COUNCIL ON GRADUATE MEDICAL EDUCATION (COGME)
Webinar and Teleconference
Sponsored by the Health Resources and Services Administration (HRSA)

Meeting Minutes: Rural Health and Workforce Training

December 8-9, 2020

Council Members in Attendance
Appointed Members
Erin Fraher, PhD, MPP, Chair
Thomas C. Tsai, MD, MPH, Vice Chair
Andrew Bazemore, MD, MPH
Ted Epperly, MD
R. Armour Forse, MD. PhD, FRCS(C), FACS, FCCM, FASMBS
Peter Hollmann, MD
Beulette Y. Hooks, MD, FAAFP
Warren Jones, MD, FAAFP
John J. Norcini, PhD
Ashruta Patel, DO, MS
Surendra Varma, MD
Kenneth Veit, DO, MBA, FAOFP

Federal Representatives
CAPT Paul Jung, MD, MPH, MBA (Designee of HRSA)
Karen Sanders, MD (Designee of the Department of Veterans Affairs)
Leith J. States, MD, MPH (Designee of the Assistant Secretary for Health)

Health Resources and Services Administration Staff Present:
Shane Rogers, Designated Federal Official, COGME
Kennita R. Carter, MD, Subject Matter Expert, COGME; Chief, Graduate Medical Education, Division of Medicine and Dentistry, HRSA
Raymond Bingham, MSN, RN, Writer and Editor, Division of Medicine and Dentistry, HRSA
Janet Robinson, COGME Advisory Council Laision, Advisory Council Operations, HRSA
Kim Huffman, Advisory Council Operations, Director

Day 1: Tuesday, December 8, 2020

Welcome and Roll Call

Mr. Shane Rogers convened the meeting of the Council on Graduate Medical Education (COGME or the Council) at 10:00 a.m. on Tuesday, December 8, 2020. The COGME meeting was conducted via webinar and teleconference, sponsored by the Health Resources and Services Administration (HRSA). Mr. Rogers conducted a roll call and confirmed the presence of a quorum, allowing the full meeting to proceed.

Meeting Overview

Mr. Rogers turned the meeting over to Erin Fraher, PhD, MPP, COGME Chair. Dr. Fraher welcomed three new members to the Council:

- Peter Hollmann, MD
- Warren Jones, MD, FAAFP
- Surendra Varma, MD

Dr. Fraher acknowledged the unprecedented difficulties faced by the nation and the world over the past year as a result of the COVID-19 pandemic. She noted that in early 2020, the initial outlook was that the pandemic response would be a "sprint" focused on expanding the health care workforce to meet immediate needs. At the current time, ten months later, the response had transitioned to become a "marathon," with the incumbent needs not only to expand the future workforce but to support and sustain current workers, who have served diligently to provide care under stress and while facing significant personal risks of exposure to infection.

Dr. Fraher noted that the Council had submitted a letter to Congress and the Secretary of the Department of Health and Human Services (HHS), posted on the COGME web site, recommending immediate action to address the COVID-19 response by bolstering telehealth accessibility, providing financial relief for vulnerable practices and critical access hospitals, and strengthening and modernizing the public health workforce.

Bureau of Health Workforce Updates

Luis Padilla, MD, Associate Administrator, Bureau of Health Workforce, HRSA

Dr. Fraher introduced the first speaker, Dr. Luis Padilla, Associate Administrator for the Bureau of Health Workforce (BHW), HRSA. Dr. Padilla noted that much of the work of COGME is in alignment with the HRSA's mission to address the needs of vulnerable populations and communities. He listed the four BHW program aims as:

- Enhance access to culturally competent care.
- Achieve supply equilibrium in numbers of health workers.
- Improve distribution of the health workforce.
- Augment quality of the workforce and care provided.

Dr. Padilla noted that the health care system is transitioning to an emphasis on value-based care, and BHW had taken steps to examine its own processes. The result was the *BHWise* (*W*orkforce *I*nvestments to *S*upport *E*quity) strategy. He noted that the BHW workforce programs are geared toward reducing disparities and improving access to health care. Current efforts include:

- Improving data collection to understand the health needs of communities,
- Implementing a portfolio approach to its health workforce programs to improve coordination and collaboration, and
- Engaging key stakeholders to amplify the impact of the programs.

Dr. Padilla also noted several BHW initiatives to improve telehealth training, broaden access to health workforce data, and modernize the process for health care shortage designation, with a particular focus on health equity and sustaining change.

Dr. Padilla highlighted the recent Opioid-Impacted Family Support program, which seeks to strengthen the paraprofessional behavioral health workforce and provide support services to families facing the opioid crises, as one example of BHW targeting its resources, diversify the health workforce, and address needs of rural and underserved communities.

Dr. Padilla commented that provider well-being and resilience is a top concern in supporting the health workforce, not only to manage the current environment of the pandemic but to prepare and strengthen the workforce to face future local, national, and global emergencies.

Dr. Padilla examined some of the external forces across the nation that are impacting the health of communities, including: the COVID-19 pandemic, disproportionately affecting underserved communities; racial inequity and health disparities that existed before the pandemic; and a shifting health care system emphasizing consumer-driven and value-based care. With these challenges, BHW has had to think differently to adapt its approach. For example, both the opioid epidemic and the COVID-19 pandemic have deep impacts on mental and behavioral health, especially in rural and other underserved communities.

Dr. Padilla said that BHW has piloted a portfolio approach to its behavioral health programs, bringing six previously separate programs together to collaborate by developing shared priorities and tactics, and determining the resources and stakeholder involvement needed. The Bureau is working to apply data on community need to program planning and execution, refine priorities based on community need, roll out integrated operating models, and adapt tools and data for use by program managers and the health workforce.

Dr. Padilla noted that HRSA continues to be a leader in field of telehealth. The pandemic response has highlighted telehealth as a safe mode of care delivery. From HRSA's 2018 National Sample Survey of Registered Nurses, roughly one-third of nurse respondents indicated that their workplace had telehealth capability, and half said they were using telehealth in their practice. The implementation of telehealth has dramatically changed and accelerated since that survey. HRSA has used additional funds received from the Coronavirus Aid, Relief, and Economic Security (CARES) Act to support programs that are developing telehealth capabilities for education, increasing the capacity to train the current and future health workforce to provide telehealth services to rural and underserved populations.

He commented that certain infrastructure challenges for telehealth remain beyond HRSA's scope. However, HRSA has taken the opportunity to highlight the need for more digital literacy for users and to enhance the skills of clinicians, students, and trainees in telehealth modalities. For example, HRSA now allows the provision of care through telehealth as an eligible component for the service obligations of National Health Service Corps (NHSC) trainees.

Dr. Padilla said that in June 2020, HRSA awarded an additional $5.8 million to 52 states and regional primary care associations to enhance the COVID-19 response and address their workforce needs. The health centers will complete a survey tool, the Readiness to Train Assessment Tool (RTAT). HRSA will use the RTAT data to develop targeted workforce development plans. The goal is to have more of these centers able to take advantage of HRSA

funding opportunities, such as the Behavioral Health Workforce Education and Training (BHWET) and Teaching Health Center Graduate Medical Education (THCGME) programs.

Dr. Padilla added that HRSA is making the workforce data it collects more publicly available through the development of data dashboards. He highlighted the Clinician Dashboard, released in February 2020, which can provide valuable information on the retention and distribution of BHW program participants who have completed their training or service.

Dr. Padilla discussed HRSA's Shortage Designation Modernization Project. HRSA has traditionally used its health provider shortage designation score as a proxy for community health need. Since 2013, HRSA has been modernizing its shortage designation process. As a result, more clinics are able to serve as training and service sites for the NHSC and Nurse Corps.

Dr. Padilla listed several BHW activities related to the COVID-19 response, which include:

- Providing flexibilities in the NHSC and Nurse Corps service requirements.
- Awarding $15 million to improve telehealth capabilities.
- Developing the framework for the Federal Healthcare Resilience Task Force and COVID-19 Workforce virtual toolkit.
- Enhancing workforce well-being, and assessing the impact of the COVID-19 pandemic on the workforce.
- Funding over twenty health workforce research projects on COVID-19.

Dr. Padilla updated the Council members on the HHS health care workforce coordination plan required under the CARES Act. He noted that the chairs of the five BHW advisory committees had participated in a conference call to provide feedback. HRSA has also worked in coordination with other Federal agencies and departments that fund or administer health care workforce development programs. The HRSA Office of Planning, Analysis, and Evaluation is reviewing the draft plan, and HRSA remains on target to submit the plan by the March 27, 2021 deadline.

Lastly, Dr. Padilla discussed efforts by HRSA to better understand community health needs in relation to the health care workforce. Dr. Padilla reviewed the efforts of HRSA to better understand community need. He outlined the issue of demand vs. need: in this context, demand is a market-based concept indicating the provider sources desired by consumers that are actually being used and where the payment occurs, while need is a public health concept of what provider services are required and ought to be consumed for a community to be considered "healthy." The issue of community need is very diverse, and there are gaps in the availability and quality of data to assess need. He expressed interest in hearing from the Council on other data sources HRSA might access to enhance this definition of need.

Dr. Padilla referenced the COGME rural health issue brief published in July 2020, which highlighted how disparities and access to health care services between rural and urban populations are contributing to a shorter life expectancy for rural residents, and summarized the main drivers that have led to a demand capacity mismatch between the needs of rural communities and the resources that are available to address those needs. He thanked the Council for its evidence-based recommendations to strengthen rural health workforce training and

improve access to health care in rural communities.

Q and A

Dr. Fraher reviewed some of the key takeaways from Dr. Padilla's talk to highlight the synergies between HRSA's programs and the COGME rural health issue briefs in development. She asked Dr. Padilla if he could provide more insight in four areas:

- What data sets might HRSA and the federal government need to better measure community health care needs?
- How can HRSA improve health workforce distribution, especially as health is shifting from acute settings to community-based ambulatory clinics and home-based care?
- What is needed to create metrics that both target investments and evaluate the return on investment, and how might COGME help BHW to propel this work forward?
- How can HRSA promote interprofessional teams, looking beyond graduate medical education (GME) to support team-based training?

Dr. Padilla agreed that he saw synergy between COGME's recommendation and many of HRSA's programs. In regard to data sets and metrics, he said the discussion first needed to center around the model of training, and what was most appropriate for rural settings. He noted that many programs focus on an urban-centric model of training. Even the ways that communities use hospitals differs between urban and rural areas. Many small rural hospitals emphasize outpatient facilities and clinics over in-patient services. He agreed on the need for training-in-place models to support and increase the rural workforce. However, HRSA lacked a sense of where those students and trainees come from, or where they ultimately decide to work.

He also expressed the need to get a better handle on paraprofessionals in rural settings, in order to adjust the models of training to better incorporate interprofessional, interdisciplinary teams. For example, the data on long-term care facilities is unreliable, as occupations such as nursing aides or home health aides are not clearly delineated.

Dr. Surendra Varma stated his concern that many rural hospitals are closing. Dr. Padilla agreed that if training remains largely based in hospitals, then the future of health workforce training in rural areas is under threat as these hospitals face constant financial pressures. He noted there may be opportunities to link more training in federally qualified health centers (FQHCs) or other community-based settings in those rural areas. Dr. Fraher mentioned the Rural Residency Program Development Grant from the Federal Office of Rural Health Policy (FORHP), which is trying to address this issue of bolstering training not only in community-based hospitals but also FQHCs and other community-based organizations in rural communities.

Dr. Armour Forse asked if common outcome measures of healthy communities could be applied to both urban and rural areas. Dr. Padilla replied that it is not feasible to have one outcome that could be applied across the country. For example, definitions of community health differ between Alaska and Midwest, even though both areas are primarily rural. One proposal that has come up in discussion is an area's ability to integrate primary care and behavioral health, which HRSA might be able to incorporate into its funding opportunities and assess the outcomes.

Dr. Thomas Tsai noted that the initial phases of the COVID-19 pandemic response was hampered by shortages of materials and supplies such as personal protective equipment (PPE), while the current phase is experiencing a workforce shortage, and the workforce problem is more challenging to solve. He asked about the opportunities for rapid innovation around reimbursement waivers which then inform new delivery models, such as telehealth, to help alleviate workforce concerns. Dr. Padilla replied that workforce solutions are difficult in the short-term. One approach could be for HRSA to advocate for the use of allied health professionals and paraprofessionals to meet some of immediate community needs.

Dr. Beulette Hooks said that in the State of Georgia, not only are rural hospitals closing, but rural practices are struggling. One issue is that many rural physicians have not been trained in telehealth, while even those that use telehealth are not getting adequate reimbursement compared to face-to-face visits. Dr. Padilla noted the additional investments that HRSA was making in both training and implementation for telehealth. The HRSA-funded Area Health Education Centers (AHEC) program has been providing support in the transition to telehealth, working with both students and clinicians in the field on the effective use of telehealth modalities.

Dr. Peter Hollmann acknowledged the great challenge to train people in a health system as it is evolving, but he noted some grounds for some optimism. First, he said that even urban health systems and primary care practices are developing health care teams with community health workers from the local community to improve support for patients. He further noted that many primary care practices are incorporating behavioral health to provide more comprehensive services. Telehealth is providing greater and more efficient access to specialist services. Lastly, he said that as a geriatrician, he appreciates the availability of a hospital in times of need, but his focus is on allowing patients to remain at home as much as possible. So, developing the ability to take care of people remotely and use remote physiologic monitoring, and improve understanding of how we can use personnel in the home, can apply to both urban and rural areas.

Dr. Armour Forse asked about how to accomplish effective team training. Dr. Padilla replied that challenges include inadequate infrastructure, a need for faculty training, and lack of familiarity with the roles and scopes of practice of workers from multiple disciplines, including pharmacy, social work, behavioral health, and others. The central questions for the organization to address are – what goals are they trying to accomplish, and what types of workers do they need to incorporate into their team?

Dr. Varma followed up with a technical question on providing tele-emergency and telehealth services across state lines. Dr. Padilla acknowledged that as a longstanding issue. Some states and regions have tried to address this problem through reciprocal compact licensure agreements. He said that further resources should be available through FORHP, which is the lead HRSA office on telehealth matters.

HRSA Welcome

Brian LeClair, Deputy Administrator, HRSA

Mr. Brian LeClair, Deputy Administrator, HRSA, provided a general overview of HRSA's major activities over the past year. Mr. LeClair said HRSA is the primary federal agency responsible

for improving access to quality health care services, particularly for those populations who are geographically isolated and economically or medically vulnerable. He described the agency's mission as to improve health outcomes and address health disparities through access to quality services provided by a skilled health workforce and through innovative, high quality programs. HRSA oversees over 90 programs that provide grants and other assistance to over 3,000 awardee organizations, including community and faith-based organizations, colleges and universities, hospitals, state, local and tribal governments, and private entities. HRSA's programs reach millions of people at risk and in need, including families, pregnant women, children, people with HIV, and other hard to reach populations. They promote primary care service delivery, provide financial relief for critical access hospitals, and support providers on the front lines of the COVID-19 pandemic, among many functions.

Mr. LeClair reviewed six long-term HRSA programmatic activities. HRSA's flagship **Health Centers** program funds nearly 1,400 health centers that operate almost 13,000 clinical sites that cover every state and territory of the United States. Around 30 million people, or 1 in 11 persons nationwide, rely on HRSA-supported health centers for affordable health care. Almost all (96 percent) of these centers offer behavioral and mental health services, which has proven vital in battling the nation's opioid epidemic. The Health Centers have taken on a central role in combating the COVID-19 pandemic.

Closely connected with the Health Centers program is the **Ryan White HIV/AIDS Program**. Almost 200,000 patients with HIV enrolled in the Ryan White Program receive their primary care through one of the HRSA-supported Health Centers. One of the signature accomplishments of HRSA is that an estimated 88 percent of Ryan White Program clients are virally suppressed, which far exceeds the national average of 65 percent.

The **Maternal and Child Health Program** works to improve the health and wellbeing of an estimated 60 million people, including pregnant women, infants, children, children with special healthcare needs and their families. In 2019, HRSA's Maternal and Child Health Services Block Grant Program funded projects in 59 states and jurisdictions.

The HRSA **Bureau of Health Workforce** is helping develop the public health workforce to meet current and future health care needs of the nation. Some important examples include:

- The THCGME Program, which has added almost 1,200 primary care physicians and dentists to the healthcare workforce.
- The BHWET Program, which is on track to eliminate over 40 percent of the projected shortfall of behavioral health providers by 2025.
- The HRSA Health Workforce Connector website lists healthcare facilities in underserved communities that have job vacancies, to help improve the health workforce distribution.
- The NHSC and Nurse Corps programs, both of which support scholarships and loan repayments for more than 17,000 current and future clinicians in exchange for service in high need areas.

HRSA's **FORHP** is the primary office at HRSA for supporting grant programs that focus on the development of rural health networks. Their efforts include advancing telehealth, addressing the opioid crisis, and funding black lung clinics. Millions of rural patients are saving transportation

time and millions of transportation expenses by receiving some their healthcare at home through telehealth. In addition, FORHP has awarded $150 million to more than 1,700 rural health hospitals, including 57 tribal organizations, to support the pandemic response in rural areas.

Finally, HRSA's **Healthcare Systems Bureau** oversees an array of programs that include organ procurement and transplantation network activities, as well as the 340B Drug Pricing Program which allows certain safety net hospitals and other covered entities to obtain discounted prices on covered outpatient drugs from drug manufacturers.

Mr. LeClair described the impressive work of HRSA to address the COVID-19 pandemic. He noted that HRSA swiftly mobilized major COVID-19-related funding in support of the American people. Since March 2020, HRSA had awarded more than $2.5 billion to grantees from across its existing programs in emergency supplemental funding to support COVID-related activities, a huge undertaking that was accomplished without a lot of drama and that delivered real relief to the healthcare landscape across the United States.

In April 2020, HHS charged HRSA with distributing roughly $175 billion to support healthcare providers and hospitals responding to COVID-19. These funds were targeted to hospitals and other healthcare providers on the front lines of coronavirus response to cover healthcare-related expenses and lost revenues attributable to coronavirus. HRSA is also administering an additional $2 billion to reimburse providers for COVID-19 testing of uninsured individuals.

Mr. LeClair closed by thanking the Council for their longstanding work on physician workforce issues, and in particular for their work on issue briefs and recommendations focused on helping rural communities by combatting rural health challenges, strengthening rural workforce training, and improving access to healthcare.

CARES Act, Section 3402: Update

Mr. Shane Rogers and Dr. Erin Fraher

Mr. Shane Rogers provided a brief refresher of the 2020 CARES Act, in particular some provisions of section 3402 that impact COGME. He outlined some routine administrative updates. More substantively, the CARES Act increased the Council's membership to 18 members by adding the HRSA Administrator as an *ex officio* member. The HRSA Administrator named Captain Paul Jung as the HRSA official designee. Lastly, the Council must submit its next report by September 30, 2023, and then submit a report every five years thereafter.

Mr. Rogers said that the CARES Act also charged HHS to develop a comprehensive and coordinated plan with respect to its healthcare workforce development programs. HRSA was named as the HHS lead to develop this plan, the CARES Act called for it to be developed in consultation with two HRSA advisory committees, COGME and the Advisory Committee on Training in Primary Care Medicine and Dentistry. HRSA leadership decided to seek additional input from its other three health workforce advisory committees: the Advisory Committee on Interdisciplinary, Community-Based Linkages, the National Advisory Council on Nurse Education and Practice, and the National Advisory Council on the National Health Service Corps. In November 2020, HRSA convened a meeting of the chairs of the five committees to

present the initial framework of the plan and request feedback. Each of the five advisory committees provided their feedback in the form of a letter to the HHS Secretary. By legislation, the final plan must be submitted no later than March 27, 2021.

Dr. Fraher stated that COGME wrote and submitted its response letter on the CARES Act in November 2020. She wanted to review the letter in this meeting to: 1) orient the new Council members to its content, and 2) have the full Council consider the themes from the letter that could be incorporated into the Council's rural health issue briefs.

In its letter, COGME suggested that a major gap facing the country was a lack of a central authority to direct public investments toward healthcare workforce training so that it could better meet population health needs. This theme has been echoed by the National Academy of Medicine and other organizations and stakeholders. COGME noted that the creation of a central authority would serve to coordinate, align, and evaluate the HHS Workforce Programs.

Second, COGME felt that the framework reflected historic HHS workforce programs but did not present a path forward toward developing both the health and social care workforce needed for the future. The strategic plan should help HHS target its investments. As already discussed, strengthening the health care workforce will require not only investing in the pipeline, but retooling and retraining the existing workforce to address emerging opportunities and challenges such as telehealth and the integration of behavioral health into primary care.

Third, COGME noted the need for interprofessional teams to provide integrated, whole person care, along with the movement towards use of allied health professionals and paraprofessionals. The strategic plan should help in the coordination and alignment of these reforms. Furthermore, as the nation moves towards care delivery models that integrate primary care and behavioral health, COGME recommended enhanced coordination between HRSA and Substance Abuse and Mental Health Services Administration.

In addition, the CARES Act referenced performance measures to determine the extent to which HHS Programs are strengthening the nation's health workforce. COGME expressed its support for better workforce data to drive training investments and evaluate the degree to which those investments are both meeting population health needs and congruent with health care delivery reform efforts underway by the Centers for Medicare & Medicaid Services (CMS).
Other points offered in the letter included:

- Rather than focus only on increasing workforce supply, enhancing flexibility in the workforce to respond to emerging health needs, changing models of care and reimbursement, and care delivery reform,
- The need to target workforce investments toward supporting the shift from acute care to community-based and home-based settings, and
- Reframe improving provider quality as improving patient outcomes,

In its letter, COGME underscored that team-based care and an equitable health workforce distribution aligns with the HHS and HRSA missions to address health disparities. The composition of the health workforce should reflect the diversity of the populations being served.

COGME also noted that state governments control many of the policy levers for health workforce, and many states invest heavily in the development of health workforce training through state appropriations and Medicaid payments. Thus, the strategic plan would need to incorporate states as laboratories of innovation, and as key partners with the federal government in workforce development, data collection, and training.

Council Discussion on Issue Brief 2: *The Rural Healthcare Workforce: Necessary Investments*

Moderator: Dr. Andrew Bazemore, COGME member

Dr. Fraher introduced Dr. Andrew Bazemore to moderate the Council's discussion on the draft Issue Brief 2 (IB2): *The Rural Healthcare Workforce: Necessary Investments*. Dr. Bazemore recalled that roughly two years ago COGME had decided to take on rural health disparities in relation to GME and related health workforce training and practice. There was a determination to divide this review into three issue briefs to highlight the most pressing concerns. The briefs would then be consolidated into a final COGME report. He noted that the first Issue Brief (IB1) was published in July 2020, and provided on overview of the needs and challenges of health care in rural America and the implications for healthcare workforce education, training, and practice. Dr. Bazemore summarized the recommendations from IB1 as calling for: 1) an assessment of the needs of rural areas on a national scale to drive and direct resources allocated, and 2) creative investments to improve rural health through changes to GME and health workforce training.

For IB2, Dr. Bazemore noted that the current draft is Version 6, and it has been reviewed and developed through two cycles of new Council members who have provided a wide range of insights and input. He also noted the challenge faced by the Council in developing a brief that conveys a lot of information in a short space. The introduction of IB2 links back to the recommendations from IB1 that federal GME investments be connected to population health needs, particularly in rural areas. The next section provides a short review of federal GME financing to provide context. IB2 then describes:

- Place-based training programs that provide care in rural areas and help encourage more clinicians to practice in rural settings, and what that means in terms of investment.
- Some financial and regulatory barriers that have gotten in the way of reforms that might help to advance GME investments that serves rural better.
- The need for measurement and the development and implementation of relevant outcome measures.
- The need to support and test sustainable alternative payment models and enhance the delivery of team-based education in rural areas.
- The call for a more comprehensive and strategic plan to direct the health professional workforce and the education pathways that serve rural populations best.

Next, Dr. Bazemore drew the attention of the Council to the five IB2 recommendations, each addressed to the subtopics above.

Recommendation 1 addresses the expansion and extension of successful place-based training initiatives that promote access to care for rural communities. Dr. Bazemore commented that the Council had expressed the need to get more physicians to train in rural areas, as a growing body

of evidence supports place-based education as one of the pathways to increase the number of physicians who choose rural practice.

Recommendation 2 states the need to identify and eliminate financial and regulatory barriers to health professional education expansion and innovation in rural areas. He cited the example of directing CMS to eliminate regulatory barriers that inhibit expansion and flexibility in rural training, along with the need to craft more specific regulations to help rural health access.

Recommendation 3 notes the need to develop a set of measures that ensure value and return on the federal investment in rural health education, which has been supported by the National Academies of Medicine, as well as the General Accountability Office and other federal bodies. These measures might address characteristics of clinicians in terms of diversity and cultural competence, practice locations, and rural training experiences. This recommendation also covers the need for outcome measures such as a proportion of graduates that are working in areas of need, and mechanisms of tying financial accountability to downstream training outcomes.

Recommendation 4 covers supporting and testing sustainable alternate payment models that enhance the delivery of team-based interprofessional education and practice. The Council has shaped the recommendation to increase the number of community- and team-based rural training positions receiving public funding, create pathways for financing innovative payment models to support rural health, and engage accreditation bodies to address the needs of rural training programs and their faculty.

Recommendation 5 notes the need to authorize the creation of a strategic plan for investing in health professional workforce education across the professional continuum for rural populations. The Council noted the need to involve rural stakeholders and health workforce assets, and to identify and scale-up bright spots. A strategic plan should address how to create a more dynamic or plastic workforce trained in team-based care and able to practice as generalists, especially to address health issues across the lifespan. There is also a need to explore reforms to existing financing to help promote sustainability. Council members have pointed out three key elements for reforms to be sustainable: quality, access, and payment.

Discussion

Dr. Hollmann commented that most rural clinicians like their work, but they need assistance to survive. Clinicians in a small town often feel they are always on-call, without much opportunity to get away or take a vacation. Thus, it is important to develop networks of clinicians who can support each other. He referenced the federal Comprehensive Primary Care Plus (CPC+) Program that has helped to transform healthcare in Rhode Island by building a network health practices that can provide educational support for training in such areas as team-based care and telemedicine. There was further discussion on how to strengthen the statement on specific patient outcomes, such as blood pressure control, as a measure of success.

Dr. Carter reminded the Council members that the charge of the Council extends beyond GME, and includes providing advice to the Secretary and Congress on the physician workforce beyond the GME pipeline. One of the key points for HRSA in evaluating its activities is sustainability.

There was discussion on the alignment between CMS and the CPC+ program and the health

workforce. CPC+ and related programs are driving healthcare reimbursement policy towards preventive care, primary care, and population health. However, these payment changes have not been integrated into workforce investments despite the fact that the move towards these value-based models or risk-based alternative payment models will fundamentally change the workforce.

Concern was expressed that the IB2 text centers on physicians and GME, while many Council members have voiced support for team-based, interprofessional models of care. Physicians in practice, especially those working in rural communities, need access to teams that include behavioral health, geriatrics, primary care, and other providers. However, financing for health workforce training has been silo-based, with separate funding streams for nurses, behavioral health providers, and other disciplines. It was suggested that one recommendation say that *in order to support physician training in rural communities, payment models need to support interprofessional training and education.*

Another suggestion was to add a sentence in IB2 calling out the need for training in teams and for workforce flexibility and plasticity, which will then be expanded upon in the Council's next brief, Issue Brief 3 (IB3).

Another line of discussion emphasized the need to promote population health. One example is a population-based payment mechanism on a capitated basis to practices that provide health care to the community. Payment models for team-based care need to provide ways to keep the community healthy.

Dr. Bazemore asked the Council members to provide feedback and edits in writing after the meeting, to be incorporated into a revised draft for the Day 2 discussion.

Adjourn

Mr. Rogers adjourned Day 1 of the meeting at 3:30 p.m.

Day 2: Wednesday, December 9, 2020

Welcome and Roll Call

The second day of the meeting was convened at 9 a.m. Mr. Rogers took a roll call, confirming the presence of a quorum. He turned the meeting over to Dr. Fraher, who offered a brief review of the discussions from Day 1. Dr. Fraher introduced Dr. Bazemore to continue the Council's review and discussion of IB2.

Council Discussion on Issue Brief 2, Continued

Moderator: Dr. Andrew Bazemore, COGME member

Dr. Bazemore offered a quick review of revisions made in response to the previous day's discussion. He noted that IB2 had been in development for almost 18 months, and in that time the Council's thinking had evolved. He thanked Dr. Fraher for outlining a revised introduction to set up the main points. He highlighted several changes to the language of the brief related to:

- Clarifying the section on identifying and eliminating regulatory barriers.
- Strengthening the discussion of the Children's Hospital Graduate Medical Education Quality Bonus System, as a bright spot to shape future incentives programs.
- Added language to emphasize the role of population health in directing changes to outcome measures.
- Emphasizing the need for alternative payment models to enhance the delivery of team-based interprofessional education and practice in rural areas.
- Supporting sustainability of interprofessional education and practice in rural areas.

Dr. Bazemore then went over changes that had been made to the wording of the Council's recommendations related to:

- Funding for the THCGME program, and for rural residency training tracks.
- Supporting other HRSA programs providing interprofessional training, to promote investments in health professional education and incentives for training expansion and innovation that improves rural population health.
- Revising regulations that permit rural hospitals to establish fair per-resident amounts consistent with their higher cost of training.
- Increasing diversity and cultural competence of the health workforce to represent the communities that are being served.
- Inserting specific mention of population and community health, and having a mechanism for linking financial accountability to community health.
- Working collaboratively with public and commercial payers to develop innovative population-based health payment strategies.
- Leveraging technology to enhance access to care quality, maximize health outcomes and control health care costs.
- Including explicit language about requiring new alternative payment mechanisms to encourage interprofessional teams and networks, measures to prevent burnout, and plans to ensure sustainability.

There was discussion on recommending permanent funding for the THCGME program, a point expressed in the Day 1 public comment session. Residency training programs may be hesitant to take residents into training when they are funded by the Teaching Health Centers Program because the funding is subject to short-term Congressional appropriations. Council members also discussed funding for rural residency programs coming from state governments. There was further discussion on clarifying the recommendation for flexibility in the residency caps to support rural-based training programs in needed specialties, to prevent the language from being misinterpreted as a general call for lifting the Medicare GME cap, which was not the Council's intent.

There was mention of the need to include language that would allow the HHS Secretary and HHS agencies to identify communities that have particular need, to ensure appropriate distribution of programs and funding. There was a suggestion to strengthen the statement on rural-based training programs and needed specialties. There was also discussion on strengthening language related to physician and health care team well-being. Because of the pressures inherent in rural practice, burnout is a significant problem. It was further noted that the language of the recommendations should be direct and actionable, as much as possible.

After further discussion and review of the edits, Dr. Varma made a motion to approve IB2 with the consensus that a writing group would finalize the language and the technical sides of the brief, in alignment with the Council's discussions. Dr. Hooks seconded the motion, and the motion passed by consensus. The members of the IB2 writing group were:

- Dr. Fraher
- Dr. Bazemore
- Dr. Hollmann
- Dr. Forse
- Dr. Epperly

Council Discussion on Issue Brief 3: *Training Needs to Prepare the Healthcare Workforce for Rural Practice*

Moderator: Dr. Thomas Tsai, COGME Vice Chair

Dr. Fraher introduced Dr. Tsai to lead the discussion on the Council's third rural health issue brief (IB3), *Training Needs to Prepare the Healthcare Workforce for Rural Practice.* Dr. Tsai noted that IB3 is focused on the training needs to prepare more healthcare professionals for rural practice. Dr. Tsai outlined the goals of the discussion:

- To introduce to the new COGME members and the public to some of the ideas that COGME had voted on in previous meetings, and summarize the key principles;
- To take some of the principles from previous discussions and hone in on a few specific and concrete recommendations that are actionable and directed either towards HHS or Congress; and
- To achieve some consensus around terminology on training needs and the health profession workforce.

In previous discussions, the COGME members had coalesced around a core set of principles.

The first principle, building on the discussions of the first two Issue Briefs, was to recognize that rural communities have a range of specific needs, centering on community-based health care delivery. As a result, rural health training programs should focus on incorporating healthcare providers of different professions working together and in conjunction with public and private partners invested in the local community. Health professionals training for practice in rural areas must be prepared to be adaptable and flexible to meet community needs.

The next principle was the emphasis on team-based care. Rural communities may have limited access to facilities such as hospitals and clinics, and may have a limited number and range of health professionals in the community. Putting these limited resources to greatest use will require that local providers work together in teams to complement each other's skills and scopes of practice within flexible models of care.

The third principle reflected the need to promote generalism in rural healthcare practice. Clinicians training for rural practice need to develop a broad range of skills that they can adapt to meet the specific needs of the local community. One example from an earlier discussion involved incorporating behavioral and mental health training into primary care to address such issues as the opioid crisis. Included within this principle is the need to promote broader, lifelong learning, not just in GME but in the training of all rural healthcare providers.

The final principle was to recognize the need to invest in recruiting and training individuals from rural communities into the health professions. Data suggests that these individuals would be more likely to remain and work in rural areas. This principle incudes developing a pipeline and promoting opportunities for medical and related health care professions education for residents in rural communities.

Dr. Peter Hollmann noted that the principle of lifelong learning and updating skills applies across all of the health professions. In particular, international medical graduates from other countries who work in rural areas will need to learn not only about the practice of medicine in America, but about the local community resources. He recommended that the Council develop a very specific recommendation about the need for continuing education, retraining, and skills updates, so that this process becomes a purposeful and conscious approach across all health professions, and all professionals become connected to a teaching institution or process.

Dr. Tsai suggested recommending that HRSA or HHS fund a training program for mid-career healthcare professionals, including physicians, nurses, and those from other disciplines, in rural team-based medical care. Dr. Hollmann replied that the recommendation could cover both mid-career professionals wanting to change or adapt their practice, and for faculty development.

Dr. Hooks supported the concept of lifelong learning, adding that there is a need to develop and upgrade the infrastructure in rural areas to allow practitioners to become more connected to the medical centers and make better use of available technology for learning. Many rural communities lack the bandwidth to communicate with a local hospital or training program. When rural practitioners travel away from their communities for training or professional development, that may leave the community without access to a provider.

Dr. Bazemore stated that the United States had seen a decline in generalist training and practice, along with a rise in workforce sub-specialization and fragmentation. Meanwhile, several nations in Western Europe are reincorporating concepts of generalism within their national health systems. Building off the Council's first two rural health issue briefs, he suggested the need to frame training as holistic and within a model of team-based care, with the intent to deliver essential, broad, and comprehensive care that is patient-centered and population focused. He noted the need for generalist thinking across all health professions to develop a dynamic team-based workforce. He added that he would like to see strains of generalism retained across all health professions, and to promote both generalist training and generalist thinking. One goal would be to get the Accreditation Council on Graduate Medical Education (ACGME) and other professional certification boards to explore how they can retain and enhance the principles of generalism across disciplines to build a more flexible, dynamic, team-based workforce.

Dr. Armour Forse described two issues to address for lifelong learning to succeed in rural areas. First, while some didactic education can be completed online, hands-on training might require educators or educational institutions to reach out to rural centers to offer local in-person programs. Second, rural inhabitants will need to have good foundational training in the use of technology, and learn how to interact with clinicians and specialists through telehealth. Dr. John Norcini brought up a model developed by the World Health Organization (WHO) called the WHO Academy, to facilitate lifelong learning. The WHO Academy has both hands-on and distance learning components, and is developing processes to support the quality of the education and related services it provides.

There was discussion on Project ECHO, a national initiative originally developed to help rural health practitioners learn how to manage patients with hepatitis and other chronic conditions. Project ECHO uses a hub-and-spoke approach that allows clinics in underserved communities to connect with one another and facilitate knowledge sharing. There was a suggestion for COGME to recommend that HRSA fund a similar model to train students and current practitioners in interprofessional care, rural health, telehealth and other vital topics.

There was discussion among several of the Council members on the need to develop both the training and the infrastructure for telehealth, including distance consults. In response to a question on reimbursement for services, Dr. Hollmann confirmed that such consults are covered under current Medicare billing codes. Dr. Hooks noted, however, that a lack of interoperability between different electronic medical records systems may limit the accessibility of such consults in rural areas. Dr. Tsai said that new rules and waivers related to the COVID-19 pandemic response had expanded opportunities for telehealth consults, pointing to the need for more training both for rural clinicians and the specialists receiving the consults.

Dr. Kenneth Veit raised another issue that impacts the retention of clinicians in rural practice, which is the willingness of the spouse, significant other, or family to remain in or relocate to a rural community where suitable employment opportunities or educational resources might be scarce. There was further discussion around the potential pool of clinicians who might be willing to relocate to rural areas, but fear they lack the skills or training to succeed.

There was discussion about providing relocation bonuses and training programs for mid-career

professionals, along with assistance for their spouses and families, to encourage a move to rural health and primary care. Dr. Carter noted that the Department of Veterans Affairs has modeled some programs for family support, but the funding was discretionary and lacked long-term stability. It was suggested that some funding should come from state and local sources, to enhance collaboration between federal and local agencies. There was further discussion around the terminology to use in describing the proposed model.

After further discussion on the proposed recommendations for IB3, Dr. Tsai summarized the main themes as:

- Providing opportunities to train new practitioners and retrain mid-career professionals around rural health and the needs of rural communities, with a focus on training practitioners who want to move to rural communities. Part of the solution involves addressing the social and family concerns of the clinician.
- Promoting rural training tracks and ongoing education and training in the identified needs of rural communities.
- Supporting interprofessional teams and training for team-based care, developing leadership in interprofessional teams.
- Promoting generalism in training and practice.

Based on these themes, the Council developed and approved by consensus an initial draft set of recommendations for Issue Brief 3, to state COGME recommends that:

HHS fund a mid-career professional training program for practitioners interested in transitioning to rural practice and developing competency in rural team-based healthcare, and for faculty development for rural training. This funding would:

- Offer financing and support for community-based midcareer retraining of 'specialized generalists' to meet evolving needs of rural populations.
- Support development of a program for training and support for relocation, resettlement of practitioners and their families:
    - Supporting the establishment of the practitioner in the community.
    - Supporting retention in the community.
- Provide additional funding for the Area Health Education Centers (AHECs) to operationalize this recommendation.

HHS support targeted infrastructure investments to facilitate initial training and lifelong multi-modality learning for practitioners in rural communities. These investments would:

- Support rural training tracks in identified needs for rural communities.
- Provide training in the use and provision of telehealth.

HHS support promoting or expanding integrated care by interprofessional team models by:

- Allowing flexibility in the composition of the team.
- Providing training in team function, team management, leadership, and sustainable team business models.
- Promoting training and understanding in professional scope of practice.

HHS direct HRSA to conduct an assessment of generalism in publicly financed GME to support

the health of rural populations.

The Council identified a writing group to continue work on IB3, to include:

- Dr. Tsai
- Dr. Hooks
- Dr. Norcini
- Dr. Varma
- Dr. Forse

Wrap-Up and Next Steps

Dr. Erin Fraher outlined the next steps for the Issue Briefs and the COGME compilation report:

- A writing group led by Dr. Bazemore will finalize Issue Brief 2.
- A writing group led by Dr. Tsai will continue the development of Issue Brief 3, with the expectation of have a draft near final by the next COGME meeting in April 2021.
- Based on the issue briefs, the Council will develop a full compilation report to address the health workforce and infrastructure needs of rural communities in the United States, to include a section on how the COVID-19 pandemic has changed these needs.

Business Meeting

Mr. Rogers reminded the Council members of the next COGME meeting on April 14-15, 2021. He stated that the meeting was currently planned to be in-person, pending the status of travel restrictions related to the pandemic response. Otherwise, the meeting would be held virtually through teleconference and webinar. He noted that HRSA would be shifting to the use of the Microsoft Teams platform for future virtual meetings.

Mr. Rogers stated that the COGME response letter for the CARES Act, discussed above, had been submitted and would be included in the health workforce strategic plan. However, it will not be posted to the COGME web page until the plan is sent to Congress.

Public Comment (Day 1 and Day 2)

Mr. Rogers noted that several written comments were submitted prior to the meeting and distributed to the full membership, to become part of the official record:

- Dr. Caleb Atkins sent a letter from an organization representing a group of physicians who had not received a match for a residency position and thus were unable to complete the final stage of their training. He asked for the support of COGME to help prevent U.S. citizen doctors from going unmatched.
- A second comment, provided via email by Jean Public, emphasized that the education of doctors must start to include substantial time on studying vaccines and what they do to the human body.
- A third set of comments to the Council involved a letter that was sent from several different individuals pertaining to International Medical Graduate match eligibility.

The meeting also included several oral public comments:

- Dr. Atkins provided an oral comment to follow up on his letter. He stated that over 6,500 doctors failed to match for a residency position the previous year, and the problem had been getting worse since 2005. Many of these doctors have accumulated tremendous debt to finance their medical education. Through its funding for GME, the federal government serves as a gatekeeper for residency training. He asked the Council to continue to advocate for legislation addressing the issue of unmatched physicians, HR 1763 in the House and SB 48 in the Senate.
- Jennifer J. Walsh, Esq., senior vice president at the Wright Center for Graduate Medical Education and the Wright Center for Community Health in Northeastern Pennsylvania provided a comment in support of the importance of the community needs assessment.
- Dr. Karen Mitchell, from the American Academy of Family Physicians (AAFP), commented on the need for permanent funding of HRSA's THCGME program, and the need for CMS to clarify its definitions of needed specialties in geographic regions. She added another comment to recommend that funding for training, support, and relocation of mid-career physicians focus on meeting the needs of the community, with the intention of retaining the physician's original specialty.
- Dr. John Aguilar, also with the AAFP, added his support for permanent funding for the THCGME program.
- Dr. Mary Smithers, also representing unmatched physicians, noted that many have primary care training and would be willing to fill residencies in rural training tracks.

Due to technical challenges, Dr. Randall Longenecker was unable to provide an oral comment during the meeting and thus, sent in a written statement after the meeting had adjourned. The DFO forwarded the statement to the full membership. Dr. Longenecker's comment pertained to supporting Rural Training Tracks (RTTs) as a frugal solution to many of the issues raised during the COGME meeting.

Meeting Adjourn

Dr. Fraher thanked the members of the public for their comments and their engagement in this meeting, underscoring the importance of the Council's work. She thanked the panelists for sharing the expertise, and the Council members for their work in the previous weeks to draft the initial recommendations, helping to make the meeting a success. She also thanked the HRSA staff for their support of the Council.

Mr. Rogers adjourned the meeting at 5:00 p.m.

Acronym and Abbreviation List

AAFP	American Academy of Family Physicians
ACGME	Accreditation Council for Graduate Medical Education
AHEC	Area Health Education Center
BHW	Bureau of Health Workforce
BHWise	Workforce Investments to Support Equity
BHWET	Behavioral Health Workforce Education and Training
CARES Act	Coronavirus Aid, Relief, and Economic Security Act
CMS	Centers for Medicare & Medicaid Services
COGME	Council on Graduate Medical Education
CPC+	Comprehensive Primary Care Plus
FORHP	Federal Office of Rural Health Policy
FQHC	Federally Qualified Health Centers
GME	Graduate Medical Education
HHS	U.S. Department of Health and Human Services
HRSA	Health Resources and Services Administration
NHSC	National Health Service Corps
RTAT	Readiness to Train Assessment Tool
THCGME	Teaching Health Center Graduate Medical Education
WHO	World Health Organization

The COGME Rural Health Issue Brief series:

Issue Brief 1 (IB1) [published July 2020]: *Special Needs in Rural America: Implications for Healthcare Workforce Education, Training, and Practice*
Issue Brief 2 (IB2) [in development]: *The Rural Healthcare Workforce: Necessary Investments*
Issue Brief 3 (IB3) [in development]: *Training Needs to Prepare the Healthcare Workforce for Rural Practice*