COUNCIL ON GRADUATE MEDICAL EDUCATION (COGME)

Webinar and Teleconference
Meeting Minutes

August 12, 2019

Council Members in Attendance
Lois Margaret Nora, MD, JD, MBA (Chair)
Erin Fraher, PhD, MPP (Vice-chair)
Ted Epperly, MD
Kristen Goodell, MD, FAAFP
John J. Norcini, PhD
Beth M. Roemer, MPH
Eric J. Scher, MD, FACP
Thomas C. Tsai, MD, MPH
Kenneth Veit, DO, MBA, FAOFP

HRSA Staff:
Kennita Carter, MD, Designated Federal Official, COGME, Senior Advisor, Division of Medicine and Dentistry
Raymond Bingham, MSN, RN, Writer and Editor, Division of Medicine and Dentistry, HRSA
Janet Robinson, COGME Liaison, Advisory Council Operations, HRSA
Kimberly Huffman, Director, Advisory Council Operations, HRSA
Robin Alexander, Management Analyst, Advisory Council Operations, HRSA

Welcome and Agenda Review

Kennita R. Carter, MD, Designated Federal Official, COGME
Lois Margaret Nora, MD, JD, MBA, Chair, COGME

Dr. Kennita Carter, Designated Federal Official (DFO) for the Council on Graduate Medical Education (COGME, or the Council) convened the meeting at 10:15 a.m., on August 12, 2019. The meeting was conducted via webinar and teleconference from the headquarters of the Health Resources and Services Administration (HRSA), 5600 Fishers Lane, Room 15SWH01, Rockville, MD 20857.

Dr. Carter conducted roll call and confirmed the presence of a quorum for the meeting. She then turned the meeting over to Dr. Lois Nora, COGME chair. Dr. Nora welcomed all Council members. She said the meeting's purpose was to continue working on the three issue briefs under development:

1) Special needs in rural America and implications for healthcare workforce education and training.
2) Training needs to prepare the healthcare workforce for rural practice.
3) The rural healthcare workforce: Necessary investments.

Dr. Nora acknowledged the substantial work on the issue briefs already carried out by Dr. Erin Fraher, Dr. Kristen Goodell, Dr. Andrew Bazemore, and other COGME members in three workgroups since the last meeting. When completed, the issue briefs would be folded into a full COGME Report on rural health workforce issues.

In addition to the report discussions, Dr. Nora said the Council would review a draft letter to the Secretary of the Department of Health and Human Services (HHS) recommending continuation of and increased funding for HRSA's Health Careers Opportunities Program (HCOP). Dr. Nora turned the meeting to Dr. Fraher, the COGME Vice-chair.

Issue Brief 1: Special Needs in Rural America and Implications for Healthcare Workforce Education and Training

Discussant: Erin Fraher, PhD, Vice-Chair, COGME

Dr. Fraher stated Issue Brief 1 would discuss the strengths of rural communities, and identify the special healthcare needs of rural areas. She explained that the workgroup had developed a foundational value statement to serve as a critical touchpoint for the development of the report:

> *The needs of patients, families, and communities should be at the center of policy discussions about improving both health and access to care in rural communities.*

The focus of the first issue brief would be: Different rural communities have different health care needs that require a broad and diverse health workforce that is deployed in teams to address patients' health and social service needs throughout the life course, from prenatal/maternity to end-of-life and palliative care.

Discussion

- Dr. Fraher emphasized that training should go beyond graduate medical education (GME) and include various health professions. Dr. Eric Scher and Dr. Ted Epperly agreed.
- Dr. Kenneth Veit suggested clearly defining what the Council means by "rural" at the beginning of the report, and proposed using the Federal Office of Rural Health Policy definition for congruence in interpretation.
- Ms. Roemer suggested framing the issue as needing "national action" rather than having each state or community address rural health needs individually.

Issue Brief 1: Recommendations (Draft)

The workgroup proposed four recommendations for Issue Brief 1. There was a suggestion to label each recommendation as a short-, medium-, or long-term target.

1. Promote and fund training in community-based settings to keep pace with new payment, delivery, and technological incentives that are shifting care upstream to outpatient, community, and home settings. (Medium- to long-term)

   Comments:

- Dr. Fraher said it is important to keep in mind that technology is an important tool that can connect rural and urban communities.

2. Health workforce investments need to leverage the natural plasticity – or flexibility – of rural providers' practice by supporting and enhancing generalist practice in both initial and ongoing training. (Long-term)

   Comments:

   - Dr. Scher said that value-based contracts could not only support training needs through a viable practice, but also the practice itself. He added that supportive practice is also covered in Recommendation 4 and the Council may not want to discuss it twice.

3. Expand funding for team-based health workforce training beyond current professional specialties to include general surgery, psychiatry/behavioral health, and more allied healthcare providers. (Short-term)
   Comments:

   - Dr. Carter said that HRSA currently supports various non-physician providers, including nurses, nurse practitioners, behaviorists, social workers, community health workers, and others. She added that support is available through the National Health Service Corps (NHSC) and other mechanisms.

   - Dr. Veit noted that funding is also available through the Centers for Medicare and Medicaid Services (CMS).

   - Dr. Sher said that, since funding streams for various allied health professions already exists, perhaps the focus should be on bringing all of them together through innovative, interprofessional education models, as opposed to each profession having its own individual and separate training track.

   - Dr. Tsai mentioned the need to support salaries for specialties with long training residencies, such as surgery, in addition to providing loan forgiveness programs. Dr. Nora agreed and said that, in the rural setting, general surgeons are a linchpin to services that go beyond what people usually consider general surgery.

   - Dr. Fraher suggested adding a rationale for the inclusion of general surgery, since some surgical residencies are not eligible for certain funding opportunities.

   - Dr. Carter reinforced this comment by clarifying that HRSA provides funding through the NHSC for psychiatry, psychologists, and other behavioral health specialties as well as OB/GYN, but not general surgery.

   - Dr. Norcini asked if the term "professional specialties" applies only to physicians.

4. Support and test sustainable alternative payment models that support the delivery of team-based interprofessional education and practice by the rural health workforce (Long-term).

Comments:

- Dr. Fraher said this recommendation encompasses leveraging past efforts as well as new funding opportunities. For example, some successful efforts of the Center for Medicare and Medicaid Innovation (CMMI) involving nurse practitioners, and graduate nurse education could be expanded in rural communities.

- Dr. Epperly said that having a different payment model could help practices become more sustainable. Going outside a traditional GME/CMS funding model into a value-based payment for team-based care specifically focusing on rural areas could help transform the field.

Public Comment

- Dr. Linda Thomas-Hemak, president of The Wright Center for Medical Education, suggested developing a logic model with a framework, key external drivers, inputs, outputs, and short/middle/long-term outcomes.

Issue Brief 2: Training Needs to Prepare the Healthcare Workforce for Rural Practice

Discussant: Kristen Goodell, MD, Immediate Past Chair, COGME

Dr. Goodell said that the second issue brief would address the special training needs of physicians and other healthcare professions to prepare them to work in rural areas and as part of interprofessional healthcare teams. She read the statement the workgroup had developed:

The health care needs of individual communities and the potential resources that exist within those communities should be assessed to ensure that health workforce infrastructure and training programs are created or expanded to optimize available resources to meet specific community health care needs.

Comments:

- Dr. Veit asked who would perform the community assessment, since many communities may not have resources to carry out an assessment. Dr. Goodell said one of the challenges is to determine who would need to perform an assessment and what constitutes an adequate assessment. She added that that in some areas, assessments had already been completed.

- Ms. Roemer suggested adding a recommendation that a national mechanism or infrastructure be developed to enable individual communities to use existing assessments or create new ones.

- Dr. Epperly noted that assessments are typically performed between rural critical access hospitals and public health departments.

- With respect to training, Dr. Tsai said that HRSA could require grantees to demonstrate integration of care in outpatient, home, and community settings when awarded a Rural Residency Planning and Development grant.

- Ms. Roemer noted that GME has constraints related to outpatient, community, and home settings, in contrast to other health professions or undergraduate medical education, the standards and the requirements do not preclude more upstream, outpatient, and community settings. She also suggested complementing GME by adding opportunities for community-based training, rather than completely revamping the GME model.

- Dr. Fraher suggested that funded training programs incentivize proposals that include innovative, interprofessional community-based training.

- Dr. Tsai said that in the state of New York, the Accreditation Council for Graduate Medical Education (ACGME) has specific rural training curricula for each of the different Residency Review Committees.

- Dr. Carter mentioned the importance of discussing maldistribution of the physician workforce.

- Ms. Roemer suggested using the term "population health" as well as the term "community-wide approach."

Issue Brief 2: Recommendations

The workgroup proposed four draft recommendations for Issue Brief 2.

- The varying needs of different communities should be addressed in an individualized and flexible manner.

  Comments:

  - Dr. Goodell suggested adding a "bright spot" related to this recommendation.

- Key principles must be emphasized as rural training programs are developed, including team-based care, an emphasis on generalism, and strategies for life-long, multi-modality learning in an integrated practice setting.

- *Comments:*

  - Ms. Roemer said that one of the key principles emphasized through this recommendation are health care technologies – more specifically telehealth. Trainees should learn how effectively use telehealth and other technologies that are relevant to rural health. Dr. Tsai agreed.

- Ms. Roemer added that another key principle discussed with respect to training was a focus on prevention and population health. Most training focuses on individual patients being treated for individual conditions rather than on a population health approach. Dr. Goodell agreed.

- Ms. Roemer suggested framing the issue as a lack of capacity in rural health and rural communities in terms of a shortage of healthcare services, rather than on a shortage of a particular type of clinician or health professional. Dr. Goodell agreed and suggested adding an emphasis on healthcare services to the overarching recommendation.

- Ms. Roemer said one strategy is to reduce the need for services by taking a population-based approach to meeting the needs of rural communities. This would mean focusing on health promotion and disease prevention to help reduce the long-term need for healthcare services.

- Dr. Carter agreed to focus on services but said that – given the charge of the Council – one should also consider physician maldistribution and how to address this challenge in rural communities, based on needs. The Council agreed.

- Dr. Fraher said that maldistribution is not only geographical – there is also maldistribution by specialty and setting.

- Expand existing funded training opportunities like Rural Training Tracks beyond family medicine to include other health professions in interprofessional education (e.g., internal medicine, psychiatry, and general surgery) (Short-Term).

- *Comments:*

  - Dr. Goodell said this recommendation could be positioned as one of several strategies to address maldistribution.

- Invest in people such as scholarships and loan repayment programs in rural communities to expand the health professions pipeline.

  Comments:

  - Dr. Epperly suggested adding as an example "grow-your-own" training programs. Dr. Goodell suggested including such programs in the "bright spots" section of the issue.

  - Dr. Carter said that the Division of Health Careers and Financial Support, which is in the Bureau of Health Workforce at HRSA, funds a number of "grow-your-own" programs.

  - Dr. Tsai said it would be useful to add a recommendation for the development of a strategic plan. For example, one of the mechanisms to help implement this recommendation could be to collaborate with professional societies.

Public Comment

- Dr. Linda Thomas-Hemak said it is important to emphasize connectivity for rural health providers. This involves three issues: 1) Multidimensional collaboration and training networks for practice, care, and value-based modeling; 2) Connecting providers to trusted information filters; and 3) Exposure to experiential learning networks.

- Dr. Anu Ashok, from the Greater New York Hospital Association, asked if anyone on the Council had discussed the idea of Rural Training Tracks with ACGME.

    - Dr. Fraher replied that, as part of the Rural Residency Program Development Technical Assistance Center, conversations were underway with ACGME leadership about existing barriers. She added that COGME will be collecting information to identify these barriers and determine the status of conversations with ACGME with respect to promoting and enhancing the expansion of rural training tracks.

    - Dr. Epperly said that, until recently, he was on the ACGME Board of Directors. He was asked to stay on with ACGME and work in a committee focused on issues regarding medically underserved areas. The committee is working on the expansion of rural training track models into multiple specialties.

Issue Brief 3: The Rural Healthcare Workforce: Necessary Investments

Discussant: Erin Fraher, PhD Vice-Chair, COGME

Dr. Fraher said that Issue Brief 3 would look at the investments needed for programs to prepare and expand the rural healthcare workforce. The workgroup developed a statement:

> *Immediate policy action is needed to advance a sustainable financing model for rural health practice and training that advances a measurably more flexible workforce to meet patient and population health needs in rural communities.*

The workgroup developed five recommendations for Issue Brief 3.

Recommendations (Draft)

1. Develop and expand successful place-based training initiatives that promote access to care for rural communities.
    - Reauthorize for at least five years and expand the Teaching Health Center Graduate Medical Education Program (Short-Term).
    - Appropriate funding for Indian Health Service (IHS) Professional Training in rural areas (e.g. preceptors) (Short-Term).
    - Authorize additional seed funding for Rural Training Tracks and other rural residency education.

Comments:

- Ms. Roemer suggested adding a definition of placed-based training in the document's body.

- Dr. Norcini suggested adding examples beyond medicine. Dr. Fraher suggested perhaps adding examples of HRSA's BHWET or GWEP programs. Dr. Carter agreed it would be a good idea and suggested also considering HRSA's innovative nurse and nurse practitioner residency programs.

- Dr. Tsai said that one of the issues discussed was the difficulty in recruiting preceptors. The Council could recommend expanding funding or determining other ways to attract preceptors to the IHS residency program.

- Dr. Tsai added that one of the "bright spots" could be the rural residency elective at Brigham and Women's Hospital, where students go to Shiprock Medical Center within the Indian Health Service to train.

- Dr. Carter suggested that the Issue 3 Work Group prioritize some of the sub-bullets in this Issue and perhaps bring some clarity to some of the nonspecific items.

2. Identify and eliminate regulatory barriers to health professional education expansion and innovation in rural areas, including:
    - Direct CMS to eliminate regulatory barriers that inhibit expansion and flexibility in rural training programs and to craft specific regulations where helpful to rural health access (Short-Term).
        - Offer cap flexibility for sponsoring institutions starting "new" programs, such as rural training tracks.
        - Create regulations that permit rural hospitals to establish fair "total resident amounts" for funding.
        - Create cap exceptions for rural hospitals establishing Rural Residency Training programs.

Comments:

- Dr. Fraher suggested a dialogue with experts from the Technical Assistance Center of the Rural Residency Development program, as well as from ACGME, to learn more about regulatory and accreditation barriers.

3. The Department of Health and Human Services (e.g., the Center for Medicare & Medication Innovation) should immediately develop and deploy a pilot that tests alternative payment models to support team-based, rural, interprofesssional training, and practice (Short-Term), with incentives that:

    - Connect services delivered to a community needs assessment.

    - Engage social and public health providers in pursuit of patient and community health.

    - Train in Place: Develops local assets, precept rural trainees.

    - Show accountability to community through patient-engagement committees.

    - Demonstrate measurable outcomes.

Comments:

- Dr. Fraher said that HRSA's Rural Residency Planning and Development – Technical Assistance Program has examined some financial barriers affecting rural-area critical access hospitals and sole community hospitals that can be cost-based reimbursed for GME.

- Dr. Carter said she would also examine interprofessional education ties with the National Advisory Council on Nurse Education and Practice (NACNEP), a separate HRSA advisory council.

- Dr. Tsai suggested modifying some of the existing CMMI alternative payment programs to expand into rural areas, rather than creating a program from scratch.

4. Develop a set of measures to ensure value and return on investment for rural training (Medium- to long-Term).

Comments: No comments offered.

Create a strategic plan to promote health professional workforce education across the professional continuum for rural populations (Medium-Term) which can:

- Engage stakeholders to ensure that health workforce training reflects the local needs and assets in rural areas.
- Identify and scale "bright spots" where work is already underway to address rural health needs.
- Support and test sustainable alternative payment models that enhance the delivery of team-based interprofessional education and practice.
- The strategic plan should explore and elaborate how new financing or reforms to existing financing could help to:
    - Create a more dynamic or "plastic" rural workforce that is trained in teams to practice as generalists to address health issues across the lifespan.
    - Address specific needs of rural populations across a diversity of settings.
    - Promote the utilization of cutting-edge technology and communications.
    - Include strategies for financing, implementation, accountability, and governance.
    - Coordinate interagency and federal-state efforts.

Comments:

- Dr. Norcini said this recommendation could perhaps fit better under Issue Brief 1 because it is overarching and covers topics under Issues 2 and 3. Dr. Fraher said this recommendation could also help to "set up" the other Issue Briefs.

- Dr. Scher noted that the Council had previously recommended a GME strategic plan, and asked if a more overarching framework for health professions education for various populations could be developed.

- Ms. Roemer suggested referring to previous Council's recommendations regarding strategic plans in the body of the report.

- Dr. Carter said that the Council's last report made high-level recommendations about what should be included in a strategic plan, with an understanding that there would also be coordination across HHS and feedback from key stakeholders.

- Dr. Carter said that CMS had developed a rural strategic plan, which has a CMS focus. CMS obtained feedback from rural communities.

- Dr. Carter asked if the Council wished to provide additional examples of efforts that could be coordinated at the interagency and federal/state levels. She suggested incorporating those states that have the biggest rural area workforce challenges. Dr. Fraher added that the federal-state collaboration comes to the forefront around Medicaid GME funding.

Public Comment

- Dr. Thomas-Hemak suggested that the issue brief include a more intentional and strategic role of Area Health Education Centers as potential bridges to rural communities. She also suggested inviting a stakeholder group to the conversation that includes cutting-edge innovations such as the Rural Health Coordinating Center, the Institute of Medicine, ACGME, and the Veterans Administration.

- Dr. Thomas-Hemak added that ACOs, such as the one by Geisinger Health System, have been able to leverage CMS investments to develop a neutral governmental "collaboration table."

Discussion on Unifying Document

The Council discussed folding the three Issue Briefs into a unified report. In addition, they agreed to include or discuss the following items in the unified 24th Report:

- Include in the body of the report a description of several concepts for a non-healthcare audience, including: GME, healthcare financing, etc.

- Include a definition of "rural health" and the rationale for selecting such a definition.

- Include a description of the process by which COGME identified and engaged stakeholder feedback in the development of the report.

- Avoid recommendations on specific funding amounts, and instead highlight cost-benefit or return on investment based on information from the current literature.

- Identify programs, agencies, or entities responsible for actions in the recommendations.

- Discuss why the Council decided to discuss funding for other health profession, team-based care, and practice support in rural areas.

- Explain why a strategic plan is important for rural workforce, finance, and training.

HCOP Letter to the Secretary

Dr. Nora moved to the next agenda item, discussion of a letter to the Secretary and Congress requesting reconsideration of the recent budget recommendation to defund the Health Careers Opportunity Program (HCOP). Dr Carter noted that HCOP which has been in place since 1972, serves populations that are both geographically underserved and historically underrepresented. After reading through the letter draft, the Council unanimously voted to move forward, with the recommendation:

- The Council believes not only that HCOP needs to remain funded, but that the funding for fiscal year FY 2020 should be increased by 25 percent over the FY2019 appropriation of $14.2 million, to a level of roughly $18 million.

Business Meeting

Kennita R. Carter, MD, Designated Federal Official (DFO)

Dr. Kennita Carter informed participants that the terms of Dr. Lois Margaret Nora and Ms. Beth M. Roemer will expire at the end of August 2019. She thanked them both for their service.

Dr. Tsai was nominated for the position of COGME Vice Chair. Through a council vote, he was unanimously confirmed by the other Council members.

Next Steps

The Council agreed to move forward with the HCOP letter with any necessary changes made by staff as long as they do not modify the letter's meaning. The Council also agreed to the draft timeline which would be reviewed and revised after the meeting for stakeholder review of the issue briefs.

Dr. Nora said it had been a tremendous privilege to be part of the Council and thanked both COGME members and HRSA staff, including Dr. Carter. Ms. Roemer and Dr. Goodell also said it had been an honor and a privilege to serve on the Council.

Public Comment

The American College of Surgeons (ACS) submitted a letter as their public comment, which Dr. Carter read for the record. The letter highlighted a report from the American Association of Medical Colleges, which projected a shortfall of between 14,300 to 23,400 surgeons by 2032. The shortage is especially acute in rural areas, where many patients lack timely access to general surgery services and may delay necessary surgical procedures. For these reasons, ACS supports efforts to train more surgeons, and to attract then to areas where they are most needed. Policies such as making general surgeons eligible for existing loan repayment and related programs can have a meaningful impact on addressing access in rural and other underserved areas.

Meeting Adjourn

Dr. Fraher thanked all Council members for their engagement and efforts. She also thanked the public, Dr. Carter, and HRSA staff for their support and help, especially for all pre-meeting preparations. The meeting was adjourned at 5:00 p.m.

Acronym and Abbreviation List

ACGME	Accreditation Council for Graduate Medical Education
ACS	American College of Surgeons
CMMI	Center for Medicare and Medicaid Innovation
CMS	Center for Medicare and Medicaid Services
COGME	Council on Graduate Medical Education
DFO	Designated Federal Official
DMD	Division of Medicine and Dentistry
GME	Graduate Medical Education
HCOP	Health Careers Opportunity Program
HHS	U.S. Department of Health and Human Services
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
NACNEP	National Advisory Council on Nurse Education and Practice
NHSC	National Health Service Corps