two more residents in the training program.

Dr. Atkinson: It looked like you had a very large list of faculty that would be there already. How many do you have on your faculty? Was it fifteen or sixteen?

Dr. Spogen: Currently we have sixteen faculty.

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Ramu Komanduri: If I am looking at this correctly, the Elko faculty add up numbers is about 2.0 FTE to essentially train two residents if I am not mistaken.
Dr. Spogen: Yes that is correct.

MOUNTAIN VIEW- Internal Medicine
Representative: Mahendra Solanki, Vice President – Academic Affairs, Siri Kjos, MD, Program Director - GBYN Residency Program, Benjamin Bauman, CFO, Daisy Rosado, Administrative Director of Graduate Medical Education, Darren Swenson, MD, Vice President of Graduate Medical Education

Dr. Komanduri: I was a little bit surprised with unique assessments when you talk about ethnic diversity, you did not mention anything about the percentage of Hispanics in this community. I was surprised it was not in this application.
Dr. Siri Kjos: We apologize. It is about 30%.
John Dougherty: It looks like a big chunk of your capital expenses are in simulation equipment and materials. Can you outline how that is going to be part of the program?
Dr. Siri Kjos: Yes. Today training has moved a lot to simulation, particularly as you use highly technical surgical equipment from robotics to laparoscopic, as well as obstetrics, where it is no longer acceptable to teach forceps vacuum breaches without doing simulation. There are very standardized ways to teach this in terms of running staff through simulation. Also, another change in obstetrics and surgical specialties include the critical care when you have to have coordinated multi-specialty teams. That is why there is a simulator there for emergencies. They include emergency C-section, hemorrhage drills, seizures, codes, and things that take coordinating of the anesthesia, as well as the nurses and physicians.
Mark Penn: On page 11 of your proposal, under 2D, could you explain where you talk about the time to train first and second cohered residents in this program. You talk about the first year cohorts three years and subsequent cohorts one year. I am not clear on what that means.
Mahendra Solanki: First we are taking eight residents in. The first group we turn out in three years will be 2020 in June and then every year we are graduating four residents.
Mark Penn: I see.
Dr. Atkinson: On your application it shows the different specialties the students have to learn, but it has “to be determined MD’s” in all the spots.
Dr. Siri Kjos: Actually in our ACGME application all those people are named. Currently we are working on expanding our community physicians. We also have a core faculty that we are naming and meeting with. We have our first town hall with the community physicians this month.
Dr. Atkinson: Maybe you could tell me what kind of faculty development you have.
Dr. Siri Kjos: We have partnered with the university and are using their faculty development information and starting for interviews we will be doing an

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orientation on interviewing. Faculty development is key and working with our community physicians, we have the support of the university.

Dr. Schwenk: In the spirit of disclosure, I just want to emphasis that the University of Nevada, Reno School of Medicine is named as an economic partner as was just mentioned. I conferred with Brian Mitchell and it was concluded that I could review the application, we are not the sponsoring institution. My question is philosophical, with the issue of providing a startup support for a program that is already accredited to which the institution is clearly committed and to some extent gets to Dr. Atkinson's question about faculty being named and faculty expense. It seems to me start up for the faculty positions, which is roughly $446,000, appears to be more compelling expense because those are the startup costs that can be inhibiting to a program unless you are sure about other costs. Please comment on that.

Benjamin Baumann: When we put in for the grant we included what we considered to be future expenses for the program. So some of the expenses we had for the OBGYN program, we had already invested in and we did not put that into the budget. What you see here as far as staff is concerned, it is future investment to the program and that amount for $446,000 represents 2017 expenses. It starts, we estimate mid-year July through end of December, which is what we put forward as part of the budget.

Dr. Schwenk: Just to be clear, I assume you have already opened up applications and you are expecting to receive those and interview for the next summer. Is that correct?

Dr. Siri Kios: That is correct.

Ramu Komanduri: I realize that HCA is a gigantic corporation, with regard to HCA, you have other institutions where they essentially sponsor residency programs as their way to reach HCA to utilize your other partners to see how they have built theirs and developed an OBGYN program.

Benjamin Baumann: HCA does have other GME programs around the county and we do have a unified corporate office that looks over that and we receive a lot direction and guidance from them.

Mahendra Solanki: Also to enhance the educational experience for the residents.

Dr. Siri Kjos: Is there a specific question about that that you would like to ask?

Ramu Komanduri: I do not know how strong HCA is in to the education component of developing graduate medical education or whether there is a national approach where they will build, in essence, our future workforce?

Dr. Darren Swenson: Vice President for Graduate Medical Education for NV and California for HCA Corporation. We recently met with HCA to hear about the national approach. Currently today there are 2,500 residents in training in HCA facilities across the country. Their commitment to the graduate medical program dates back to the next four years to have numerous programs developed across primary care specialties. Crozier hospitals are approaching around 5,000 resident physicians in numerous states. We are truly committed to training the doctors who have completed their medical school education and need to go the next step and bring them back into our communities. HCA wants

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to train doctors in our community hospitals which is where most doctors will go to practice or send the patients for care.
John Dougherty: I can confirm this commitment from HCA, I have seen the letter that is going around therefore I can second his statement.
Ramu Komanduri: Regarding sustainment, it says sustainment is based upon GME reimbursement. HCA obviously has an additional commitment beyond just the reimbursement, which was not included in the application.
Mahendra Solanki: There is a letter of commitment, which says we continue to offer support for the program.
Ramu Komanduri: Regarding Funding, your associate program director, the point 5 FD total cost was approximately $222,000. Is that typical? It seems higher than what I have seen in other descriptions for the point 5 FD.
Dr. Siri Kios: This is based on actual salaries in the community and current salary bases.
Ramu Komanduri: MGMA and various other national data bases estimate, certainly in our system we look at three different data bases to come up with an average number, not necessarily only what they are making in their practice.
Dr. Darren Swenson: You are correct. When we look at the formula, for fair market evaluation, we take all three data bases to create the ranges and try to look at the experience of the individual and the value they would bring to the training and look at their administrative time. We look at the assistant program director committing to fifty percent administrative time, the education of residents, the ongoing curriculum, faculty development, and curriculum development and committee time to support that.
Gregory Boyer: I would like to commend the Mountain View folks for putting in what I think is an excellent proposal, the level of focus and detail is outstanding. I like having a high impact program online for 2017 for a very fast startup. Your timeline is well detailed and I think it is a job well done.

UNSOM- UNR- Geriatric Medicine
Representative: Neila Shumaker, M.D., Program Director for Geriatric Medicine, Dr. Catherine J. Goring, Associate Professor, Chair of Medicine

Laura Hale: I remembered much of your application from a few months ago, it appears there was some telehealth and rural health added. Could you please give us a summary of the changes from the last one?
Dr. Neila Shumaker: Since the last one, we had received feedback that impact was part of the problem, so we tried to increase the FTD fellows a bit while still being realistic as to what we could improve. That was one of the changes was an increase in the targeted number of fellows and we adjusted downwards in costs. Both faculty cost and build-out cost. We eliminated one item of the build-out at the Stanford Center. As far as the rural, I believe that was in the first application, it is a strongpoint that they will make a strong point with their experience at the Stanford Center, which is participating in the Rural Echo Clinic Program, which maybe they will get some of that experience.

Mark Penn: I would also be very complimentary of your proposal. I did want to ask whether the alternative pathway fellows, which is a very intriguing idea and how common that is, whether it really supports those that are already in practice which is a unique idea. Is that a common thing across this country and has it been successful?
Dr. Neila Shumaker: It is being started in a few places. I have looked at the curriculum for that. It is not common. Recruitment is obviously is a challenge in geriatric medicine. It is apparent that many of us develop our love for geriatrics a little bit further along than in our twenties. It has a lot of promise. Dr. Goring and I have had conversations about the hospitals that may have been hospice for five or ten years and then experiencing, perhaps some burnout. This model has been tried with at least one other program in a mid-career approach to the hospitals. We currently have a faculty member that is doing the program for over two years and has been careered, so that has been very successful and we would like to replicate that.
Mimi Burn: I would also like to emphasize that not only do we have this mid-career alternative, halfway in geriatrics, but we have been very successful as a school in having a number of mid-career people. We currently have someone in pulmonary critical care fellowship, we have had people in sports medicine, and from various fellowships sponsored by the family medicine department. This model is very attractive to the career faculty as a whole.
John Dougherty: I would say this is a successful model. I see that you currently have four faculty members in the fellowship, is that correct?
Dr. Neila Shumaker: Yes. At the VA I have four part-time faculty members that have full time VA jobs?
John Dougherty: Are they all considered core faculty members?
Dr. Neila Shumaker: Yes.
John Dougherty: So you have four core faculty members and three fellows, so you want to add one additional FTE and faculty for one more fellow, so your ratio will be five to four?
Dr. Neila Shumaker: The one we are adding will not be full time dedicated to geriatrics. It will be shared between geriatric medicine and internal medicine. The main reason we need this individual is because the VA faculty cannot practice outside of the VA, they are full-time at the VA. The whole purpose of this grant is to increase the community exposure of these fellows and hopefully to integrate them more into the community, and retain more in Nevada.
John Dougherty: So if I am interpreting this correctly, you are asking for $225,000 for a part-time faculty member?
Dr. Catherine J. Goring: No. We are asking for $134,000 for a part-time faculty member in year one, and $90,000 in the year two.
John Dougherty: So over two years?
Dr. Catherine J. Goring: Correct.
Mimi Burn: I would also like to say it is 1.5 fellows as opposed to one fellow. It is an extra fifty percent of the FTE.

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Dr. Neila Shumaker: I think one thing that is important to remember with these fellowships, is that these are one year fellowships and you get your 1.5 trained at the end of one year. This is not going out over two or three years.
Ramu Komanduri: I have a comment on the application. The data you used was essentially on Washoe County data and not really addressing the rest of the state, I would have added a paragraph or something including that there is state beyond Washoe County.
Dr. Neila Shumaker: Yes, I actually corrected the number of individual physicians that choose geriatrics as a focus. Whether or not they are board certified and I included the numbers statewide rather than just Washoe County which is why the number of geriatricians changed in this application. The vast majority are in Clark County.
Dr. Catherine J. Goring: She listed these as 43 in Clark County, 2 in Douglas County, 1 in Nye County and 19 in Washoe County.
John Dougherty: For clarification relative to the expansion of the program, let me know if I am interpreting this correctly. The current plan is to extrapolate this additional fellow from the current approved ACGME number of residents under internal medicine?
Dr. Neila Shumaker: Correct. From the number of geriatric medicine fellows. Our program is located within internal medicine. We are a fellowship within internal medicine.
John Dougherty: So how many slots are you approved for?
Dr. Neila Shumaker: Three.
John Dougherty: Total?
Dr. Neila Shumaker: Yes.
John Dougherty: Okay, so you are approved for three. Is the expansion of the program going to be an expansion application to the ASGME?
Dr. Neila Shumaker: Yes.
John Dougherty: Has that application been developed?
Mimi Burn: It is not an application. It is a request through web ads.
John Dougherty: Okay. Will the total number of your residents be allowed to increase? If it is sixty seven and remains there, are you just going to transition one?
Mimi Burn: No. Geriatrics has its own program number and their compliment is eighty two following the approval of the additional fifteen residents. It was approved in the last budget cycle. Geriatrics has its own program number and it is permanent compliment for right now, which is three per training year, which since it is a one year fellowship, it is three per year. The request will be for an increase in compliment to four point five.
John Dougherty: Has that application been placed yet?
Mimi Burn: It is a request through web ads.
John Dougherty: Okay.
Dr. Neila Shumaker: Again, when we asked to increase, when we went from two to three that was a very quick process.
Dr. Catherine J. Goring: I would just like to comment that when we receive our grant for primary care track, we submitted the application post the grant

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approval for fifteen additional slots, it took the ACGME expansion committee about a week and a half to respond and approve those slots.

VALLEY HEALTH – Infrastructure Development – 4 Programs
Representative: Dr. Andy Eisen, Chief Academic Officer, Valley Health System

Dr. Andy Eisen: I would like to give a quick over-view of the decision making process. This is a carryover from our application for round one. Our application from round one is partially funded and we are very thankful for the generosity of the task force and the State for providing those funds. There is still a significant chunk of capital expenditure we are facing for the startup of our robust GME program that is underway. Several members of the committee did approach me after the meeting recommending that we carry this forth into round two and seek some additional funding for this purpose. You will notice that we basically took that same amount and the rationale that we brought forth originally into this application less the grant that was already provided and we did take out the parking. We still need to find a way to build some more parking. We have many more employees with the residents and faculty, but we did take that out of the grant request. That is how we came to the number that we did. Just as I had presented a few months ago, in the first round, our thought process here was focused on the defined priorities and scoring. The impact of this and the sustainability and for that reason we sought to find expenses that didn't require sustaining funds over the long haul. This capital effort was exactly that. We have in our consortium four hospitals, Desert Springs, Centennial Hills, Summerlin and Spring Valley that were built without GME in mind. It requires us to put some work into construction in the facilities to support the GME programs. I can put the references in the application of the ACGME, who expects that. Certainly aside from the requirement ACGME, we know the practical terms, we need space for the residents as well as teaching space. We recognize that was a one-time cost to get these programs started. There was not an issue in sustaining funds. We addressed the operational plan, we know we will get CMS reimbursement for the work the residents are doing and cost incurred there over the long haul that will support this program that will help us to pay back the investment that the system is making in GME. The big factor here was that of impact. A point that has been raised a number of times already today. When we talk about the bang for the buck, essentially, we are looking at construction and infrastructure development that will support 220 positions in these disciplines alone. This does not include the other discipline we are developing. Just looking at internal medicine, family medicine, obstetrics, gynecology, and psychiatry. We are talking about 220 positions. We are talking about infrastructure that is not a one-time use obviously. We are looking at a life span in the ballpark of ten years for the work we are doing and that means that this effort would facilitate 2,000 plus graduates from our programs in these disciplines. That means for $1,000 per head the state is going to be generating these new positions. I think that is an important part of why we

came to this as we did. How could we maximum the impact of the dollars the state has available in terms of physicians. Again, it is a two million dollar number, that's big, but that also equates to more than 2,000 graduates in these fields. We felt that was an incredibly important thing for us to consider. We do know that the thought process is, if it's only a $1,000 per head, why is that such a big deal for you. Our cost per resident to train is roughly $130,000, so the argument may very well be, if you are going to do $129,000 why not do $130,000. Again that goes to the nature of the work we are seeking to fund here. This is work we have to have done before we can have the residents here. Those fund to support residents is ongoing, which is money we would be able to have reimbursed, which are those operational funds over that 10 year span. But we have got to have this construction done before we can have the residents begin, so this will allow us to make that move. This support from the state will facilitate the development of that infrastructure to allow the programs to begin and does not require us to come back to the state later and ask for additional money or from anything else to get money. You will notice that we did not identify on the application other partners whose financial support is necessary, because that is not part of the deal here. We are moving forward as an entity and we are asking the state to help us with this initial outlay that is required in order to facilitate the programs.

Ramu Komanduri: How far along are you right now? Your support letter says you will start 2017, but it looks like it is delayed for another year to 2018. Is this correct for starting programs?

Dr. Andy Eisen: Yes. We have pushed the calendar back as we have recognized the complexity and frankly how large our programs are. We made that decision very recently to push back the anticipated start date. The bottom line for us, and we thought this was key, that quality has to trump the calendar. We were not interested in trying to cobble something together to make it happen on that 2017 date, which was an artificially selected date in the first place. We thought it was more important that all the pieces were in place and obviously for a residency program you are stating on July 1st. You can't delay it by two months. If you are going to push things back, push them back by a full year.

Ramu Komanduri: Regarding the faculty time, if we are looking at this large number of faculty for example, you said 70% for the program director, which is 120 internal medicine residents, 50% with 24 OB residents, 50% time for the psychiatry resident director for 16 residents. It seems like a fairly small time commitment for a large number of graduates. Seems like almost inadequate in a sense for time of faculties.

Dr. Andy Eisen: Those are minimum requirements established by the ACGME. There are however other requirements set that do vary based on the size of the program. For an intro medicine program the size we are anticipating, there are 120 residents, we are required to have in addition to the program director a minimum of four associate program directors. So that certainly is part of our plan. That is on the operational side, which is why it is not detailed in terms of cost, because that is not something we are seeking from the state to support

and recognize that this is a part of this. There are specific requirements for the number of core faculty that are required. Family medicine for example. In our plans for family medicine, were looking at a large family medicine program with 60 residents. Even though family medicine review committee does not require it, our plan is to also have an associate director in place for that program.

Dr. Mark Penn: Looking at your budget and understanding this is infrastructure, is it repurposing space already existing, or is this new space? Can you talk a little bit more about how you are putting this together?

Dr. Andy Eisen: It is actually a mixture of those things. Much of it is repurposing space that is already in existence, however that is going to require moving some folks around within the hospital, moving departments from one place to another so we can then build out space that was used for something else. Some of it is new construction however and really depends on which facility we are talking about. We have done an analysis from facility to facility of what is available and what the needs are at those various facilities based on the number of residents we anticipate to have at each facility as we build out the program. For example, Centennial Hills will require less new construction than perhaps Desert Springs. Don't quote me on those specific references, they are just examples, I am just making a point to say that this does vary from hospital to hospital, however it is the combination of refurbishing space and easements.

Dr. Schwenk: I appreciate Dr. Eisen's comments on removing the parking. I still have concerns about faculty offices verses space that is clearly educational. I would just like to put those comments back on the record. If you look at the budget of just a little over two million and do a rough calculation of space that is clearly education which I think is important to support and I want to support that because I am impressed that Valley is prepared to commit to such a large GME commitment and I think we should try to support that. I look at educational space versus office space, which I have a little more difficulty with. I see about $1.3 million or so, clearly in educational space and other technical support and that sort of thing. The other issue I want on the record, again in the context of wanting to support this, is that when we are dealing with a budget that has only to do with facilities, no programmatic support, no resident salaries, Valley is clearly committing to sustainability that could total $200 million over the next ten years. Either the impact is trivial or it is huge. I cannot decide where it is in there. I tend towards wanting to support educational space. As I understand for private hospital systems that is a stretch. Call rooms, conference rooms and that sort of thing is not what private clinical enterprises think about. I just want to put it out to the committee to think about in terms of whether we are having the sort of impart here that we wish to have, relative to resident salaries and faculty salaries. To close and in general, I would just like to support something here.

Dr. Andy Eisen: To address those two points on our application you will note a reference that I have quoted verbatim, "adequate clinic and teaching space must be available including meeting rooms, classrooms, examination rooms, computers visual and other educational aids and office space for teaching staff". That space for teaching space is not simply something we want but

rather something that the ACGME requires us to have which is why we have included it. We are appreciative of any and all support that the state can make and help offset these costs. With reference to your second point, we agree this is a massive undertaking. There is a huge amount of money involved in this over the next decade and well beyond, even though we do not plan for this to be a ten-year project. This will be much longer than that. Again this about timing. It is about having the funds available to get the facilities in place and ready to go so we can move forward with ACGME's approval and blessing to make these programs happen. It is a timing matter much more so than what the percentage of these dollars for total investment for the next ten years.

Dr. Atkinson: I like this application, however, my problem is that it is hard to judge what the outcome is going to be and I think because it is space and it is so early it is hard to tell whether the money is going to be there and to do it and do it to the levels you want to do it. I think about four associate program directors, for a program with one hundred twenty residents when UNSOM has only seventy four internal medical residents and twenty four faculty, which I do not think is an adequate number of faculty even for that amount. Those are pretty much full time faculty, besides the other people and volunteers that help with the program.

Dr. Andy Eisen: Certainly we recognize that this is a massive commitment, however, this is not a fly by night organization. Valley Health System and UHS are national organizations. I have looked at this very carefully and to be blunt, it is not something the corporation would get involved in if it was not financially feasible. This is not intended to be nor ever will be a major profit source which will come with major expense as well. It will not be a profit center for us in any way. We have done the math to address what our cost would be and we have been quite forward with estimating the costs. For example, looking at the cost of continuity clinic training and calculating that into the plan with us providing 100% support. That may not be necessary because continuity clinic activity regenerates revenue itself. To make sure that this is financially feasible, we have been very conservative in our estimates in that manner. We obviously know what our expected CMS reimbursement will be. We calculated that out with no increases in payments to be conservative about this. We know these are not numbers from a purely financial standpoint. If you compare this to another venture that the company could pursue and you were comparing it purely on a financial basis, I don't think you would get people real excited about it, but the math has been done so that it can sustain itself over the long haul. There is a big investment up front, which is why we are coming now to ask for some offset with that big of an investment. We also recognize that there are massive alternate benefits. It is not just a matter of doing the math. We do recognize what this means for the long term physicians work force in the community. This affects us directly in terms of recruitment for physicians to staff our hospitals. We recognize what this means for the quality of care and the patient experience to have residents and medical students in your presence in the facilities. We know patients appreciate that and patient satisfaction is meaningful. This is not a statistic to put in a binder, those statistics mean

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something and those are improved with the presents of residents. The commitment from UHS and VHS is solid. Our focus in this is not to ask for sustaining operational funds, which is a commitment we made. It is recognizing that because our facilities were built purely with a clinical care focus in mind and without regard for needing the space required for educational activities that we need to make this significant upfront investment. This is what we are asking for from the state.

Dr. Atkinson: I understand, but I have two issues in mind. One is the quality of the programs. I started with the continuity clinics because you have to have one person supervising four interns. So for every resident it is a lot of training and the quality of that, we have no way of judging at this point. Your development and what the quality will be and whether enough physicians are going to exist just to be able to do those kinds of supervisions for you. Also, we asked the HCA a very direct question and got a very direct answer about the commitment nationally. I am interested in that national kind of commitment from your system as well.

Dr. Andy Eisen: On the terms of quality, this is one of the reasons we decided to push back the calendar. It takes time to put these things in place and we are not going to sacrifice quality for those things, it makes no sense. A bad program is worse than no program. It is simply not an option. The nature of being a new program that we cannot come to you with a track record of what we have done. We can only offer that reassurance that quality is the primary concern here as we develop this. It is not our intention that we are going to just throw the residents out there somewhere and hope that there are some good folks out there. We are engaged with physicians that are already a part of the Valley family in gauging their interest, gauging their experience and developing the faculty on the programs to prepare people for that. In fact, we partnered with Roseman University with Dr. Bruce Morgenstern, wherein he and I put on a program for one of our medical executive committees regarding teaching in a clinical setting. It was not just a 'hey this is what we are going to do', we put them through a workshop because we are counting on our executive medical committee member obviously to be engaged with these programs. That was our pilot effort with them a couple of months ago. We are engaged with the existing Valley Health System University that provides education to our staff and non-physician staff throughout our system. We have a nurse residency program that we put on for new grad nurses that are coming to work in the system, which I am addressing six days from now. We recognize the team effort to get everybody prepared for this, which goes back to our decision to delay. Regarding the commitment of the corporation nationally, while this program is certainly is the big new effort on that part of UHS, we do have some GME around the country. We certainly have the GME here in town at Valley Hospital, also managing a hospital in Florida, Georgia Washington University in Washington DC and in South Texas. We are developing more. We even have an upcoming conference call with our national office for just that. We try to identify where in the country amongst our U-care facilities, is this something

we should consider. These facilities, we are not ready to do that. This is a major initiative on the part of UHS as well.

Sam Kaufman: In full disclosure, being a CEO for UHS for the last 25 years, I did not score the Valley Health system application but I did review it. I liked the comment on Dr. Atkinson's questions for the Valley Health System along with UHS. Valley Health System has been in the community for forty plus years and definitely would not undertake something with these five, soon to be six, hospitals unless it felt it would be a phenomenal community partner and do something with the highest quality. While UHS is nowhere near the size of HCA and our twenty six acute care hospitals, the hospitals Dr. Eisen mentioned in Manatee Memorial, which is in Florida, northwest Texas and Amarillo, Texas, GW along with the Valley Health System. We will be looking at almost 50% of our hospitals that will be undertaking GME development or GME. That is something UHS is definitely looking at because it will increase quality, increase outcomes and increase community partnerships. Like HCA, nowhere near as large, but we definitely see the pluses.

Ramu Komanduri: During the last go-around we looked at about $400,000 for the IT portion. Since then, how much of the work is already been done? Are you waiting on this funding to come in on part of the construction?

Dr. Andy Eisen: Some of the work has begun. We have not yet starting tearing down walls yet, but we have engaged with our internal planning folks and we have engaged a contractor for the IT and video conferencing portion of this. They are putting together a package in terms of what that will look like and what the software and equipment needs will be. We have already engaged with an architect and designer about some of the renovation work that needs to be done, which as I understand is trickier than new construction. We are trying to renovate inside a functioning hospital. It obviously brings its own challenges. We have already engaged some of those folks. The work has begun. Partially because we knew this opportunity was coming and we wanted to come back and make a further request. None the less we have to do this. It would certainly facilitate making this happen for us as we know it has to get done.

John Dougherty: I would like to walk through this timeline with you to make sure I have it correct. You will be putting in your first class of interns, your first years in family medicine and internal medicine will start a year from next July, correct?

Dr. Andy Eisen: Yes.

John Dougherty: That is sixty first year slots that will start a year from July and a subsequent ten first year slots the following July. So seventy first years in just these four programs?

Dr. Andy Eisen: Not necessarily so. Those are the target sizes for the programs. We recognize that we may follow in suite with what many other programs have done, that in that first year start with a slightly smaller class and then build up quickly from there.

John Dougherty: So just first year slots between those four programs excluding the other ones including your transition, how many in the transitional year are you planning on?

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Dr. Andy Eisen: Currently the transitional year is a little bit up in the air, but probably in the ballpark of eighteen to twenty.
John Dougherty: So that is potentially looking at ninety first year positions between the transitional year and the four programs you have listed?
Dr. Andy Eisen: Yes.
John Dougherty: So that would increase the number of first year residency slots in the state to roughly 145 to 235?
Dr. Andy Eisen: Yes, in these programs.

V. Discussion and Possible Vote on Scoring and Making Recommendation to the Governor
Vance Farrow, Chair

Chair Farrow said that the second round of GME funding totals $5 million dollars and the total ask for programs in this round exceeds $6.587 million dollars. He said that if in fact we are going to have a similar experience as we did in round one, there will certainly have to be some give and take with the budgets. He added that because we are almost $6 million dollars over the $5 million dollar ask, we must now look at wiggle room within budgets so we can get the maximum return on the states investment to expand GME. He asked whether any members of the task force have any suggestions or recommendations for any of the recipients so we can see what sort of play there is. He said that ultimately we need to make sure whatever the agreed amounts are, we will still yield a program that will be sustainable over time so we can assure the states investment is going to be realistic and worthwhile. He said we all understand that everyone knows their own budgets better than we do. He added that we need to ask for some leeway as you think about what it took to put your budget together and your absolute truths would be in moving forward so we can bring some funding to these programs and try to make them as whole as possible.
Dr. Schwenk said he has a proposal to put before the task force for their consideration. He said that given the relatively tight clustering of the scores and the generally positive comments proposing that all programs be funded to a certain level and taking into account various comments that were made along the way, he would propose the following: Touro University - $1.2 million, because of the comments about the cost per fellow; Family medicine in Elko - $1.4 million, with expectation that there would be some greater contribution from the Elko community; Mountain View - $0.6 million, to focus mainly on jumpstarting faculty recruitment and the faculty startup expenses that were listed plus some of the teaching materials; Valley - $1.3 million, to focus on the primary educational space requirements, and Geriatrics - $0.5 million.
Chair Farrow said that certainly does bring a $5 million dollar total to that bottom line. He stated that as suggested by Dr. Schwenk, each of the applicants should consider what those suggested budget items can do to and for their programs and whether or not they feel that could be sustained from their perspective and welcomed speakers on behalf of what those budgets can do.

He asked that they speak in order and whether there is any heartburn or certainly some leeway so we can move forward.

Gregory Boyer said he believes this is a great running start. He commented that he would support those numbers with one exception. He said he would shift, giving the impact of Mountain View OBGYN, some dollars could be shifted to the Mountain View program and increase that to about $850,000. He said he would move Valley to the difference between the increase in Mountain View and Valley Health. He continued that this is especially in light of the fact that Mountain View did not have any dollars from the round one allocation and recognizes they need to have a haircut as well as everybody else. Brian Mitchell asked Mr. Boyer for the full amount for Valley. Chair Farrow said the amount was $850,000 for Mountain View and $1,050.000 for Valley Health.

Shelley Berkley asked a question regarding the haircuts everyone is taking. She said it seems that UMSOM took the least haircut, and was wondering why they are only cut by $23,000 where Valley is cut by half. She said it doesn't seem quite fair and is curious how they arrived at that number. Chair Farrow said he would certainly think it would be because of the size of the program, particularly in this aspect, the tier point. He pointed out that certainly in the initial round they looked at what was still possible for programs to be able to conduct business and he believes that cutting $523,000 to $220,000 will probably decimate a part of that program. He said it would not have an impact on other programs, and he is not speaking for programs. Dr. Schwenk said he thinks it was just dollar for dollar per FTE and some proportionality as outlined by Chair Farrow.

Shelley Berkley speaking on behalf of Touro University, said the $1.2 million would be acceptable if we had to take that haircut in the interest of fairness and giving everybody the opportunity to move forward. She said the $1.2 million is acceptable and $1.241 million would be better.

Dr. Andy Eisen said he was going to shy away from the haircut comment. He stated that in terms of reductions, he appreciates the starting point that Dean Schwenk offered and Mr. Boyer's suggestions. He said they are appreciative of any and all the support the state can provide. He pointed out that just in terms of a target number, rather than looking from the top down, look from the bottom up. He said that in their proposal they have put forth the inclusion of construction renovation and a section on IT and video conferencing which was entirely funded in the last round, so it is a wash. He said that perhaps if we disregard the furniture portion and look purely at the construction renovation line that totals $1.419 million, plus a portion of the funding from the first round that we were able to apply to that totaled $169,000, which puts us at $1.25 million for the construction alone, which is net. He said they will appreciate any support the state can provide, but as a target, he thinks that $1.25 million would be a very nice number believes they can do a lot with it. Chair Farrow asked for clarification on what the round one funding for the Valley application was.

Dr. Andy Eisen said Valley received $600,000 in round one that covered projected cost for IT video conferencing and left about $169,000, which they were able to apply to the construction costs and is why they backed $169,000

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out of the approximate $1.4 million in construction, which comes to the $1.25 million. Chair Farrow replied okay.

John Dougherty asked for follow up on a couple of precious statements. He stated that the faculty training ratio seems disproportionate. He said that five faculty for 4.5 trainees in geriatrics is unusually high for the geriatrics fellowship in Reno. He asked whether you have four existing faculty, you should be able to train four fellows. He stated this may give them some opportunity to clear a little space there.

Darren Swensen said they are very appreciative of the comments and recommendations made today. He said he had just spoken with Benj, their Chief Financial Officer, and believes that they would find a way, in view of the recommendation of $850,000 for office space and furniture for Mountain View, to take care of those things without having any impact in the educational experience of the residents, faculty simulation lab or training for the residents.

Chair Farrow asked whether that would be a full complement of the slots proposed. Darren Swensen said yes they would.

Dr. Schoemaker said she believes there to be some misunderstanding about the faculty. She said the core faculty are required at .25's, and there is actually no requirement by the ACGME to dedicate approximately 2.5 at the VA to teaching and supervising fellows in the nursing home at the VA clinics and the like. She pointed out that this is not four full time faculty, but rather defined as core faculty, and are not full time, they are about 025 dedicated to the program. Again as pointed out before, the expansion we are trying to do outside of the VA is to get these fellows out into the community, to get to know the community and to hopefully convince some of them to stay in the community. She said that none of these faculty can supervise them in community based settings.

Mimi Burn stated that in order to expand the fellowship and provide a robust educational experience and opportunity, they would like to take advantage of the resources at the Sanford Center for the Aging which is on the UNR campus and as Dr. Shoemaker stated, the faculty from the VA cannot participate there. She pointed out that in addition, there are a fair amount of community activities which fellows should and will participate in, but again since this is a training program, they require supervision. She said the supervision needs to be provided by faculty or external with the VA, and the VA faculty who are outstanding do comprise only a certain percentage of FTE even though they are whole bodies.

Mark Penn asked Dr. Eisen if the number he ended up with was $1.25 million, and is because they have two numbers; $1.3 million and $1.05 million. He asked for clarification of the number.

Dr. Andy Eisen said he believes it is $1.249 million. He said that essentially if you look at the budget table and the construction number of $1.41 million, then subtract the portion from the round one grant we come up with approximately $1.25 million. He added that they appreciate any and all support they can get.

Chair Farrow said they had clarification on columns O and P. Brian Mitchell said he would just like to note that the family medicine program from UNSOM is at the table to clarify for themselves. Chair Farrow acknowledged them.

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Dr. Spogen stated that they very much appreciate the task force and believes they can work with the $1.4 million, which would probably involve a delay in the start of hiring of faculty in Elko. He pointed out that this would still be okay, because they would not be expected to be at that site until 2018. He said there is that clinical need at this point and the Nevada Community Health Centers may very well want them on board earlier anyway.

Chair Farrow commented they had heard from everyone regarding the financial total under column P that would provide a green light to move forward, and certainly for Valley, which is about $200,000 less than what their construction line ask would be. He added it would certainly cause a slight downtick in that line item. He asked if they could get the green light from all of the other programs where the belt is tightened the most but still have maximum yield.

Chair Farrow asked if there were any additional comments from the task force and that he would accept a motion.

Dr. Atkinson moved for column P, Dr. Schwenk seconded the motion.

Chair Farrow said the funding suggestion for column P has been moved and seconded. The motion passed unanimously.

Chair Farrow asked Brian Mitchell to provide some additional information to those that need to readdress budgets to be submitted to his office for approval at this time.

Brian Mitchell stated that since everyone's budget has been tinkered with, we will need revised budgets submitted to my office. He said he would like to propose those revised budgets to be submitted within ten days, if that works for everyone. He stated it would help us take care of our process to move this money out the door as soon as possible. He added for clarification that he believes the deliverables all remain the same in terms of the number of slots and the number of residents trained even though there were reductions to every budget.

Chair Farrow asked for a hard date whether it can be by close of business next Friday. Ramu Komanduri acknowledged the close of business on the 23rd day of September. Chair Farrow said will go ahead and log that in as the 5:00 pm deadline on next Friday to have those budgets submitted to Brian Mitchell attention as his office. He added it will encompass the recommendation that we make on behalf of the task force to present to the Governor's office for funding.

VI. Consider Agenda Items for the Next Meeting (For Possible Action)
Vance Farrow, Chair

Chair Farrow said this is something we don't really have to do at this point with the legislative session coming up. He added there will be a conversation about the deliverables of this task force that will be presented to the legislative session. He said he will keep all informed as to when that might be and possible participation in that effort. Chair Farrow stated that certainly as primary care and behavioral health was the focus of this initial round, we will be looking to expand that round to any and all specialties, because we certainly

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need those that we will be able to build on regarding the foundation of primary care that we have funded and will fund through round one. He said they will be looking for support in that aspect and will forward that information and look for support for the expansion of GME in the specialty areas.

VII. Discussion and Possible Vote on the Next Meeting Date (For Possible Action)
Vance Farrow, Chair

Chair Farrow said this does not really require a conversation about a meeting date.

VIII. Public Comment (No action may be taken upon a matter raised under public comment period unless the matter itself has been specifically included on an agenda as an action item.)

Chair Farrow asked whether there was any public comment in Las Vegas. There was none. He opened the public floor to anyone in Carson City. Ramu Komanduri responded there is none.

IX. Adjournment
Vance Farrow, Chair

Chair Farrow adjourned the meeting at 11:30 am.

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