COUNCIL ON GRADUATE MEDICAL EDUCATION (COGME)
Graduate Medical Education (GME) Planning Meeting
Webinar and Conference Call
April 7-8, 2016

Council Members in Attendance
In Person:
Gamini Soori, MD, MBA, FACP, FRCP, CPE, Chair
Kristin Goodell, MD, FAAFP, Vice Chair
Peter Angood, MD, FRCS(C), FACS, MCCM (April 8, 2016, only)
Erin Corriveau, MD, MPH
Lois Nora, MD, JD, MBA
Beth Roemer, MPH
David Squire, MPA
D. Keith Watson, DO, FACOS, FAODME

By teleconference:
Nida F. Degesys, MD
Kenneth Shine, MD
Karen Sanders, MD
Miechal Lefkowitz, MBA (April 7, 2016, only)

Others Present:
Joan Weiss, PhD, RN, CRNP, FAAN, Designated Federal Official, Council on Graduate Medical Education (COGME), Health Resources and Services Administration (HRSA)
Candice Chen, MD, MPH, Director, Division of Medicine and Dentistry, HRSA
CDR Daniel Coviello, MPH Deputy Director, Division of Medicine and Dentistry, HRSA
Kennita R. Carter, MD, Senior Advisor, Division of Medicine and Dentistry, HRSA
Marshala Lee, MD, MPH, Chief, Graduate Medical Education Branch, Division of Medicine and Dentistry, HRSA
Kandi Barnes, Management Analyst, Advisory Committee Operations, HRSA
Janeshia Barnard, Advisory Committee Operations, HRSA
Michael Diamond, Division of External Affairs, HRSA
Lauren Spears, MPH, Division of Policy and Shortage Designation, HRSA
Raymond Bingham, MSN, RN, Technical Writer, HRSA

Presenters:
James Macrae, MA, MPP
Luis Padilla, MD, FAAFP
Thomas J. Nasca, MD, MACP
Erin Fraher, PhD, NPP
George Thibault, MD
Susan E. Skochelak, MD, MPH
Janis Orlowski, MD, MACP

Thursday, April 7, 2016

Introduction

The Council on Graduate Medical Education (COGME, or the Council) convened its meeting at 8:30 a.m., on April 7, 2016. The meeting took place at the headquarters of the Health Resources and Services Administration (HRSA), 5600 Fishers Lane, Room 5A02, Rockville, MD 20857. The meeting was also accessible by teleconference.

Dr. Joan Weiss, Designated Federal Official, opened the meeting and conducted a roll call. She informed the Council that eight members were present in person or on the phone at that time, which did not constitute a quorum. She noted that other members were planning to join shortly by teleconference, and that the initial items on the agenda did not require a quorum. However, by statute the meeting would have to stop if member attendance remained below quorum. Other COGME members joined the call by 10 a.m. to achieve a quorum, and the meeting proceeded.

Dr. Weiss turned the meeting over to Dr. Gamini Soori, the COGME chair. Dr. Soori welcomed the Council members and stated that all COGME meetings are conducted in the public domain, with time set aside for public comment. Dr. Soori introduced the first speaker, Mr. James Macrae, HRSA Acting Administrator.

HRSA Overview

Mr. Macrae thanked the COGME members for taking the time to serve on COGME and for accepting the challenge of thinking about the future of graduate medical education (GME) in the United States. He shared that since taking on the role of Acting Administrator for HRSA in April 2015, he has been most impressed with the impact that HRSA has on the lives of people across the country. HRSA programs and services reach 1 in 3 individuals living in poverty, and 1 in 2 living with HIV. The National Health Service Corps (NHSC) has over 10,000 health professionals who provide primary care services to over 10 million people, many of whom live in medically underserved areas. The HRSA Maternal and Child Health Bureau reaches almost half of pregnant women in the United States for services such as prenatal care, while also dealing with emerging crises like lead in the drinking water in Flint, Michigan, and concerns about the Zika virus. Grants from the HRSA Federal Office of Rural Health Policy help provide care to over 800,000 individuals living in rural regions of the country. HRSA also supports all organ donations, with the number of transplantation procedures surpassing 30,000 last year for the first time, although the need remains much greater.

Mr. Macrae stated the strategic goals of HRSA as:

1. Improving the access to and quality of health care particularly in underserved communities and for vulnerable populations, and supporting delivery system reform with an increased focus on quality and value. He added that the Affordable Care Act (ACA) has made a significant impact in terms of providing access to health insurance.
2. Strengthening the health care workforce and promoting interdisciplinary, team-based care.

3. Building healthy communities, with a focus on preventive care and population health.
4. Addressing health equity, in terms of improving health outcomes in vulnerable populations and decreasing disparities in outcomes.
5. Improving HRSA's processes and operations to better serve the American public.

Mr. Macrae informed the Council that the HRSA budget request for FY 2017 is $10.7 billion, representing less than one percent of the total U.S. Department of Health and Human Services (HHS) budget. HRSA is proposing to increase the size of the NHSC, focus on the integration of behavioral health into primary care, and improve prevention and treatment of substance abuse and opioid addiction. Toward this last goal, HRSA is seeking ways to provide more training around opioid abuse, expand the rural opioid overdose reversal program, and get more information to health providers who are dealing with ongoing and emerging health issues. In response to several recommendations, HRSA has proposed changing the funding for the Children's Hospital GME (CHGME) program from discretionary to mandatory, recognizing this key resource in the training of pediatric physicians and specialists. HRSA is conducting an innovative pilot initiative through the Ryan White program to address management of patients co-infected with HIV and hepatitis C. Finally, HRSA has proposed to increase the home health visiting program, an evidence-based success in improving outcomes for pregnant women, young mothers, and families with small children.

Mr. Macrae referenced the recent new initiative at the National Institutes of Health (NIH) on precision medicine. He concluded by stating that he is looking forward to receiving recommendations and suggestions about the ways that HRSA, and the nation as a whole, can move forward to improve health care.

Discussion

Dr. Soori thanked Mr. Macrae for his informative and timely presentation, particularly in terms of healthcare delivery and the challenge to physicians in addressing population health. He added that medical educators are now engaging incoming medical students in learning healthcare delivery science, which was generally not discussed in years past. COGME has a role to play in addressing the training issues of the new generation of physicians.

Ms. Elizabeth Roemer asked about funding for the Teaching Health Center GME (THCGME) program. Mr. Macrae replied that the THCGME budget is funded through the Bureau of Health Workforce (BHW). The funding provided through the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) meant a reduction in the amount of money available for resident training. In the current President's budget, there is a request to restore this funding to previous levels and to expand the program.

Dr. Erin Corriveau asked about funding for interdisciplinary training programs, as several residency programs in family and community medicine have been successful with that model. She also asked about the tension between individual "precision" medicine and the community and population health model. In response, Mr. Macrae mentioned a cooperative agreement with the University of Minnesota to encourage more interdisciplinary training. A comment was added that HRSA's Primary Care Training and Enhancement (PCTE) program also

promotes interprofessional training by having physician assistants train alongside psychologists, pharmacists, and other health professions students. In terms of precision medicine, Mr. Macrae stated that the National Institutes of Health (NIH) has recognized the need to engage underserved communities and populations, and has reached out to HRSA to work with community health centers.

There was discussion about a potential consortium of government health agencies to prepare educational materials related to the growing problem of opioid abuse, for use by local health departments and medical schools. Mr. Macrae replied that HRSA has been working with the Centers for Disease Control and Prevention (CDC) and others, and referenced the recently released opioid prescribing guidelines from CDC.

Dr. Kristin Goodell described efforts in her home state of Massachusetts to deal with prescription drug abuse. She expressed a desire for a more comprehensive approach, starting with thinking differently about how to treat people with pain and avoid addiction to opioid medications. Mr. Macrae replied that HRSA has received feedback from frontline care providers on the difficulties of treating pain and breaking the cycle that can lead to opioid abuse, noting that patients and communities need to participate in finding the solutions.

Bureau of Health Workforce Overview

Dr. Soori introduced the next speaker, Dr. Luis Padilla, Acting BHW Associate Director. To open his presentation, Dr. Padilla reiterated the HRSA goal of strengthening the health workforce. He reviewed the process that BHW undertook to develop its own strategic plan covering 2016-18, in the face of a changing healthcare landscape and anticipation of a new administration.

Dr. Padilla stated that BHW resulted from the merger of two older bureaus, which enhanced the ability of HRSA resources to reach health professionals along all points of the career timeline, from early education to professional training to entry into service. BHW facilitates coordination and communication between HRSA's workforce programs to address shortages in underserved areas and to develop ongoing strategies to monitor and forecast long-term health workforce needs. The BHW strategic goals are to:

1. Guide and inform national policy-makers around health workforce development and distribution
2. Develop a strategic approach to health workforce investments
3. Strengthen academic, clinical, community, and public health partnerships
4. Inspire and align the Bureau workforce in support of the BHW vision.

Dr. Padilla stated that having a more diverse workforce increases the likelihood of providers working in underserved areas and critical areas of need, noting that 47 percent of HRSA-funded trainees are from minority populations and/or disadvantaged backgrounds. He added that the NHSC provides loans and scholarship opportunities for clinicians in primary care, and 87 percent of participants continue to work in areas of critical need beyond their obligation. Dr. Padilla noted that the president's FY 2017 budget requests an increase in funding for the NHSC, which

is heavily oversubscribed, that would go towards addressing the prescription drug and heroin use epidemic and an expansion of mental health services. As for transforming healthcare delivery, 23 HRSA programs involving over 2,600 students emphasized an interprofessional focus to help break down healthcare education siloes in academic year 2014-15. Dr. Padilla highlighted the THCGME program, which has trained over 550 residents each year since its enactment in 2011, with over 70 percent of those graduates staying in communities in need. He added that the Geriatric Workforce Enhancement Program works with community-based organizations and integrates behavioral and primary care.

Dr. Padilla concluded by saying HRSA is considering holding a broad meeting of several of its advisory councils, to allow Council members to get to know each other and share ideas, while promoting the concept of interprofessional training and collaboration.

Discussion

Dr. Soori stated that he was impressed that 40 percent of the funded training is conducted in underserved communities, noting the real challenge of retaining new physicians in underserved communities when they have other, more lucrative, employment options. Dr. Padilla replied that the NHSC program exposes trainees to a variety of communities in need.

Dr. Kenneth Shine commented that he had written in *Health Affairs* and others journals about the THCs, and that he was concerned about their connection to academic medical centers and about the instability of funding. He mentioned that several states are making investments to expand GME, using both Medicaid money and general funds, in the interest of building the primary care network, and asked if federal funds were available to the states to match these funds.

Dr. Padilla referred the questions to Dr. Candace Chen, Director of the HRSA Division of Medicine and Dentistry. Dr. Chen stated that many THCs have developed strong community ties but that some do not have access to a medical school willing to be a strong partner, and HRSA would not want to block those community sites from primary care residency programs. As to the funding question, she replied that HRSA is limited in what it can do by statute. However, HRSA has supported state-level initiatives, such as a cooperative agreement with the National Governor's Association which can help states learn from each other.

Dr. Keith Watson commented that 240 critical access hospitals in the Washington, Oregon, and Idaho region are scheduled to close over the next year, indicating that rural areas are increasingly at risk for losing health care services. These hospitals are excluded from GME funds, even though the THCs could place trainees there. He noted that the ACA has expanded insurance coverage, but people in rural areas may not have a place to go for services once a critical access hospital closes.

ACGME Strategic Planning: Intentional Embrace of Uncertainty as a Strategic Management Tool

Dr. Soori introduced the next speaker, Dr. Thomas Nasca, chief executive officer of the Accreditation Council for Graduate Medical Education (ACGME). Dr. Nasca described ACGME as an independent, not-for-profit, non-governmental agency that accredits over 10,000 programs involving more than 122,000 medical residents and fellows. ACGME has a voluntary board of directors, with three members from the public and two members from the federal government – one representative from HRSA and one from the Veterans Administration. He stated that there were currently separate accreditation systems in the United States for allopathic and osteopathic medical schools, but these are being combined into a single system. He added that ACGME also has an international arm, and currently accredits GME programs in eight other counties. ACGME is also working with the Education Commission for Foreign Medical Graduates (ECFMG) and the American Board of Medical Specialties (ABMS) to create oversight of the non-standard training of international medical graduates who come to the United States. Outside of accreditation, Dr. Nasca noted that ACGME had convened a meeting in the previous year to examine the growing problem of physician depression, burnout, and suicide.

Dr. Nasca said that ACGME formulated a strategic plan in 2005 that focused on moving away from a minimum standards educational accreditation (process-oriented) model to a continuous improvement (outcomes-oriented) model. To this end, the ACGME Executive Committee developed four strategic priorities:

1. Foster innovation and improvement in the learning environment
2. Increase the emphasis on educational outcomes
3. Reduce the burden of accreditation
4. Improve communication and collaboration with key stakeholders.

Dr. Nasca stated that the result was the emergence of the Next Accreditation System (NAS), which involves annual screening, an emphasis on departmental and institutional oversight, and a concentration on working to improve programs that underperform. NAS was marked by two unique programs: the Clinical Learning Environment Review (CLER), which involves a non-accreditation visit centering on safe practice, quality of care, resident supervision, and professionalism; and the Milestones project, which assesses the developmental trajectory of trainees. As part of the Milestones project, ACGME receives specialty-specific, behaviorally assessed "milestone" evaluations of every resident and fellow in the United States twice a year. The milestones will be revised in the upcoming years as validation studies are completed.

Dr. Nasca noted that healthcare delivery in the United States is not systematically planned at a national level. There is no strategic plan for healthcare in the United States. In contrast, Singapore has a clearly articulated national strategic plan and delivery model laid out to 2040. This is not the case in the United States, in that scope of practice is fluid with multiple drivers and to some extent is politically determined. Physician knowledge and skills must be adaptive over a 35-40 year career.

Recently, ACGME had gone through another strategic planning process that was designed to embrace, rather than mitigate, uncertainty about the future. He referred to this process as

alternate futures scenario planning, a methodology designed to deal with ambiguity and provide flexibility. While traditional strategic plans envision the most likely future and try to devise strategies to reach this future, scenario planning uses a framework involving several different possible scenarios of the future, examines the ambiguities in each situation, and devise strategies adaptable to each. He briefly outlined ACGME's strategic planning process.

The ACGME strategic planning process took place over an approximately two year period (2013-2015) and was led by the board of directors. The members of the board of directors are voluntary and consist of 34 members including – three nonmedical public members, and two members from the federal government (HRSA and Veterans Health Administration). ACGME engaged a broad audience of stakeholders conducting over 100 interviews with individuals from both academic medicine as well as healthcare, and outside of the United States, to try to understand the wide range of factors that would be influencing the future of healthcare. Analysis of these interviews found no consensus on the future shape and stability of healthcare delivery.

A core team, composed largely of internal organizational individuals, created 16 possible scenarios, addressing 56 drivers which included four major drivers of healthcare that are not directly related to healthcare. The four major drivers were: 1) U.S. economic vitality, either strong or weak; 2) the social contract, whether it was encompassing or narrow; 3) the degree of societal change, rapid change or very slow change; and 4) a gross measure of healthcare, its role in society, and whether healthcare was increasing or decreasing as a percentage of the gross national product.

Across the scenarios, there was no consensus on the future shape and stability of healthcare delivery. There was no single specialty mix distribution that fit all scenarios. There was no single model, for instance a single-delivery system for reimbursement did not emerge in this analysis. Since there was no consensus on the future shape and stability of healthcare, maximization of provider career flexibility would be crucial. Dr Nasca posed some of the following challenges impacting the profession: "What do you do if a specialty goes away? Think it's a theoretical construct? Ask cardiovascular surgeons that question, or ask nuclear medicine radiologists that question. These are real stresses on the system, and what do you do with those physicians? How do you create educational systems to support them in their transition, but also how do you, in the pipeline, create non-dead ended kinds of educational careers? It speaks to the degree of extreme early specialization, or it speaks against that model, which is currently in vogue." In addition, Dr. Nasca talked about ACGME's initiative to address physician burnout.

ACGME convened the formal organizations of the profession in November to deal with what we consider a pandemic in the United States of physician suicide, physician depression, and burnout, with most estimates of burnout in excess of 50 percent of practicing physicians, and with a depression and suicide rate that is greater than any other profession, in the United States now. ACGME considers it a crisis, and has marshaled with many other organizations to begin to address this problem.

Dr. Nasca concluded by saying that ACGME must continue to promote institutional and program excellence, be responsive to public need, and create standards that facilitate innovation.

Discussion

Dr. Soori thanked Dr. Nasca for a very thought-provoking presentation, adding that strategic planning often involves looking beyond the obvious. He mentioned the growing influence of technology, citing as an example a news item about the first delivery of medications to a remote health facility in Virginia by a drone. Common technological innovations such as smartphones are becoming more powerful tools, and will require regulation and accreditation processes to adopt.

A question was raised on how to increase the efficiency and decrease the cost and burden of accreditation. Dr. Nasca replied that burdens can extend beyond direct costs, to the time required to fulfill the accreditation requirements. He noted ACGME reduced the frequency of site visits for most programs and the extent of annual data requests, while redefining standards and promoting innovation. Dr. Nasca also mentioned a change to ACGME's approach, shifting from creating uniform standards to a system focused on milestones, individual performance in medical knowledge and clinical judgment, and aggregate outcomes.

Dr. Kristen Goodell asked Dr. Soori if he expected the ACGME strategic planning process to serve as a model for COGME in considering how to develop a national strategic plan for GME. Dr. Soori reminded the Council members that COGME had made a request to the HHS Secretary for the resources to develop such a strategic plan, and the response was that COGME serves in an advisory capacity, and developing such a plan is not within its charge. Dr. Soori noted that Dr. Nasca presented one strategic planning model, but that there are many models to consider. The mission of COGME is not to create a strategic plan for GME, but to articulate the need for one and provide some direction to push the concept forward.

Dr. Soori asked about the involvement of ACGME International with medical education accreditation in other countries. Dr. Nasca replied that ACGME International was formed in response to a request to help redesign the medical educational system of Singapore. He noted that standards of accreditation, local disease prevalence, and cultural aspects such as how doctors may relate to their patients or to other healthcare providers, are often very different in other countries than in the United States. As a result, an internist trained in Singapore may have a very different clinical experience than one trained in the United States. Dr. Lois Nora added that the American Board of Medical Specialties (ABMS) received a similar request from Singapore for help in developing a certification system. She stated that a major concern was the potential for "brain drain," if accreditation and certification contributed to doctors leaving countries with poor resources for careers in more developed countries. Another issue being talked about is that international medical graduates working in the United States are often precluded from board certification because they did not undergo ACGME-accredited training, so some specialty boards are exploring alternative pathways.

There was discussion about addressing the issue of the primary/specialty physician mix, and about the relationship of ACGME to medical student education. Dr. Nasca replied that ACGME has worked with the Association of American Medical Colleges (AAMC) and the

Liaison Committee on Medical Education, to produce 13 Entrustable Professional Activities that each medical student is expected to master prior to graduation, and other steps to ensure that trainees are ready to enter the graduate medical education phase.

Dr. Soori remarked on the push for competency-based advancement through the GME process, embodying the concept that different learners progress at different rates. Dr. Nasca stated that serious talk of accelerated graduation in GME is a long way off – while some students may learn at a faster pace, others will be slower, and all need to be competent to enter into clinical practice. He reminded the Council that milestones developed by ACGME serve as markers, but are not a comprehensive list of the competencies required of a practicing physician. He also brought up the role of mentored practice in developing the master physicians, clinicians, researchers, and teachers of the future, which could be disrupted by accelerated graduation.

Dr. Lois Nora reminded the Council that the end of residency does not represent the end of learning in medicine, and that many specialty societies are working on addressing the need for continuing education. She added her concern that 80 percent of the medical students in the United States come from families whose incomes are in the top 20 percent, meaning that many segments of the U.S. population remain under-represented in the medical profession. Embracing competency-based education could provide a significant opportunity to bring in disadvantaged students and educate them as physicians, even if that may mean extending the traditional length of medical education.

Presentation: Toward a National Strategic Plan for GME: Stakeholders, Data and Innovative State Approaches

Dr. Soori introduced the next speaker, Dr. Erin Fraher, a health workforce researcher from the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill. Dr. Fraher stated her research on workforce modeling was funded by the Physicians Foundation, and other work about the stakeholders in GME was funded through a cooperative agreement with the National Center for Health Workforce Analysis (NCHWA) at HRSA.

Dr. Fraher stated NCHWA contacted her team with a request from the HRSA Division of Medicine and Dentistry (DMD) to conduct an environmental scan of major stakeholders in GME, along with an assessment of each stakeholder's roles, perspectives, and interests. The first step was to generate an extensive list of all groups or organizations with an interest in GME. Next, her team organized this list by roles, including:

- Federal advisory groups (i.e. MedPAC, National Health Workforce Commission)
- Federal agencies (i.e. HRSA, CMS, Veterans Administration)
- Professional associations and other advocacy groups (i.e. the American Medical Association, Association of American Medical Colleges)
- Regulatory or accrediting agencies (i.e. ACGME, ABMS)
- Policy organizations or think tanks (i.e. Institute of Medicine, National Health Policy Forum)
- Private foundations (i.e. Robert Wood Johnson Foundation, Macy Foundation)
- State-level health agencies

- Hospitals and academic health centers
- Other community-based, administrative, and student organizations.

Dr. Fraher said that from this list, her group created a stakeholder map, ranking the organizations from low to high in two areas: interest in GME and power to change GME. They proposed that COGME would most want to engage those organizations with both high interest and high power, as well as certain others that might have unique characteristics such as helping to maximize efficiencies or addressing population health needs. Dr. Fraher indicated that the stakeholder list was not comprehensive and the selection process was subjective, so that the resulting map was primarily meant to serve as a starting point for discussion.

Next, Dr. Fraher stated that there are proposals to expand first-year residency slots, and her team wanted to develop a methodology for allocating such slots based on projections of workforce needs by geography and by medical specialty. The team incorporated several data sources to project both the supply of the physician workforce and the demand for physician services over the 10-year period from 2016 to 2026. They used a "plasticity matrix" model based on national patterns to match the demand for services with the types of providers who can fulfill those services. The plasticity matrix can translate the anticipated number of health care visits into the number of providers needed by specialty. She emphasized that the model looks at the number of health care visits as opposed to the number of physicians needed to provide care. By allotting projected GME slots to the areas of greatest need, the team found they could equalize access to care across different geographic regions. Dr. Fraher cautioned, however, that in the real world physicians and other providers can move to different areas and into different specialties, so problems of equal access may remain.

Dr. Fraher noted some unexpected findings. For instance, the model predicted a relatively small expansion in geriatrics, despite the aging of the population. Upon closer examination, they noted that the plasticity matrix looks at current utilization patterns, and general internists are providing the majority of care for the elderly, rather than specialists in geriatrics. In other areas such as pediatrics, specialists are actually providing a lot of primary and generalist care. However, as delivery and reimbursement models change, the plasticity matrix will shift as well. More services are likely to shift to generalists, as well as to providers such as physician assistants and nurse practitioners. In addition, more care will move from inpatient to outpatient settings. She noted that these workforce projections will need to be reviewed and interpreted by experts, who can also consider such issues as the ability of different states to provide quality training and the need to "cluster" some specialties to achieve the greatest impact.

The next step for this modeling is to adapt a plasticity matrix to local labor markets to better reflect what was is going on at the state level. Dr. Fraher described several initiatives currently underway in several states to develop new models of allocating Medicaid and state funds for GME. She noted that most of these initiatives include the creation of an oversight body consisting of members from hospitals and other stakeholders, to make sure these funds are providing the greatest return on investment and meeting the health care needs of the state.

Discussion

Dr. Soori noted that several states have been innovative in addressing GME funding, but that each must create its own model for governance. He believed this variation might create a "business opportunity" for COGME to address on a national level. Dr. Fraher replied that her group is planning to develop a document with several case studies for states to follow, and that Dr. Chen had discussed GME models with the National Governors Association.

Dr. Nora asked about the appropriate level of oversight for GME funding. Dr. Fraher stated that governance of GME at the state level focuses on overseeing Medicaid investments plus any state appropriations, while federal oversight focuses more on Medicare funds. She added that workforce modeling itself may be best done at the state level. More discussion centered around best practices for developing state-level GME governance boards, particularly in terms of the distribution of GME residency slots. Dr. Fraher noted that such governance boards are often dominated by larger schools and health systems with designated GME slots, and may not fully represent smaller stakeholders such as community health centers and THCs, where many believe GME needs to shift.

Mr. David Squire observed that the list of stakeholders should include dentistry, noting that poor oral health is linked to school absence, as well as diabetes, hypertension, heart disease, and behavioral health problems. Dr. Fraher agreed, and added that the workforce projection study could be applied to dentists as well. There was further discussion on the ratio of positions in primary care or generalist versus specialties. Dr. Fraher answered that her model could be used to look at different mixes of primary care physicians to specialists, and referred to a point from Dr. Nasca's talk indicating the need to create the most flexible workforce for the future.

Panel: GME Strategic Directions

After a lunch break, the Council reconvened for a panel discussion on GME strategic directions. Dr. Soori introduced the first panelist, Dr. Janis Orlowski, Chief Health Care Officer at AAMC.

Dr. Orlowski stated that the AAMC mission is to serve and lead the academic medicine community to improve the health of all, and AAMC has had a long involvement in physician workforce projections. In the previous year, though, they modified their approach to make these projections under several possible scenarios over the next ten years, such as expansion of the ACA, increased use of retail health clinics employing nurse practitioners and physician assistants for primary care, and the expected retirement rate of current physicians. From these scenarios, two issues stood out – an ongoing shortage of primary care physicians, and a shortfall in several surgical subspecialties.

Then, using data from 2014 only, the AAMC found that the physician workforce would have needed to expand by 40,000 to 96,000 physicians if all individuals across the country had health insurance and accessed health care services at a comparable rate. This analysis highlighted the potential impact on the physician and healthcare workforce of achieving equitable access to health care, a primary goal of the ACA.

Dr. Orlowski discussed a five-year initiative underway at AAMC to optimize GME in several areas, including: the cost and accountability of services and funding; the GME learning environment and the community; the assessment of core competencies; and the duration of training. AAMC is also looking into ways to improve the transition from GME to medical residency, and address some of the significant problems reported by program directors and institutional officials. She noted that AAMC has developed tools and strategies that may be helpful to COGME, such as ways under current law to work with rural and/or non-teaching hospitals to increase GME slots, and address physician shortages in rural or underserved areas.

Next, Dr. Soori introduced Dr. George Thibault, President of the Josiah Macy Jr. Foundation, a major stakeholder organization that has produced multiple reports on improving GME.

Dr. Thibault started by saying that several societal forces are driving the need for GME reform. These include an evolving health care system, changing patient demographics, new technologies for care delivery and health information, a renewed focus on quality and safety, demands to increase the involvement of patients and their families in health care decisions, and concern over growing costs. Within the GME enterprise, there are tensions between service and education, and between autonomy and supervised practice. There is also a growing awareness of the need to balance humane duty hours with continuity of care and the experiential needs of the trainees.

Dr. Thibault listed some goals for reforming GME: (a) adding new content focused on patient safety, population health, and an understanding of the social determinants of disease and health, while incorporating new technologies such as simulation, asynchronous online learning, and the electronic health record into training; (b) exposing residents to a greater diversity of patients and health conditions outside of acute care hospitals; (c) aligning physician specialty mix and location with societal needs; (d) providing more team-based interprofessional training, both by involving students in different medical specialties and by working with students from other health professions; (e) encouraging greater engagement of families and communities in the design of programs; and (f) gaining complete institutional and faculty engagement.

Dr. Thibault noted that undergraduate, graduate, and continuing medical education have been governed separately, but now educators need to work together to focus on the continuum of education. He added that training needs to have a more flexible and competency-based approach that allows trainees to move through the system at their own pace, and to be individualized to prepare trainees for different career pathways. He noted that the Macy Foundation has held several regional meetings exploring state-level interventions that have resulted in new partnerships between schools of medicine and healthcare systems, and helped prepare residents to practice in rural and other underserved areas.

Dr. Thibault added that the system needs to remain accountable to the public for the investment of tax dollars in GME training. There is a need to link medical education with health care delivery reform, under the realization that GME programs and trainees can improve access to health care, drive health care reform to meet the needs of underserved populations, and help redesign patient services across the country.

Finally, Dr. Soori introduced Dr. Susan Skochelak, Group Vice President for Medical Education at the American Medical Association (AMA). She is the lead author of an article, *Creating the Medical Schools of the Future*, which was provided to the Council members for advance reading. Dr. Skochelak opened her presentation by stating that AMA advocates for the modernization of GME to prepare the next generation of physicians to meet the demands of 21st century medicine. Dr. Skochelak added that the AMA Council on Medical Education has produced reports on the value of GME and sources of GME funding. In 2013, the AMA started work on a new strategic plan which includes three prongs: improving health outcomes, promoting thriving physician practices, and creating the medical schools of the future.

According to Dr. Skochelak, schools looking into accelerated medical education have found that while many students may be able to shorten their time in school, others need more time to learn. A competency-based approach can allow for flexible and self-directed learning plans, with faculty serving as coaches in allowing students to set their core learning objectives and putting them on a pathway of lifelong education.

Dr. Skochelak added that the AMA initiated a five-year grant initiative to address undergraduate medical education (UME), called the Accelerating Change in Medical Education consortium. Now covering 32 schools, the consortium is working to improve medical curricula by integrating basic and clinical sciences, adding new material and new exercises, and developing partnerships with healthcare systems. She noted that the AMA has added health system science, which covers quality improvement, patient safety, and team based care, as a core science for medical education to address improvements to the health system as a whole. For example, Indiana University School of Medicine created a teaching electronic medical record that can be a key tool for training students in the use of this very important piece of technology. Meanwhile, some schools have students work as patient navigators to gain insight into how the healthcare system works from the point of view of the patient and the family. According to Dr. Skochelak, these AMA-supported changes in UME will have an impact on GME by training students to be self-directed learners and enter residency better prepared to work in systems-based practices and team-based care.

Discussion

Dr. Soori invited questions for the panelists. Dr. Orlowski was asked about how the state-level movement to allow independent practice for more "midlevel practitioners" such as nurse practitioners and midwives, physician assistants, and clinical pharmacists, would affect projections of the physician workforce. Dr. Orlowski stated that these practitioners help address the nation's primary care needs, and that AAMC accounted for these trends.

Another question was raised in regard to state governments that have attempted to enact legislation to create a new category of provider, the "assistant physician," to apply to GME graduates who do not get matched to a residency in their first attempt. Dr. Orlowski replied that AAMC had studied these "unmatched students." Several go into research or return to school to get a second degree, and are matched at a later date. Others go into such areas as healthcare information technology, and may never have intended to practice medicine. Only a

very small number of students do not match and do not re-enter residency or have a second career.

Dr. Soori stated that the GME enterprise faces frequent criticism for being too long, inefficient, and costly. Dr. Thibault commented that the current system remains too hospital-centric, and that training settings need to diversify to match the needs of the public and provide new career pathways. He cited the THCGME model, funded through the ACA, as a novel approach to GME. He noted that the GME system may move toward multiple funding sources, but that the need for governance remains to make sure educational and health care standards are retained.

Dr. Shine noted the increasing focus on population health and asked if public health approaches such as epidemiology and statistics to study population outcomes should be brought back into medical education and research. Dr. Thibault agreed that the disconnect between public health and medicine no longer served the public's needs. He mentioned a recent paper he had published about public health education reform in the context of reforming all health profession education. He believed that clinicians would benefit from the insights of public health, while public health would benefit from a greater understanding and insight of into clinical medicine and the challenges facing health practitioners.

Presentation: Creating a Strong Mission and Powerful Vision: Toward a Strategic Plan for GME

Dr. Soori introduced Dr. Kennita R. Carter, Senior Advisor in the Division of Medicine and Dentistry at HRSA. Dr. Carter expressed a personal connection to the days' discussion, as both her mother and grandfather were physicians who practiced in underserved communities. She briefly reviewed the past proposal by the Council to develop a GME strategic plan, which was rejected. Still, COGME could provide advice on the need for strategic planning in GME and serve at the forefront by developing a strong vision and mission for GME, along with a set of guiding principles. She added that several past COGME reports had articulated core values of GME such as diversity, accountability, and flexibility. She stated that a strong vision statement serves to communicate clearly, point to the future, and inspire and uplift, while a strong mission statement focuses more on "the what and the why" of an organization or initiative.

Breakout sessions

The Council then broke out into three different groups, with the objective of drafting versions of a vision statement, mission statement, and core values. After the sessions, the Council reconvened to review and discuss the draft statements.

Group 1

Group 1 proposed as a mission statement: to prepare the nation's physician workforce to meet the population's health care and health needs through progressive stages of independence and competency development. They offered two vision statements: (1) preparing our physicians in training to practice high quality, value-based medicine that meets the needs of their patients and

the public, (2) transforming medical education through innovation in order to prepare physicians to be proficient in sub-specialty competencies.

For guiding principles, the Group 1 proposed: (1) multiple pathways to develop future administrators, leaders, policymakers, researchers, clinicians, and educators; (2) addressing social justice and social determinants of health, and population health; (3) transforming clinical practice environments to include team-based care; (4) improving geographic distribution and specialty mix; (5) improving cultural competency and (6) addressing health literacy.

There was discussion about including workforce diversity. While more women are entering medicine, other groups remain underrepresented. In acknowledging that the current physician workforce lacked diversity, there was a concern that this issue might not be addressable through GME as promoting diversity goes back to medical school admissions, and even further into college or pre-college years. There was a discussion about the importance of mentoring and communication which might promote more diversity.

Group 2

Group 2 reported that the key idea in its vision is to have a GME system – there are organizations that offer GME and others that credential GME, but there is no coherent GME system. The proposed outcome for a GME system would be: excellently prepared health professionals who meet the health needs and improve the health of the community. For a vision statement: a system of continuous post-graduate education and training that provides excellently prepared health professionals that meet the nation's health care needs.

Guiding principles included: creating a coherent, evidence-based GME system; flexibility with GME training so that the number of allocated slots and different specialties can change over time; achieving the right balance of specialty and subspecialty versus primary care; promoting a geographic distribution that meets society's needs; lifelong learning and professional development; a focus on excellent, high-quality care; and continuous quality improvement. The group reported that their discussion also covered the value of GME and how federal funding is a good investment in improving the health of individuals and communities.

Group 3

Group 3 proposed two mission statements: (1) to educate the highest-quality and compassionate physicians to serve all segments of society with concern for the welfare of trainees and educators, and with financial accountability, responsibility, and transparency; (2) to prepare the next generation of providers by coordinating GME training; transferring knowledge and scholarly activities based on continuous quality improvement (CQI) principles; and providing equitable funding based on both local and national needs.

The group proposed four vision statements:

1. We want to provide the world's most advanced medical education for our physicians.

2. We take responsibility to ensure excellent and equitable care for all individuals and communities through training health care professionals steeped in quality and compassion.
3. To ensure the nation has the healers, educators, and leaders who will provide equitable, patient-centered, evidence-based healthcare services, and improve the total health of all populations.
4. To train the next generation of life-long learners.

There was some concern over the use of the word "healers," and how it might be interpreted, particularly among interprofessional groups. There was further discussion about the inclusion of other disciplines, such as dentists.

The group also proposed a list of guiding principles:

1. To eliminate health disparities
2. To train high quality physicians, who are stewards of health care resources
3. To improve patient experiences through patient- and family-centered care
4. To support physicians and health care systems that are accountable for equitable funding
5. To commit to pipeline systems that create the physician workforce that reflects the diversity of the population served
6. To commit to physician wellness
7. To promote innovation in the educational system that aligns with society's changes

Dr. Soori referenced the letter from May 2015 from COGME to the HHS Secretary, which outlined several principles: integrate future manpower predictions with the needs of the country; better align the GME system with national priorities; maximize efficiencies presently lacking in the system; add transparency to the funding of GME; and establish an enduring method for continuing to realign physician training with the needs of the country.

There was discussion on the notion that the GME training system is too long and too costly, particularly for specialties such as surgery. It was suggested that COGME could examine models from other countries in regard to the length of medical education.

Public Comments

At this time, Dr. Soori opened the meeting for public comment.

The first to comment was Dr. Stan Kozakowski, of the American Academy of Family Physicians. Dr. Kozakowski supported the comments by Dr. Goodell about the lack of a cohesive system within the United States for GME, with no unifying principle to guide the annual $15 billion investment of public funds in GME. He also expressed hope that COGME will connect with a wide variety of stakeholders in developing its strategic plan report.

The next comment came from Holly Mulvey, Director of Workforce and Medical Education Policy at the American Academy of Pediatrics (AAP). She reminded the Council that pediatrics

has a different funding stream for GME, and the majority of funding does not come from Medicare. She stated that AAP had recently finalized a policy statement about GME funding.

Discussion

There was some discussion among the Council members on how to proceed with the information presented in the day's meeting. It was confirmed that COGME will engage key stakeholders in the developed product related to mission, vision, guiding principles. It was noted that HRSA does not have financial resources, and has limited staff resources, so much of the work of the strategic plan report will have to be done by the committee. One task will be to shorten and focus the list of stakeholders to engage in the planning process.

Dr. Weiss stated that Drs. Shine, Corriveau, Watson, and Soori were due to rotate off of the Council but will be extended until November 2016, by which time it is hoped the report will be ready. She added that a list of new nominees for the Council has been put forward, and is working through channels.

Dr. Soori stated that the strategic plan report process does not end with the vision, the mission, and the guiding principles. It is a multi-tier process, and will likely involve future COGME involvement. He asked if it was allowed for COGME to post a draft work in progress to its web pages as a way to obtain public comments. This possibility would be explored.

There was a question about funding support to COGME for the strategic planning process. Dr. Soori clarified that COGME cannot request funds to do the strategic planning, but through its report it can work to move the needle a little bit more towards creating identifiable strategies and the goals. Dr. Weiss added that the work of COGME is limited to gathering information with the purpose of making recommendations to the Secretary and Congress, and that COGME is not developing or writing a strategic plan. COGME is looking to come out with a vision, mission, and guiding principles to recommend to the Secretary and to Congress.

Conclusion

The meeting was adjourned for the day at 5:00 p.m.

Friday, April 8, 2016

Dr. Soori called the meeting to order at 8:00 a.m. and welcomed Dr. Peter Angood, a Council member who had missed the first day of the meeting. He then introduced Laura Ridder, HRSA ethics advisor.

Presentation: Federal Ethics

Ms. Ridder provided the Council members with an overview of the ethics rules for members of federal advisory committees, who serve as special government employees (SGEs) for the time of the committee service. She stated that the definition of an SGE is "someone who serves 130 days or less in the Federal Government as an employee." The presentation covered conflict of interest, standards of ethical conduct, and restrictions on outside activities.

There was discussion among the members about how the specific ethics rules might cover the efforts of COGME members to interact with their own organizations and others as stakeholders in the GME strategic planning enterprise. Ms. Ridder addressed the questions and provided her contact information, encouraging any members to contact her or her colleagues in the HRSA ethics office with any further questions or concerns.

Review of Day 1

Dr. Soori quickly reviewed the presentations and discussions of the previous day. There was some discussion about what the Council was striving to achieve. Dr. Soori emphasized that COGME is looking to create a mission and a vision statement for the GME enterprise. From his experiences with strategic planning, he commented that a vision statement should be succinct, like a slogan, describing "where we want to be." A mission statement should be broader and more encompassing, helping to define "who we are and why we exist." He noted that the individuals at the center of the GME enterprise are the trainees, while major stakeholder groups include educators, academic medical centers, and teaching health centers. The goal for the Council is to describe what a national GME enterprise should look like as a coordinated effort.

Dr. Shine agreed, saying that COGME is looking to provide a framework in which society can reach some consensus on the direction of GME. The GME mission should be to train graduate physicians who will provide competent care while producing a workforce distribution and specialty mix to meet society's needs, a key element in advancing the strategic planning process.

Dr. Angood expressed concern that the vision and mission statements that came out of the first day did not relate to the core competencies for trainees as embraced by ACGME and ABMS. He noted the important concept of professionalism in delivering care. The health system is evolving rapidly, and the providers themselves need to be involved in improving the system.

A comment was made about emphasizing the ways in which GME meets the healthcare needs of the broader society. Another comment noted that one of the proposed vision statements refers to "health," while the mission statements tend to refer to "health care," and these are different concepts. Other discussions brought up the ideas expressed in the previous day for a seamless

system, the need for providers to be involved and dynamic, and the need for a continuum of education involving undergraduate, graduate, and continuing medical education.

Dr. Watson stated that the important principles in affecting public policy are to be accountable, efficient, data-driven, and responsive to the needs of society. There was further discussion on the wording of the vision and mission statements. He added that one of the criticisms of the current GME system is the lack of coordination. The biggest argument in favor of a strategic plan for GME is to promote coordination and support funding that is consistent, adequate, appropriate, and relevant.

There was some discussion over wording, exploring the use of the terms "doctor," "physician," or even a more generic term like "healer." In reviewing the COGME statute, the term used is "physician," and it was suggested that this would be the best choice going forward.

Dr. Soori thanked the Council members for their ideas, and suggested moving on to look at the guiding principles. He said one benefit of a strategic planning process was to examine the inefficiencies of the current system to see how it could be reformed and improved. He noted the opportunity to incorporate newer learning methods, such as simulation techniques and new technologies to train surgeons. So, one of the guiding principles should include opportunities for innovation and improving the efficiency of GME.

Dr. Shine suggested addressing the public policy issue of governance of the GME system. He emphasized the need for data to formulate policies on such issues as medical specialty distribution supported by the Centers for Medicare and Medicaid Services (CMS), and the need for both federal- and state-level governance. Dr. Watson added the importance of integrating the sources of GME funding. He described working with the current system of funding through THCs, CMS, the Veterans Health Administration, and even for certain populations, such as, the Department of Defense, as extremely complex. Mr. Squire emphasized the need to separate out clinical care skills and professionalism skills, along with systems-based quality improvement.

Dr. Shine indicated that there was the potential for a large number of guiding principles, which would need to be sorted into different groups. Dr. Soori warned against going too deeply into process issues with the guiding principles, wanting to keep them general and broad as they are meant to guide the initial thinking. Dr. Shine felt the principles needed to be specific enough to capture the attention of policymakers in HHS and Congress, while including a process for state planning and oversight.

Dr. Watson noted that state legislators are often bewildered over the concepts of GME, so the locus of control for the GME system needed to be federal. Mr. Squire agreed with the need for federal oversight to equitably distribute funds across all states and regions, but believed that the data leading to the disbursement of funds needs to come from the local level.

There was a question about the purpose of the guiding principles. Dr. Soori replied that the planned COGME report would include recommendations, and one might be to have the Congress and the Secretary of Health and Human Services take on the idea of developing the strategic plan and determine the feasibility of accomplishing it. Another question addressed the issue of

controlling the funding streams for GME in a coordinated, integrated, and coherent system. Dr. Soori noted that the coordination of GME funding was a major concern of an Institute of Medicine report, which made a recommendation for two entities: one to coordinate and oversee the GME enterprise, and the other to coordinate funding.

Dr. Goodell asked if COGME would have a continuing role, in the event a new federal body was created to oversee GME. Dr. Soori replied that COGME is the only Congressionally authorized advisory board for GME, and it would retain this advisory role. Several other members offered comment on the continuing role of COGME in advising and overseeing a federal GME entity. However, it was noted that COGME does not have the authority or resources to carry out the oversight of the full GME system. The role of COGME in any future system as defined by a strategic plan could only be determined by Congress.

Discussion: Engagement of Stakeholders

Dr. Soori moved to the next item on the agenda, a look at the potential list of stakeholders with an interest in the GME enterprise. He noted that COGME had been provided with an extensive list, which needed to be winnowed down. The Council would need to select stakeholders to be contacted and provided with preliminary versions of the work products, including the vision and mission statements and the guiding principles, with an opportunity to provide feedback.

Dr. Angood mentioned that he is chair of the steering committee of a newly formed initiative called the National Coalition for the Improvement of Clinical Learning Environments. He noted that this organization is already struggling with whom to include within this coalition. As a result, he recommended a limited initial approach to the types of organizations included as stakeholders.

There was extensive discussion around the characteristics an organization should have to be included on the stakeholder list. It was suggested that "umbrella" organizations representing several stakeholders might help to keep the list as short as possible while allowing for input from the widest range of groups. There were suggestions to include organizations representing resident physicians, medical specialties, children's hospitals, and various consumer organizations. It was noted that including an organization like the AMA could be valuable for buy-in.

The question was raised about what documents or information COGME would send to the selected stakeholders. Dr. Soori recommended the vision and mission statements, the list of guiding principles, and a fourth question that was open-ended, providing an opportunity for comments on preferences for a national GME strategic plan.

Dr. Shine stated that the request should include a preamble to the material indicating some of the current issues and concerns of GME, along with certain questions such as:

- Do you think there would be value to developing a national strategic plan for graduate medical education? Would you support such a development?

- If there was to be such a strategic plan, should COGME coordinate its development? If not, what other entity or entities do you think should oversee the plan's development?
- Who should be involved in the completion of the plan?

There was discussion about the mention of COGME, as reference to any specific entity might disrupt the development of a consensus on the need for the strategic plan.

Travel Guidelines

Dr. Soori introduced Ms. Regina Wilson, the HRSA travel advisor. Ms. Wilson reviewed the requirements for advisory council members when making travel arrangements to attend a meeting, and the documentation required. There were several questions related to specific requirements, and arrangements for for those who came from more distant areas. Ms. Wilson provided her contact information for any further questions.

COGME Business Meeting

Dr. Weiss moved to the business meeting for COGME. She stated that Dr. Soori was the chair, and Dr. Goodell the vice chair. In the previous meeting, the Council had decided to implement a succession plan in which the chair serves for a year, then moves to the role of past chair, while the vice chair assumes the role of chair, to provide for continuity of leadership and the incremental building of knowledge and responsibilities. Dr. Weiss indicated that Dr. Soori would be rotating off as chair, and Dr. Goodell would be assuming the role of chair, so the Council needed to select a new vice chair. Dr. Nora was nominated and the nomination was seconded. There were no other nominations. Dr. Nora was elected by unanimous consent.

Dr. Weiss also mentioned that the Council members would be receiving an evaluation sheet to complete on the meeting, and asked all members to provide their feedback. The business meeting was then closed.

Stakeholder Discussion (continued)

Dr. Soori re-stated COGME was going to send out information to the selected stakeholders, provide a deadline to send a response to HRSA staff, and then the staff will collate and summate that information in some fashion to allow the Council to make meaningful observations. Dr. Shine noted that there are 24 stakeholder organizations identified from the earlier discussions. Dr. Weiss noted that each Council member could research two of these organizations to identify the most appropriate contact. HRSA staff would draft a letter, with the approval of Dr. Soori, to distribute to these contacts. HRSA staff would collect, collate, and summarize the responses, and provide the summary to a subcommittee of the council to review and write proposed recommendations for the 23rd COGME report.

Dr. Soori clarified that the 23rd report will contain recommendations to develop a strategic plan for GME, and some of those recommendations would be embodied in the founding principles that COGME developed. He added that there may be additional recommendations related to creating a mechanism for funding. The Council may also make a recommendation for where this

enterprise would be located, either within HHS or as a separate entity. Dr. Weiss added that the Council members could let her know what organizations they wanted to contact, but that the larger concern was the letter to go out to the stakeholders. She suggested keeping the letter concise, with some open-ended questions. Dr. Soori noted that Dr. Shine had offered some questions to include in the letter, with one question being: would you support a national GME strategic plan? A council member suggested getting input from Dr. Thibault with the Macy Foundation. Further discussion ensued about the content of the letter and the questions to ask.

A request was made to form a writing group to review the stakeholder document before distribution. Drs. Soori, Shine, Corriveau, and Nora volunteered to work with HRSA staff.

Dr. Soori stated that HRSA staff would develop a document containing the draft mission and vision statements and the guiding principles, and a brief set of questions for the stakeholders. The document would be provided to the initial writing group for review and revision before it is sent out. Ms. Roemer stated that the Council would not want the stakeholder recipients to engage in wordsmithing, but rather to voice their alignment with the statements and principles.

Dr. Angood brought up the issue of working with the ECFMG, including discussion around physician shortage and the matching of unfilled slots with international medical graduates. Dr. Shine emphasized the importance of getting people from a broad cross-section to buy into the notion of the need for a national GME strategic plan. There was a proposal to have stakeholders list three challenges they saw in the current GME system. The COGME report could then acknowledge the challenges, and indicate that the strategic planning process would review and address the challenges. It was discussed that getting buy-in to the plan was a vital early step.

The Council was reminded to "not let the perfect be the enemy of the good," in revising the vision and mission statements, and to keep the statements brief and focused.

GME Report Outline

Dr. Soori moved the discussion to the outline of the COGME 23rd report. He reviewed the structure of the COGME reports. The sections include a background, a discussion of the current topic, a presentation of specific reports, initiatives, or studies in support of the need for change, and a list of recommendations, with a conclusion to tie the full report together. From this meeting, the Council has already decided on draft versions of a vision statement, a mission statement, and guiding principles, and these can be reviewed and revised before going out for stakeholder comment. The stakeholder feedback will provide a much broader perspective to include in the report, and a better idea of what recommendations are needed to move the needle forward toward the national GME strategic plan. One recommendation COGME can make is the allocation of resources to devote to developing the strategic plan. The members agree on the need to ask Congress for resources, as a mandate with no or poor funding will not get off the ground. There was discussion on how much funding might be needed. Dr. Soori suggested asking NCHWA at HRSA to conduct a broad evaluation to determine an approximate level of funding and resources required. Dr. Weiss agreed that Dr. Soori's suggestion was feasible. Dr. Angood brought up the example of the Patient Centered Outcomes Research Institute, a part of the ACA, as a program that was well-funded, got off to a rapid start, and filled a strong need.

Dr. Soori stated the goal of the report is that: in X number of years, there will be an entity that will develop a national strategic plan for GME. This might be supported by other entities, such as a resolution from the AMA stating that GME is in crisis. Other specialty organizations will also be needed to weigh in on the need for a plan. Discussion continued as the Council members indicated what stakeholder groups they were willing to contact with the initial letter and questions. There was discussion of how much time to allow the stakeholders to respond, the response was from 4 to 8 weeks. Dr. Soori noted his concern of getting the report out by November 2016.

Public Comment

At this time, Dr. Soori opened the meeting to public comment. There were none.

Dr. Soori adjourned the meeting.