COGME Meeting

September 9-10, 1998 – Washington, DC

Minutes

The meeting was held in the Columbia Room South of the Holiday Inn Capitol, Washington, D.C. It began at 8:30 a.m., September 9, held a breakout group meetings that afternoon, and reconvened later that day. The Council convened again at 8:30 a.m. and adjourned at noon, September 10. Dr. David Sundwall, Chairman, presided.

MEMBERS PRESENT:

David N. Sundwall, M.D., Chairman
Lawrence U. Haspel, D.O., Vice Chair
Paul Ambrose, M.D.
Macaran A. Baird, M.D.
Regina M. Benjamin, M.D., MBA
JudyAnn Bigby, M.D.
F. Marian Bishop, Ph.D.
Jo Ivey Boufford, M.D.
Sergio A. Bustamante, M.D.
Ezra C. Davidson, Jr., M.D.
Carl J. Getto, M.D.
Kylanne Green
David P. Stevens, M.D., Designee of the Department of Veterans Affairs
Barbara Wynn, Designee of Health Care Financing Administration

Others Present:
Stanford Bastacky, D.M.D., M.H.S.A.., Acting Executive Secretary
F. Lawrence Clare, M.D., M.P.H., Deputy Executive Secretary
Neil Sampson, Acting Associate Administrator for Health Professions
Claude Earl Fox, M.D., M.P.H., HRSA Administrator

WELCOME AND ANNOUNCEMENTS

Dr. Sundwall opened the meeting. Following introductions, he covered the agenda for the session, and noted the two important action items during the meeting to get Council sign-off on the pending reports of the Council. He also expressed the hope that significant progress can be made on the outline for the next major report, tentatively labeled “Beyond Medicare: Financing Of Graduate Medical Education in Ambulatory Settings.” Later in the session, the minutes from the last meeting were approved.

Welcome was provided by Neil H. Sampson. He mentioned that BHPr reauthorization is pending, but that the Bureau is moving along with its programs. New initiatives will emphasize diversity, oral health, and improved nursing performance.

Dr. Stan Bastacky reported on a press briefing that was held June 23 at the National Press Building to publicize the Council’s Minority in Medicine report. In an effort to increase the visibility of COGME, staff is developing slides on selected reports that will be available for COGME members to use. An improved COGME web page is also being planned. Dr. Bastacky stated that COGME meetings have been planned for 2 - 3 years into the future. He mentioned that the leadership of COGME met in previous weeks with the Bipartisan Commission on the Future of Medicare and the American Hospital Association’s coordinating committee on the health professions.

Panel - Beyond Medicare–Ambulatory GME Financing

Dr. Haspel introduced the panel participants.

James Boex, Ph.D., M.B.A., Director, Office of Health Services Organization and Research of the Northeastern Ohio University’s College of Medicine, discussed the results of a two- year project that he directed to study the costs of ambulatory primary care training of residents and medical students, nurse practitioner students, and physician assistant students. Probably the most important finding was that the operating cost of the average teaching ambulatory care site was 36 percent higher than the non-teaching site. Of that 36 percent, about 65 percent was due to components similar to Medicare’s DME for teaching hospitals, and the remaining 35 percent were similar to its IME, or education infrastructure costs.

Lucy Osborn, M.D., Associate Vice President for Health Sciences of the University of Utah Health Science Center, presented on Utah GME financing and organization. In 1997, Utah’s state legislature formally accepted the concept of health professions training as a public good, and established by law the Utah Graduate Medical Education Council. One of its first priorities is to make payments per resident uniform across institutions, whether in-patient or out-patient. The workforce group within the

Utah Council is working with the integrated requirements model developed by BHPr, and will be conducting a survey of health professionals in the state.

Ed Salsberg, Director of the Center for Health Workforce Studies of the School of Public Health, SUNY at Albany, gave an overview of state GME activities gleaned from a survey that he directed that was partially funded by COGME and the Commonwealth Fund. States currently spend over $2 billion through the Medicaid program on GME. Nineteen states are carving out GME from Medicaid managed care premiums, up from two in 1995. Nine of these tie the funding distribution in some way to performance on workforce goals, although only one -- New York -- has a formal linkage to downsizing. Mr. Salsberg observed that the goals that the states have identified are consistent with the goals of the Council, and offer an opportunity for a federal-state partnership on workforce planning.

Panel - Innovation and Models in Ambulatory GME Training

Dr. Haspel introduced the panel participants.

John Wisniewski, M.D., Director of Managed Care and CME of Henry Ford Health System, described the ambulatory care training models that the system has under development. Included were the joint Case-Ford Generalist Initiative, funded by the RWJ Foundation; the Partnerships for Quality education Project, funded through the Pew Charitable Trust; the Great Lakes Geriatric Interdisciplinary team Training Program, supported by the John A. Hartford Foundation; and the Innovations in Primary Care Education Program, part of a $10 million carve-out of Medicaid GME funding in Michigan. Common threads linking all of these programs are a strong emphasis on population focused care in capitated environments, using concepts of population management, disease state management, and health risk appraisal.

Gordon Snider, M.D., Chief of Medical Services for the Boston VA Medical Center, described an integrated care model in operation at the Center. The underlying hypothesis for the model reflects the view that the development of specialty care over the last 50 years represents a major advance in health care delivery in the U.S., and that a reliance on primary care is necessary but insufficient for delivery of high quality, cost effective ambulatory care to patients with complex and serious illness. The integrated model is developing ways to integrate high quality tertiary care with primary care. In the model, specialists who give tertiary ambulatory care give the bulk of the primary care for their patients.

Robert Massad, M.D., Chief, Department of Family Medicine, Montefiore Medical Center, described the mission and operation of his department in training physicians to meet the needs of the community. It was the mission of his department from its inception to improve the health status of disadvantaged people living in medically underserved urban areas. Three mission components are to (1) train primary care physicians who will choose to practice in underserved communities; (2) participate in research and

policy analyses which contributes to improved health; and (3) develop a delivery system. Underlying this approach is the need to choose residents with those attributes related to inner city background or connections.

Jeannette Shorey, M.D., Director, Primary Care Residency Program for Harvard Pilgrim health Care, described her program. The program is geared to producing physicians to meet the needs of the Harvard Community Health Plan's community and the grater workforce needs of the Boston area. The program immerses its residents with people who value primary care.

Panel on GME Financing: Balanced Budget Act and Other Third Party Payers

Ms Barbara Wynn brought the Council up to date on HCFA's final rule that allows payment for GME to non-hospital ambulatory sites. Prior to the Balanced Budget Act, HCFA had authority under Medicare to pay only hospitals for GME. The Balanced Budget Act allows both direct and indirect payment to the hospital for ambulatory training. HCFA's new final rule now provides authority to pay ambulatory sites directly, to include not only the costs of the resident's salary and fringe benefits, but reasonable compensation to teaching physicians as well.

Donald Young, M.D., Senior Vice President for Policy and Clinical Services for the American Association of Health Plans, described the contributions of private payers generally and of managed care organizations specifically to the financing of GME. In contrast to the Medicare program, private insurers never made explicit payments for GME. However, they have provided substantial support indirectly by payments to hospitals for their activities that are substantially higher than the cost of producing patient care. Indeed, private payers pay substantially more revenue in excess of costs to teaching hospitals than either the Medicare or Medicaid programs. Moreover, a majority of HMOs are involved in GME programs, with a strong emphasis on providing opportunities for physicians to train in ambulatory settings. Finally, health plans are leaders in encouraging innovations in GME by stressing the need for more primary care training and for enhanced opportunities for training in ambulatory settings.

Following the panel presentations and Council discussion, the plenary broke into three ad hoc groups to consider questions and issues for COGME's Fifteenth Report on ambulatory GME training and financing. Each developed preliminary outlines which were discussed in Council after reconvening at 4 p.m. In the discussion members felt the Council should go back to "basics" in assessing the implications of GME as a public good that the nation should fund. Related to this were issues of accountability. Also discussed was the need to explore issues of funding, scope, and cost/benefit issues of ambulatory care training. Related to these issues were the benefits of conducting a literature review of trends affecting the locus of GME and an assessment of the cost/benefit trade-offs of ambulatory training for the primary vs. non- primary care specialties.

The Council adjourned at 5:15 p.m. and reconvened 8:30 a.m. the following day.

Physician Competencies Report: Dr. Macaran A. Baird presented a summary of some of the organizational comments received on the draft. The game plan was now to revise the draft to respond to many of these comments. Some of the changes will adopt language patterns that would be more gracious to the medical education community. Plans also call for Dr. Baird to spend a day with staff and perhaps other members to make sure that the report reflects "one voice." No action item was voted as the report had been approved at the previous session.

GME Workforce and Financing Policy Report: Dr. Lawrence Haspel summarized the comments received on the draft and asked the Council for approval of the report. A few written responses had come from the major outside organizations; most felt that the report did a good job of providing a snapshot of developments to the physician workforce in the late 1990s. Dr. Haspel emphasized the cautious "wait and see" approach taken by the report, as we really will not know or cannot predict with accuracy the full effects of either the market or the Balanced budget Act on the workforce. In the discussion, the members asked that the report be revised to (1) state that COGME will address in its next report issues of ambulatory GME financing; (2) reference COGME's minorities in medicine report for issues of diversity; and (3) state that it will reassess its 110/50-50 physician workforce goals in subsequent reports. It was also agreed for the Council will be canvassed on a new title of the report.

Action: The Council voted approval of the GME Report.

COGME Research and Analytic Agenda

The Council reviewed its future research and analytic agenda previously developed by the Council and staff. As a result of Council discussion, it was agreed to add to the agenda the development of a formula for financing ambulatory GME similar to the IME and DME for in- patient training.

Dr. Bastacky reviewed the status of three workforce projects that are being funded or are pending Council approval: (1) a study to use existing data to determine national requirements estimates for safety net providers at the county level, including adequacy of maternity care issues; (2) a study to examine and analyze the future supply of generalist practitioners and its implications for rural areas, and (3) a study by the Council on Medical Specialty Societies to assess the variety of workforce studies that were completed by specialty societies since 1992.

Also discussed was the need to broaden council relationships and activities with non-physician disciplines as part of the Council's workforce assessments. Dr. Sundwall expressed the hope that COGME could perhaps have a joint session with the National Advisory Council on Nursing Education and Practice in 1999.

Also discussed was a new report to serve as a “public relations” document for COGME. Conceived by Dr. Marian Bishop, the report would highlight the contributions made by COGME in its 12-year life that would be written for the general public. After some discussion, Dr. Sundwall asked Dr. Bishop to draft a first outline that can be useful in taking the project further.

New COGME Workgroups

To support the Council’s upcoming activities, it was tentatively agreed to establish two workgroups. The first, chaired by Dr. Carl Getto, would take up the issues for the Council’s “Fifteenth Report” to include issues of ambulatory GME financing, medical education as a public good, etc. The second, chaired by Dr. Jo Boufford, will take up the issues of workforce, including the work of the three workforce contracts described earlier, and reassessing the 110/50-50 workforce goals of COGME.

Other Issues

It was agreed that the front page of future reports will be constructed so as to emphasize the title, rather than the numbered sequence, of the report.

Following a call for public comment, Dr. Sundwall adjourned the meeting at noon.