COGME Meeting

September 11-12, 2002, Bethesda, Maryland

Agenda

WEDNESDAY, SEPTEMBER 11

8:30 a.m. Welcome from Chair and Approval of Minutes

Carl J. Getto, M.D., Chair

Welcome and Report from the
Acting Executive Secretary
Stanford M. Bastacky, D.M.D., M.H.S.A.
Acting Executive Secretary, COGME

9:00 a.m. Competencies in Graduate Medical Education

Marvin R. Dunn, MD
Director of Residency Review Committee Activities
Accreditation Council for Graduate Medical Education

Perry A. Pugno, MD, M.P.H., C.P.E.
Director Division of Medical Education
American Academy of Family Physicians

Donald E. Melnick, MD
President, National Board of Medical Examiners

10:00 a.m. Discussion

10:30 a.m. Break

10:45 a.m. Financial Situation of Teaching Hospitals

Susan Schooley, MD
Chair, Department of Family Practice, Henry Ford Health System, Detroit; COGME member

John Crosby
Executive Director, American Osteopathic Association

11:45 a.m. Discussion

12:15 a.m. Public Comment

12:30 p.m. Lunch

1:45 p.m. Development of a Framework for Revised COGME Physician Workforce Goals

Ed Salsberg
Director, Center for Health Workforce Studies
State University of New York at Albany

2:30 p.m. Breakout of Workgroups

Diversity Workgroup

GME Financing Workgroup

Workforce Workgroup

4:30 p.m. ADJOURN

THURSDAY, SEPTEMBER 12

8:30 a.m. Discussion of June Summit with the Institute of Medicine

9:00 a.m. Reports by Workgroup Chairs

10:00 a.m. Status of 2002 Summary Report

10:15 a.m. Break

10:30 a.m. Discussion of Future Work

11:00 a.m. Public Comment

11:15 p.m. ADJOURN

Minutes

The Council on Graduate Medical Education (COGME) met at 8:30 a.m. on September 11 in the Versailles I Meeting Room of the Holiday Inn Select, Bethesda, MD. Dr. Carl J. Getto, COGME Chair presided. The plenary meeting concluded that day at 2:28 p.m. It reconvened the next morning, September 12 a.m. at 8:30 a.m. in the same room and adjourned at 9:45 a.m. that day.

Members Present:
Carl J. Getto, M.D., Chair
F. Marian Bishop, Ph.D., M.S.P.H., Vice-chair
Regina M. Benjamin, M.D., M.B.A., Member
Laurinda L. Calongne, LCSW-BACS, Member
William Ching, Member
Allen Irwin Hyman, M.D., FCCM, Member
Robert L. Johnson, M.D., Member
Lucy Montalvo, M.D., M.P.H., Member
Jerry Alan Royer, M.D., M.B.A., Member
Susan Schooley, M.D., Member
Humphrey Taylor, Member
Douglas L. Wood, D.O., Ph.D., Member
Tzvi M. Hefter, Designee of the Centers for Medicare and Medicaid Services
Stephanie H. Pincus, M.D., M.B.A., Designee of the Department of Veterans Affairs

Members absent:
Donald C. Thomas III, M.D., Member

Staff:
Stanford M. Bastacky, D.M.D., M.H.S.A., Acting Executive Secretary
Jerald Katzoff, Acting Deputy Executive Secretary
Howard Davis, Ph.D.
Eva Stone

Welcome and Announcements:

Dr. Getto welcomed participants to the meeting and read a statement from HHS Secretary Tommy Thompson commemorating the anniversary of September 11, and a moment of silence was observed. Approval of the minutes was deferred to the second day of the meeting to allow members to review them. Dr. Getto recognized Dr. Marian Bishop for receiving the John G. Walsh Award for dedicated and effective leadership in furthering the development of family practice from the American Academy of

Family Physicians. He also recognized Dr. Regina Benjamin for becoming the first African-American female President of a State (Alabama) in the U.S. Council members made opening comments in turn.

Competencies in Graduate Medical Education:

Marvin R. Dunn, M. D., Director of Residency Review Committee Activities, Accreditation Council for Graduate Medical Education (ACGME), explained the introduction of six competency requirements that are being considered by the ACGME to further competency-based education of medical students. The six competencies are: patient care, medical knowledge, practice-based learning and improvements, interpersonal and communication skills, professionalism, and systems-based practice. He described the efforts, difficulties, and collaboration among the various medical educational organizations involved in the development of the competencies and the measurements of outcomes. Rather than evaluating the curriculum, goals and objectives as is currently done, the Residency Review Committees would evaluate programs upon how well students achieve learning objectives.

Perry A. Pugno, **M.D., M.P.H., C.P.E.**, Director, Division of Medical Education, American Academy of Family Physicians, spoke on the connection between competency, accreditation, and certification. He described the process used by the Academy to maintain quality of the

physician practice through problem-based learning assessment. A survey of prior graduates highlighted deficiencies in physician preparation in practice-based learning and improvement and in systems-based practice competencies. Dr. Pugno described efforts to improve descriptors for these two problem areas. The development of reliable measurements of physician performance is difficult, and faculty who are conversant with competency-based education and can teach these specific competencies are in short supply.

Donald E. Melnick, **M.D.**, President, National Board of Medical Examiners, explained the operational procedures used in the administration of the Clinical Skills Assessment (CSA) examination. The CSA is composed of a test of clinical skills and a test of communication skills performed on standardized patients. These tests are valid measures of the clinical skills for which they are targeted and a passing score must be achieved on each test. Implementation is currently planned for mid-2004, affecting the U.S. class of 2005. Dr. Melnick stated that ten to twenty percent of examinees who would pass the cognitive examinations are expected to fail the CSA. The deficiency of clinical training in U.S. medical schools was noted, especially since 1964 when the NBME dropped clinical skills exams.

Financial Situation of Teaching Hospitals:

Dr. Schooley, Chair, Department of Family Practice, Henry Ford Health System (HFHS), Detroit, described the impact of a constellation of adverse events on the continuing capability of HFHS to

delivery quality care because they are eroding both the health care delivery capability and the teaching and research infrastructure of the institution. These events include the increasing shift of health care costs from the purchasers to the health care providers and patients, reduced Medicare rates, disenrollment from managed Medicare, shift of demographics in the community leaving a larger proportion of sicker patients, a deteriorating economic environment, adverse legislated reimbursement changes, huge increases in uncompensated care, and other adverse factors. The impact of these events have resulted in substantial losses to HFHS, $13 million in 1999, $88 million in 2001, and forecasted double-digit loss in 2002.

Robert M. Dickler, Senior Vice President, Association of American Medical Colleges, noted that Medicare provides the lowest margin for teaching hospitals while the dependency on Medicare has increased. This increased dependency makes these hospitals vulnerable to changes in Medicare reimbursement policy. Of the 200 members of the Council of Teaching Hospitals (COTH), many had reversed the decline in revenue but 1/3rd of the membership lost money in the year 2001 compared with 13 percent in 1997, the year in which the BBA was enacted. Some of these losses are attributable to the 7 percent of expenditures for uncompensated care. The legislated reduction in Medicare reimbursement to physicians will adversely affect hospital income. "Boutique" hospitals have diverted higher profit-margin procedures from teaching hospitals. Further reduction in expenditures will be difficult to make. Dr. Dickler commented on other developing pressures that will adversely affect bottom line of hospitals.

John Crosby, Executive Director, American Osteopathic Association, noted that the same adverse developments experienced by allopathic teaching hospitals are having a devastating result on osteopathic hospitals, which are mostly small, either rural or urban, and cater to the underserved population. Reimbursement to osteopathic hospitals is based upon 1984 as a base year, which at that time included a large number of volunteer faculty, and is no longer adequate when such faculty no longer exist. The current shortfall of such faculty, which combined with the nursing shortage and limits on resident work hours, will necessitate the use of non-physician health care providers. These and other factors are imposing greater costs upon teaching hospitals.

Development of a Framework for Revised COGME Physician Workforce Goals:

Edward Salsberg reported the progress on a contract to review workforce goals. After reviewing the history of the COGME 110/50:50 recommendation, he detailed the caveats to compiling meaningful numbers on physicians to use in analytical work. Mr. Salsberg noted that demand for specialists exceeds that for generalists in many markets and that training responds quickly to demand changes. Mr. Salsberg described the two scenarios to be developed for the contract project, one demand driven, the other need driven, but he cautioned about estimating physician needs without considering the

manifested demand. He stated the goals of the study are to assess the overall supply, demand, and need in 2020.

The plenary session was adjourned at 2:28 p.m. to convene into three workgroups: Diversity, GME Financing, and Workforce.

Betty Duke, Ph.D., HRSA Administrator, visited briefly with COGME members during the afternoon. Dr. Duke stated that she was pleased to report that all of her top administrative staff was finally in place.

THURSDAY, SEPTEMBER 12

The plenary session was reconvened at 8:30 a.m.

Dr. Getto introduced Sherrie Hans. M.D., a representative of the Assistant Secretary of Health, Eve Slater, M.D. Dr. Hans conveyed the support of Dr. Slater for COGME.

June Summit With Institute of Medicine (IOM)

Dr. Getto reported on the IOM Summit, a major meeting of 300 leaders in health professions education in the U.S. He reported that an agenda was produced to implement interdisciplinary education of health professionals in various areas. There followed discussion of the summit by those who had attended.

Reports by Workgroup Chairs

Dr. Johnson reported for the Diversity Workgroup, which reviewed the 1998 12th Report of COGME report covering minorities in health care. The group agreed that the content of the 1998 report remained current because of a lack of progress in workforce diversity, but found deficiencies in the recommendations of the report that impaired their implementation. The group recommended: the development of an RFP to review the effectiveness of methods to enhance diversity throughout the continuum of education (i.e., primary and secondary education, undergraduate education, medical schools and professional organizations); the examination of the results from the 1998 report in order to review the feasibility of unaccomplished recommendations; and the development of methodologies to accomplish feasible recommendations.

Dr. Schooley gave the report of the Workforce Workgroup, which heard further detail from Mr. Ed Salsberg on his report during the first day's meeting. Mr. Salsberg presented some of the constructs to be articulated. The group discussed the merits of both current supply and demand and the needs-based modeling. The major issue will be to develop policy to move the demand model towards the

needs-based model. The group found that, on a policy level, needs should be assessed over the long-term according to individual specialties and subspecialties, and the different branches of primary care.

Will Ching presented the report of the Finance Workgroup. Members briefly discussed to contract to study non-Federal financing of graduate medical education. Agenda items were looked at, which included a review of the recommendations from the 15th report of COGME. Workgroup members agreed that RFPs might be developed to study the development of a method to assess costs arising from implementation of the clinical competencies and how those costs should be distributed and to study the costs and their allocation arising from the limitation on resident duty hours. The Workgroup also considered compiling a contingency plan in case the current litigation on the National Resident Match Program is successful that would allow COGME to advise the Federal government on ways GME financing could be used address the impacts of potential cost shifts.

Future Work

Following discussion, the Council agreed to have a presentation on the role which graduate medical education should play in efforts surrounding the strengthening of the public health workforce and combating bioterrorism.

Public Comment

Sunny Yoder, Holly Mulvey, and Dr. Sherrie Hans made brief comments.

Approval of Minutes

The minutes of the April, 2002 COGME meeting were unanimously approved, and the meeting was adjourned at 9:45 a.m.