COGME Meeting

November 18-19, 2009 - Rockville, Maryland

Agenda

November 18

8:30 a.m. **Welcome and Introductions**

- Russell Robertson, M.D., Chair

8:40 a.m. **Comments of Welcome**

- HRSA and Bureau Senior Management

9:00 a.m. **Presentation on the AAMC and the Physician Workforce**

- Darrell G. Kirch, M.D.
  President and CEO
  Association of American Medical Colleges

9:45 a.m. **Panel Presentation**

Does the Nation Have the Right Number and Mix of GME Slots?

- Edward Salsberg, M.P.A.
  Senior Associate Vice President and Director
  Center for Workforce Studies, Association of American Medical Colleges
- Fitzhugh Mullan, M.D.
  Murdock Head Professor of Medicine and Health Policy
  George Washington University School of Public Health and Health Services
- Robert Phillips, Jr., M.D., M.S.P.H., facilitator
  Vice Chair, COGME

11:15 a.m. Break

11:30 a.m. **Presentation of Bureau of Health Professions Physician Workforce Studies in Development**

- Tim Dall
  Vice President, the Lewin Group
- Sandra Karen
  Chief Operations Director
  Office of Workforce Policy and Performance Management, BHPr
- Charles Roehrig, Ph.D.
  Vice President, Altarum Institute

1:00 p.m. Lunch

2:00 p.m. **Presentation on the Adequacy of the General Surgery Workforce**

- Thomas Russell, M.D., F.A.C.S
  Executive Director
  American College of Surgeons

2:30 p.m. **Presentation on a Primary Care Recruitment Initiative**

- Patrick Dowling, M.D.
  Department Chair of Family Medicine
  University of California, Los Angeles

3:00 p.m. **The Role of MedPAC in Health Reform—Implications for COGME**

- Francis J. Crosson, M.D.
  Vice Chair, Medicare Payment and Advisory Commission

3:30 p.m. **The State of Health Reform in Legislation; Implications for COGME**

- Fitzhugh Mullan, M.D.

4:30 p.m. **Public Comment**

4:45 p.m. **ADJOURN**

November 19

7:30 a.m. **Convene in Writing Groups for COGME's 20th Report**

10:30 a.m. Break

11:00 a.m. **Plenary Discussion**

12:00 a.m. Lunch

1:00 p.m. **Re-convene in Writing Groups**

3:00 p.m. **Plenary Discussion of Near Final Drafts**

4:00 p.m. **Public Comment**

4:15 p.m. **ADJOURN**

Minutes

The Council of Graduate Medical Education (COGME) convened at the Hilton Washington D.C./Rockville Executive Meeting Center in Rockville, Maryland, at 8:35am November 18, 2009.

Members Present

Russell G. Robertson, M.D., Chairman
Robert L. Phillips, M.D., MSPH, Vice Chairman
Denice Cora-Bramble, M.D., M.B.A.
Joseph Hobbs, M.D.
Mark A. Kelley, M.D.
Jerry Kruse, M.D., M.S.P.H.
Spencer G. Nabors, M.D. M.P.H., M.A.
Kendall Reed, D.O., F.A.C.O.S., F.A.C.S.
Sheldon M. Retchin, M.D., MSPH
Vicki Seltzer, M.D.
Leana Wen, M.A., B.S.
Thomas Keane, M.D.
Wendy Braund, M.D., M.P.H., M.S.Ed (ASH)
Elizabeth Truong (designate for Tzvi Hefter of CMS)
Carole Pillinger, M.D. (DVA)

HRSA Staff Members:

Jerry Katzoff, Executive Secretary
Diana Espinosa, Acting Associate Administrator, Bureau of Health Professions (BHPr)
Daniel Mareck, M.D., Director, Division of Medicine and Dentistry, BHPr
Members Absent:
Jason C. Shu, M.D.
William L. Thomas, M.D.

Welcome

Dr. Russell Robertson, Chair, called the meeting to order and welcomed the COGME members and guests. Dr. Robertson announced his participation in meetings with the Medicare Payment Advisory Commission and the Brookings Institute.

Presentations to the Council

The first presentation was by Dr. Darrell G. Kirch, President and CEO of the Association of American Medical Colleges. The topic of Dr. Kirch's presentation was medical education with respect to pending health care reform. He covered points concerning the medical education continuum, from pre-medical school experiences through practice. He also covered issues concerning the adequacy of the physician workforce supply and the role of primary care in that supply. The presentation also covered core competencies needed for every physician. Laden through his talk were observations concerning the need to transform healthcare from "sick"-care to "health"-care and the implications these observations have for medical education. He described an emerging culture for healthcare, i.e., hierarchical to collaborative, competitive to team-based, and its implications for medical education.

The next two presentations focused on whether the nation has the right number and mix of GME slots. The first presenter on this topic was Edward Salsberg, Senior Associate Vice President and Director, Center for Workforce Studies, Association of American Medical Colleges. Mr. Salsberg described the upcoming "Perfect Storm" for the physician shortage crisis facing the Nation, which among other things included upcoming healthcare reform legislation, which would provide coverage to millions of Americans who do not currently have it, the Baby Boomer generation reaching retirement age, the ongoing obesity impact in the country, disparities among the poor and minorities, and more. He went on to describe the increase demand for services by the current patient population and provided data that within the next decade, the number of physicians entering retirement age will double. He also indicated that more and more physicians are working less hours and opting for a better quality of life.

The second GME mix presentation was conducted by Dr. Fitzhugh Mullan, Murdock Head Professor of Medicine and Health Policy, George Washington University School of Public Health and Health Services. Dr. Mullan began his presentation with a historical look at physician workforce supply in America since 1900. He went on to describe physician workforce characteristics between the U.S. and other countries and concluded his presentation with some of the physician workforce requests included in the current healthcare reform proposals.

The next three presentations focused on Bureau of Health Professions Physician Workforce Studies in Development. The first of these three presentations was given by Tim Dall, Vice President of the Lewin Group. Mr. Dall began with an assessment of the current and future state-level adequacy of primary care clinicians to include physicians, physician assistants and nurse practitioners. Mr. Dall provided detailed statistics on the current and anticipated supply and demand for these clinicians through 2020 and the adequacy of the current supply and demand by state.

The second presentation on the Bureau of Health Professions Physician Workforce Studies in Development was given by Sandra Karen, Chief Operations Director, Office of Workforce Policy and Performance Management (OWPPM), BHPr. Ms. Karen's presentation described the role and responsibility of the OWPPM, including its current activities, historical perspective, and applicable statutory authorities. She concluded her presentation with a list of recent reports and products the Office was responsible for developing.

The third presentation was given by Dr. Charles Roehrig, Vice President of the Altarum Institute. Dr. Roehrig described the Physician Supply Model (PSM) and Physician Requirements Model (PRM) developed by HRSA/BHPr. He concluded his presentation on current trends for physicians entering primary care.

After a brief lunch break Dr. Patrick Dowling, Department Chair of Family Medicine, University of California, Los Angeles, described his UCLA program to increase the number of bilingual and bicultural Hispanic family physicians in California. Dr. Dowling provided a very detailed look at the UCLA program and how it has adapted to a changing state population demographic and the anticipated shortage of 17,000 California physicians by 2015. Dr. Dowling indicated that the largest portion of the U.S. foreign-born population comes from Latin America, more specifically Mexico. One in every 10 people born in Mexico now lives within the U.S. and Mexicans now comprise 70% of all Latinos in America. He provided statistics about the U.S. surplus of GME positions versus Mexico's shortfall. There is anticipated to be between 400-2000 unlicensed IMGs in California alone. He described how the UCLA program focuses on pre-residency training to compensate for the extreme lack of knowledge of processes and skills for these IMGs to compete for residency positions. Dr. Dowling concluded his presentation to the council by describing the specifics of the UCLA program with respect to cost, challenges encountered, and immediate and long-term outcomes.

The next presentation of the day was given by Dr. Francis Crosson, Vice Chair, Medicare Payment Advisory Commission (MedPAC). Dr. Crosson's presentation described the composition and role of MedPAC and the commission's recent discussions pertaining to healthcare reform and GME.

Dr. Fitzhugh Mullan gave his second presentation of the day, which was focused on the Teaching Hospital Center and workforce provisions of the pending healthcare reform legislation. Dr. Mullan's presentation began with a comparison between the latest versions of the Senate and House healthcare reform legislation bills. He then discussed the importance of Teaching Hospital Centers with respect to promoting primary care and concluded with a review of the National Health Service Corps and how it would be affected by both pending bills.

The final presentation of the day was by Dr. Thomas Russell, Executive Director of the American College of Surgeons and focused on the anticipated coming shortage of general surgeons in America. Dr. Russell began his presentation with a short summary of historical acts that have led to this upcoming shortage. He compared the shortages of primary care physicians with those of general surgeons and how specialization has played a role in both.

The council then ended session for the day.

(Individual electronic copies of these presentations are available. Please send an e-mail to Shane Rogers to make your request.)

Review of Draft Recommendations

The council began its second day of the meeting at 7:30 a.m. The council members spent most of the day working on the development of their recommendations for its 20th Report.

Eric Moore, of the FocalPoint Consulting Group, was introduced as the contractor who will be responsible assisting the council with developing their 20th report.

The group then began supplementing and refining a base set of recommendations the council had developed during a number of conference calls conducted since September, 2009. For the calls, the council was divided into two separate groups. Group One was chaired by Jerry Kruse and co-chaired by Mark Kelley. Members consisted of Vicki Seltzer, Carol Pillinger, Ani Turner, Tom Keane, Bill Thomas and Leana Wen. Group Two was chaired by Sheldon Retchin and co-chaired by Bob Phillips. Members in the group consisted of Denice Cora Brambles, Joe Hobbs, Kendall Reed, Charlie Roehrig, Spencer Nabors, Jason Shu and Wendy Braund

During the session, the council came to agreement on a set of draft recommendations for which Jerry Kruse would work to synthesize and refine in a more presentable form send out to the council members.

Adjournment

Draft recommendations for the upcoming 20th report are listed below. These recommendations are still in a working status and will further be taken up by the Council at its next public meeting.

COGME 20th Report
Synthesized Recommendations – Working Groups 1 & 2
General Recommendations (DRAFT)

A. Primary Care.

Policies and programs should be implemented to enhance and support the practice of primary care, and to increase the supply of primary care physicians. Payment for physician services is biased in favor of hospital based and procedural services and does not provide appropriate incentives to enhance and support the practice of primary care, or to increase the supply of primary care physicians. Policy changes should be dramatic to remedy these legacy biases and have immediate effect. COGME recommends against policies that favor slow and incremental change.

B. The Number of Primary Care Physicians.

Policies should be implemented that raise the percentage of primary care physicians among all physicians to at least 40 percent from the current level of 32 percent, which is actively eroding since the proportion of current primary care trainees is even less. This goal should be measured by assessing physician specialty in practice, rather than at start of training.

C. Mechanisms of Physician Payment for Primary Care.

To sustain and support new physician specialty preference for primary care to attain a workforce of at least 40 percent primary care physicians, it is imperative that the incomes of primary care physicians be restored to at least 70% of median incomes of specialty physicians. Additional investments in primary care infrastructure, beyond reducing income disparity, will be needed to increase interest and improvement in primary care. Payment policies should be modified to support this goal.

D. The Premedical and Medical School Environment.

Medical schools and academic health centers should strategically focus and improve their choices of medical students and residents and design of educational environments to foster a physician workforce of at least 40 percent primary care physicians.

E. The Graduate Medical Education Environment.

GME payment and accreditation policies and a significantly expanded Title VII program should support the goal of producing a physician workforce that is at least 40 percent primary care. This goal should be measured by assessing physician specialty in practice rather than at start of training. Achieving this goal will require a doubling of current primary care production from residency training for a decade or more.

F. The Geographic and Socioeconomic Maldistribution of Physicians.

So long as inequities exist, policies should support, expand, and allow creative innovation in programs that have proven effective in improving the geographic distribution of physicians serving medically vulnerable populations in all areas of the country.

Specific Recommendations

B. The Number of Primary Care Physicians.

Policies should be implemented that raise the percentage of primary care physicians among all physicians to at least 40 percent. This goal should be measured by assessing physician specialty in practice rather than at start of training.

Congress and DHHS should:

1. Implement policies that raise the percentage of primary care physicians among all physicians to at least 40 percent.
2. Implement policies that result in 1 primary care physician for every 750 to 1000 people.
3. Implement policies that increase the supply of physician assistant, nurse practitioner, nursing and other staff positions committed to primary care.
4. Explore roles of Nurse Practitioners and Physician Assistants in specialties other than primary care and how those roles can be expanded to relieve need for non-primary care physicians.
5. Provide incentives and regulatory reform so that all clinicians and staff "work at the top of their degree" regardless of specialty or setting.

C. Mechanisms of Physician Payment for Primary Care.

To sustain and support new physician specialty preference for primary care to attain a workforce of at least 40 percent primary care physicians, it is imperative that the incomes of primary care physicians be restored to at least 70% of median incomes of specialty physicians. Additional investments in primary care infrastructure, beyond reducing income disparity, will be needed to increase interest and improvement in primary care. Payment policies should be modified to support this goal.

Congress, CMS, Medicaid, and Private Insurers should:

1. Develop innovative models of blended payment systems to incentivize practice and achieve appropriate payment levels for primary care. Blended models of payment should:
    a. preferentially increase fee-for-service payments to primary care practices;
    b. add significant payments for care-coordination to primary care practices;
    c. add pay-for- performance payments; and

    d. reward the PCMH financially when its physicians meet the four essential functions and the three corollary functions of primary care, and when measures of process and quality are met and improved.
2. Implement payment models that bundle payments for full-service accountable care organizations, and/or incentivize the development of community health care organizations that provide the four essential functions of primary care through collaboration of primary care physicians, public health, care coordination organizations and mental health organizations.
3. Institute further measures, such as the 2007 CMS RVU revaluation that will correct the inequities in the fee-for-service system and will provide higher payments for primary care services.
4. Dramatically expand payments for care-coordination. Congress and CMS should expand Medicaid programs and institute Medicare programs with appropriately high payments for care coordination to primary care practices that emphasize the four essential functions of primary care. Private insurers should institute similar care coordination payments to primary care physicians in primary care practices.
5. Authorize study of systems of pay-for- performance to assure simplicity and to assure that they are based on evidence that measures improvement of patients' symptoms, problems, functioning, resiliency and slow progression of ill-health.
6. Support the Patient-Centered Medical Home model (PCMH) as the construct for the practice environment that achieves optimal care coordination and integration, use of health information technology, enhanced access, appropriate payment, and study levels of funding necessary to sustain the model, and their impact on costs in settings other than physician offices.

D. The Premedical and Medical School Environment.

Medical schools and academic health centers should strategically focus and improve their choices of medical students and residents and design of educational environments to foster a physician workforce of at least 40 percent primary care physicians.

Medical Schools and Academic Health Centers should:

1. Develop an accountable mission and measure of social responsibility for academic medicine to improve the health of all, to collaborate with their communities and distribute resident training accordingly, to reduce physician income disparities, and to lead in the development of new models of practice.
2. Allocate resources to:
    a. increase the involvement of primary care physicians in the first two years of medical school;
    b. fund primary care interest groups;
    c. recruit, develop and support community physician faculty members; and
    d. require student participation in rural, underserved and global health experiences.
3. Expand medical school class size strategically to address the primary care physician deficit and maldistribution.
4. Reform admission processes to increase the number of qualified students more likely to choose a primary care specialty and to serve medically vulnerable populations.
5. Require block and longitudinal experiences of sufficient length that medical students clearly understand the essential functions of primary care and the medical home.

Medical Schools, Academic Health Centers, the AAMC, the ACGME, Congress, Regulatory Agencies, and Licensing Agencies should:

6. Reform the continuum of medical education, from premedical training through continuing education, to most efficiently impart general competencies and promote the choice of primary care careers.

The Federal and State governments should:

7. Provide increased incentives for physicians who practice primary care or other critical specialties in designated shortage areas.
8. Substantially enhance funding for scholarships, loans, loan repayment, and tuition waiver programs to lower financial obligations for students who plan and choose careers in primary care.

E. The Graduate Medical Education Environment.

GME payment and accreditation policies, and a significantly expanded Title VII program should support the goal of producing a physician workforce that is at least 40 percent primary care. This goal should be measured by assessing physician specialty in practice rather than at start of training. Achieving this goal will require a doubling of current primary care production from residency training for a decade or more.

Congress, the Administration, DHHS, Accrediting Agencies and Private Insurers should:

1. Strategically increase the number of new primary care GME positions and programs to accommodate the increased production of medical school graduates and respond to the need for a workforce made up of at least 40% primary care physicians.
2. Increase training in ambulatory, community and medically underserved sites by:
    a. removal of all regulatory disincentives including the community preceptor ruling;
    b. promotion of educational collaboration between academic programs and FQHCs, RHCs and the NHSC; and
    c. implementation of new methods of funding to include reallocation of existing GME funding, new GME funding that is not calculated according to Medicare beneficiary bed-days, and substantial expansion of Title VII funding specifically for community-based training.
3. Provide financial incentives for GME that:
    a. directly provide GME funding to primary care residency programs and non-hospital community agencies to provide the proper incentive for ambulatory and community-based training;
    b. augment payments for primary care residents, including differentially higher salaries and early loan repayments, to decrease the negative impact of educational debt on primary care specialty choice;
    c. fund all primary care residency programs at least at the 95th percentile level of funding for all programs nationally (using total DME and IME payments as a basis); and

   d. reward teaching hospitals, training programs and community agencies financially on the basis of number of primary care physicians produced to be determined by specialty in practice and not at initiation of training.
4. Change ACGME regulations to support more training in outpatient settings and experimentation with practice models to appropriately prepare residents for an evolving contemporary healthcare environment.

F. The Geographic and Socioeconomic Maldistribution of Physicians.

So long as inequities exist, policies should support, expand, and allow creative innovation in programs that have proven effective in improving the geographic distribution of physicians serving medically vulnerable populations in all areas of the country.

Congress and the Administration should:

1. Quadruple the funding for the National Health Service Corps so that the NHSC can recruit more primary care physicians, provide greater support of scholars, create special learning opportunities and networks for scholars and early loan repayers, and forge formal affiliations with academic institutions and training programs.
2. Quadruple the historic highest level of funding for Title VII, Section 747, Primary Care Medicine and Dentistry cluster grants.
3. Quadruple the funding for AHRQ, and recommend that indirect cost percentages for AHRQ grants equal the percentages for indirect costs for NIH Grants.
4. Implement programs to increase funding by AHRQ, NIH, and private research enterprises for projects that stimulate primary care and community-based research and emphasize methodologies such as population-based ecological and cluster studies, qualitative behavioral studies and comparative effectiveness research.
5. Increase funding for community health centers that commit to training students and residents and AHEC programs, particularly to raise low functioning AHECS to minimum functions.