COGME Meeting

July 28-29, 2004, Bethesda, Maryland

Agenda

WEDNESDAY, JULY 28

8:30 a.m. Welcome from Chair

Carl J. Getto, M.D., Chair

Welcome from Health Resources and Services Administration
Elizabeth M. Duke
Administrator

Welcome from the Bureau of Health Professions
Kerry Paige Nesseler, RN, M.S.
Associate Administrator for Health Professions

Welcome from the Division of Medicine and Dentistry Director, Division of Medicine and Dentistry
Welcome and Executive Secretary's Report
Jerald Katzoff
Acting Deputy Executive Secretary, COGME

9:15 a.m. Review and Discussion of Comments on Physician Workforce Report

10:45 a.m. Break

11:00 a.m. Finalize Report with Revised Findings and Recommendations (as warranted)

1:00 p.m. Public Comment

1:15 p.m. Lunch

2:15 p.m. Discussion of Future Issues Regarding (1) the Supply, Distribution, and Adequacy of the Physician Workforce in Training and Practice; (2) Financing of Medical Education; and (3) Federal Policies and non-Federal Efforts to Ensure an Appropriately Trained Physician Workforce

David Sundwall, M.D., Facilitator

5:00 p.m. Public Comment

5:15 p.m. ADJOURN

THURSDAY, JULY 29

8:30 a.m. Contractor Report on Update of COGME's Twelfth Report: Minorities in Medicine

Rhonda Ray, Ph.D.

9:30 a.m. Discussion

10:15 a.m. Break

10:30 a.m. Continued Discussion Leading to Approval of Report

12:00 p.m. Public Comment

12:15 p.m. ADJOURN

Minutes

The Council on Graduate Medical Education (COGME) convened in the Versailles Room I in the Holiday Inn Select, 8120 Wisconsin Avenue, Bethesda, Maryland, at 8:30am. on July 28-29, 2004, Dr. Carl J. Getto, Chairman, presiding.

Members Present
Carl J. Getto, M.D. (Chair)
Robert L. Johnson, M.D. (Vice Chair)
Laurinda L. Calongne (Member)
William Ching, Ph.D. (Member)
Rebecca M. Minter, M.D. (Member)
Lucy Montalvo, M.D., M.P.H. (Member)
Angela Dee Nossett, M.D., (Member)
Earl J. Reisdorff, M.D., (Member)
Russell G. Robertson, M.D., (Member)
Susan Schooley, M.D., (Member)
Humphrey Taylor, (Member)
Stephanie H. Pincus, M.D., M.B.A., Designee of the Department of Veterans Affairs
Christina Beato, M.D., Acting Assistant Secretary for Health and Surgeon General

Members Absent:
Allen Irwin Hyman, M.D., FCCM (Member)
Jerry Alan Royer, M.D., M.B.A. (Member)
Douglas L. Wood, D.O., Ph.D. (Member)
Howard Zucker, M.D. , Designee of the Deputy Assistant Secretary for Health
Tzvi M. Hefter, Designee of the Centers for Medicare and Medicaid Services

Staff:
Jerald M. Katzoff, Acting Deputy Executive Secretary
Howard Davis, Ph.D.
Eva Stone
Jaime Nguyen, M.D., M.P.H.

Welcome and Announcements

Dr. Getto welcomed the members of the Council and the public. Dr. Getto reviewed the agenda for the day and introduced **Captain Kerry Nesseler, R.N, M.S.**, Associate Administrator for the Bureau of Health Professions.

Capt. Nesseler provided a brief update on the Bureau and its continuing progress towards developing and completing the strategic plans for the performance and outcome measurements. The all grantee meeting is scheduled for early June, 2005, in Washington, DC and all current Bureau of Health Professions grantees will be invited to the meeting. Capt. Nesseler also announced some personnel changes. Dr. Carol Bazell has taken a new position at the Centers for Medicaid, Medicare Services (CMMS), and Dr. Barbara Brookmyer is now at the Frederick County Health Department. Capt. Nesseler introduced Tanya Pagan Raggio, M.D., a pediatricianboard certified in pediatrics and preventive medicine and , as the new Division of Medicine Director. Dr. Raggio will begin her appointment on August 22, 2004. Commander O'Neal Walker is the new Chief of Dentistry, Psychology and Special Programs Branch in the Division of Medicine and Dentistry. Captain Raymond Lala, D.D.S., has joined as a project officer in the Division of Medicine and Dentistry.

Due to the absence of **Elizabeth Duke, Ph.D.**, at the meeting, **David Rutstein, M.D.,** was asked to read comments written by her. Dr. Duke gave an overview of some of the programs currently in place at HRSA. She also thanks the Council for its continuing dedication and efforts in ensuring a strong and viable physician workforce in the future.

Review and Discussion of Comments on the "*Physician Workforce Policy Guidelines for the U.S. 2000-2020*" report:

A report of the physician workforce was prepared by the Center for Health Workforce Studies at the School of Public Health, University at Albany, State University of New York by **Edward Salsberg** and **Gaetano Forte**. This report forecasts future supply, demand, and need for physicians based on the historical patterns of use of services by age, gender, insurance status, type of area (urban, rural), and managed care penetration. Included in the report are the results of the data analysis and a description of the methodologies used to forecast supply, demand, and need and the potential impact of changes in the factors that influence each of those. The report also includes recommendations to assure that the future supply better meets future demand and need.

Scenarios have been constructed around the best understanding of changes occurring in health care and in medicine. For each scenario, the report presents a sensitivity analysis indicating the impact if change occurred to a lesser or greater extent than current understanding portends. The report concludes that the nation is likely to face a significant shortage of physicians over the next 15 years and recommends an increase in the number of new physicians being educated and trained in the U.S. This marks a significant change from the Council's earlier Reports and is the first to call for an increase in U.S. medical school capacity. COGME is no longer recommending that 50 percent of new physicians be in

generalist specialties but rather that the distribution by specialty should be determined by marketplace demand. The report also strongly endorses the need for additional data collection and research to guide decisions on the size and mix of the physician workforce.

Prior to the meeting, a draft of this report was sent to various organizations and institutions for review and comments were requested. These remarks and comments were compiled for all the members of the Council for their consideration.

After extensive discussions and minor modifications, the Council approved the "*Physician Workforce Policy Guidelines for the U.S. for 2000-2020*." The Council has endorsed the following revised recommendations to address the likely shortage:

1. In order to meet the future physician workforce demand and need in the United States, it is recommended that;
    a. The number of physicians entering residency training each year be increased from approximately 24,000 in 2002 to 27,000 in 2015;
    b. The distribution between generalist and non-generalist physicians should reflect on-going assessments of demand; a rigid national numerical target is not recommended.
2. Increase total enrollment in U.S. medical schools by 15% from their 2002 levels over the next decade.
3. Phase in an increase in the number of residency and fellowship positions eligible for funding from Medicare to parallel the increase in U.S. medical school graduates recommended above.
4. Develop systems to track the supply, demand, need, and distribution of physicians, and undertake a comprehensive re-assessment within the next four years to guide future decisions on medical education capacity.
5. Additional specialty specific studies are needed to understand physician workforce needs better and to inform the medical education community and policy makers of the nation's specialty specific needs.
6. Promote efforts to increase the productivity of physicians. There are several steps the nation should consider to promote productivity improvements. These include:

- Funding to evaluate the effectiveness and efficiency of alternative models of care, and practice and organizational arrangements;
- Evaluation of specific new technologies;
- Dissemination of information to physicians on the effectiveness of alternative models of care, new technologies, and other strategies to improve productivity; and
- Introduction of reimbursement policies to support implementation of productivity enhancements.

1. Expand programs and develop policies that:

- Address geographic maldistribution of physicians;
- Improve access to care for underserved populations and communities;
- Promote appropriate specialty distribution and deployment;
- Promote workforce diversity; and

- Support analyses of data related to these issues.

After the report is submitted to the DHHS Secretary and to the appropriate members of Congress, the Health Resources and Services Administration (HRSA) expects to publish and disseminate the report in the upcoming months as COGME's 16th report.

Discussion of Future Issues:

In the afternoon session, **David Sundwall, M.D.**, former chair of COGME, led the discussion on future issues regarding: (1) the supply, distribution, and adequacy of the physician workforce in training and practice; (2) financing of medical education; and (3) federal policies and non-federal efforts to ensure an appropriately trained physician workforce. After the discussion, the following issues were compiled in order to assist in directing future work and recommendations for COGME.

In regard to the supply, distribution and adequacy of the physician workforce in training and practice:

- Issues regarding the physician workforce should be differentiated from concerning those physicians in-training versus those already in practice.
- Those areas with shortages in specialties and subspecialties need to be identified and investigated, especially those areas that are beginning to experience shortages.
- Should physicians be trained to complement or accommodate the practice situations that currently exist to serve the needs of the population?
- Other groups or institutions, besides COGME, should look at how funding impacts training.
- Although Accreditation Council for Graduate Medical Education (ACGME) does not look at workforce or the requirements for residency programs, COGME should collaborate with ACGME to examine broader issues such as how health professions are prepared and how that affects safety and quality.
- The supply of the physician workforce should be analyzed in the context of access.
- Unemployment figures of physicians in medical specialties should be reviewed in discussing physician shortages.
- "Demand" is often being used when describing the needs of the U.S. population for physicians and specialty care. This approach should be focused on access and less on training of residents. Access to health care is a vital issue, specifically the ability of physicians to provide care in underserved communities and populations.
- Although mostly anecdotal evidence, the perception of a growing trend of specialist that are providing general or primary care along with specialty care and the magnitude of that care needs to be explained. Are more generalists providing more specialty care as a result of the shortage of specialists? The Mendenhall Study, which was a large, well-funded study done approximately 20 years ago, attempted to define the extent of primary care specialists were performing.
- Coordination should be done between COGME and HRSA to develop a model, similar to the one already in place at HRSA. HRSA currently uses physician supply and demand model, which basically looks at physician-to-population ratios in different settings by

demographic characteristics for more than 18 specialties on the supply and demand side. The HRSA model is a demographics-driven model and relies on existing information about utilizations rates in different settings.

- How can we train physicians to address geographic maldistribution? HRSA has a national aggregate model to obtain local geographic information. The data are limited to individual states and do not account for the impact by other states.
- A clarification is needed if access, geographic maldistribution, and specialty maldistribution are affected by incentives and reimbursements. What role does COGME have in these issues?
- Cost-effectiveness, quality, and outcomes need to be defined in order to develop an appropriate model.
- What is the impact on the current model by non-physician providers? What is the role of non-physician clinicians and their role in providing primary care?
- Workplace redesign and redesign of work performance as a method in addressing the workforce shortage.
- International Medical Graduates (IMGs) continue to play a significant role in the physician workforce and what impact they will have in the future needs review.
- Issues of global access need to be addressed, especially in regard to insurance model; the concept of "coverage" versus access; and the insured versus MC/MA versus the uninsured.

For financing of medical education:

- What is Medicare's and MEDPAC's role in financing graduate medical education?
- Another issue is that most of the teaching hospitals are providing uncompensated care and having the federal government pay for medical education.
- More accountability is needed regarding the funding for graduate medical education. What is COGME's role in recommending what the educational outputs should be?
- Hospitals and currently only two community health centers receive payments from Medicare. What then are the roles of teaching hospitals and them contributing to uncompensated care?
- Should COGME become involved with recommending the number of specialists needed in the physician workforce? In the past, COGME has always deferred to the specialty societies to determine their respective number of physicians. Further, MEDPAC has explicitly stated its lack of interest in using financing as a means to influence workforce.
- What is the impact of the increasing malpractice rate on graduate medical education, especially the growing trend of malpractice suits against residents? How does medical liability relate to the financing of medical education and patient care?
- Should hospitals receiving reimbursements also pay for ambulatory sites?
- The undergraduate debt burden is affecting specialty choice and will impact the future physician workforce.
- What is the possibility and likelihood of having flexible or target funding for graduate medical education to reflect environmental changes and to direct funding to meet the population's needs?

For federal policies and non-federal efforts to ensure an appropriately trained physician workforce:

- The federal government has historically had a limited role in dictating the physician workforce. Should the federal role be to ensure access to health care and, more importantly, funding quality care, specifically in training the physician workforce?
- The federal government should be involved in guaranteeing high quality care and access to care for the uninsured and underinsured.
- There should be fewer restrictions on hospital's opportunity to train physicians and less regulation on graduate medical education. Graduate medical education should be used to enhance the value and quality of health care providers to patients.
- Adequate funding should be provided for the development and research of the physician workforce data.
- The federal government needs to prepare the physician workforce for national defense and homeland security.
- The federal government should advocate for a program that mandates one or two years of public or community service in areas of health care disparities and physician maldistribution in exchange for debt reduction or other incentives.
- The federal government should articulate a set of workforce priorities and ensure that the programs it supports adheres to those priorities.
- In order to define the federal role in the physician workforce, the state role has, thus far, been variable and needs to be defined.
- The Council firmly recommends that the federal government establish an entity, whether it be COGME or an independent, autonomous advisory committee, that would continue to advise Congress and the Secretary on issues related to the health workforce. This advisory body should analyze the available data and invest resources into health services research.

The first day of the meeting adjourned at 5:04pm.

Discussion of update of COGME's twelfth report – "*Minorities in Medicine*":

The second day's deliberations included a presentation by **Rhonda Ray, Ph.D.**, on a draft report developed on behalf of COGME to update on the report, "*Minorities in Medicine*." The original report was disseminated as COGME's Twelfth Report in 1998.

This current report reviews the literature regarding the advancement of these goals since the 1998 COGME recommendations, assesses the progress made through 2003, and notes key findings. It also recommends ways to support the academic pipeline to facilitate minority entry into medical school, strengthen upstream (institutional and policy) efforts in medical training, and ensure cultural competence in medicine and medical education.

Research indicates that the greatest barrier to underrepresented minorities (URMs) admission to medical school is the low applicant pool of URM college graduates resulting from high attrition rates in high school and low enrollment in college. To increase the pool of URM medical school applicants, the retention of URM students must be addressed, both at the high school and undergraduate level. Increasing the number of URM physicians is an important step for

improving health care for minority and underserved populations and, consequently, for decreasing health disparities, one of the Nation's leading health priorities.

The recommendations made in the updated report addressed two main goals:

- Increase URMs in medicine, and
- Strengthen cultural competency of physicians.

Six main groups of recommendations were made (number of recommendations made under each group):

- Group 1: Strengthen programs and resources required to facilitate minority entry into medicine. (8 recommendations)
- Group 2: Enhance cultural competence. (5 recommendations)
- Group 3: Ensure minority medical career choice and entry into specialties. (4 recommendations)
- Group 4: Increase access to health care for minority communities. (2 recommendations)
- Group 5: Seek constitutional and legal efforts to increase minority entry into medicine. (1 recommendation)
- Group 6: Track minority participation in medicine. (1 recommendation)

The Council commended Dr. Ray on her well-detailed and researched report and approved it as COGME's 17th report, "*Update on Minorities in Medicine*." After the report is submitted to the DHHS Secretary and to the appropriate members of Congress, the report is expected to be distributed along with a summary letter requesting comments and responses that will be presented on COGME's agenda for its next meeting. After considerable discussion, the Council decided that due to the urgency of time, the report will not be vetted by selected organizations for comment prior to the report's transmittal to the Secretary and Congress. Rather, the Council directed that after the report is submitted to the DHHS Secretary and to the appropriate members of Congress, the report will be distributed to the public along with a summary letter requesting comments and responses that will be presented on COGME's agenda at a subsequent meeting.

The meeting on the second day adjourned at 10:24am.