

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

*Meeting Minutes*  
**April 14-15, 2021**

**Council Members in Attendance**

*Appointed Members*

Erin Fraher, PhD, MPP, Chair

Andrew Bazemore, MD, MPH

Ted Epperly, MD

R. Armour Forse, MD, PhD, FRCS(C), FACS, FCCM, FASMBS

Peter Hollmann, MD

Beulette Y. Hooks, MD, FAAFP

Warren Jones, MD, FAAFP

John J. Norcini, PhD

Ashruta Patel, DO, MS

Surendra Varma, MD

Kenneth Veit, DO, MBA, FAOFP

*Federal Representatives*

Karen Sanders, MD (Designee of the Department of Veterans Affairs)

Joseph Brooks (Designee of the Centers for Medicare and Medicaid Services)

Leith J. States, MD, MPH (Designee of the Assistant Secretary for Health)

**Health Resources and Services Administration Staff Present:**

Shane Rogers, Designated Federal Official, COGME

Kennita R. Carter, MD, Subject Matter Expert, COGME; Chief, Graduate Medical Education,  
Division of Medicine and Dentistry, HRSA

Raymond Bingham, MSN, RN, Writer and Editor, Division of Medicine and Dentistry, HRSA

Janet Robinson, Advisory Council Operations, HRSA

Kimberly Huffman, Advisory Council Operations, HRSA

***Day 1: Wednesday, April 14, 2021***

**Welcome and Roll Call**

Mr. Shane Rogers convened the second meeting of the Council on Graduate Medical Education (COGME or the Council) in fiscal year (FY) 2021 at 10:00 a.m. on Wednesday, April 14, 2021. The COGME meeting was sponsored by the Health Resources and Services Administration (HRSA), the Department of Health and Human Services (HHS), and was conducted virtually using a videoconference meeting platform. Mr. Rogers turned the meeting over to the COGME chair, Erin Fraher, PhD, MPP.

Dr. Fraher welcomed the members. She noted that the COGME co-chair, Dr. Thomas Tsai was on paternity leave and would be unable to attend the meeting. In addition, Dr. Paul Jung, the

HRSA representative, was on deployment related to his position in the U.S. Public Health Service. She welcomed Mr. John Brooks to his first COGME meeting, serving as the federal representative from the Centers for Medicare and Medicaid Services (CMS). After a roll call, the presence of a quorum was confirmed, and the meeting proceeded.

Dr. Fraher stated that the purpose of the meeting was for the Council to review and confirm the recommendations for its third rural health issue brief, and discuss the development of the 24th report, compiling the three issue briefs and addressing efforts related to the COVID-19 pandemic. She welcomed the good news of the availability of a vaccine to combat COVID-19. She noted, however, that the pandemic had exacerbated health disparities across the country, not only in rural areas but in underserved communities and populations. She asked the Council members to reflect on these disparities and the steps that COGME might recommend to form policy action. She added that the Council is grateful for the healthcare workforce that has been engaged in “a marathon” to care for patients and populations over the course of the pandemic.

## **Bureau of Health Workforce Updates**

*Carla Stuckey, Deputy Director, Division of Policy and Shortage Designation  
Bureau of Health Workforce, HRSA*

Dr. Fraher introduced the first speaker, Ms. Carla Stuckey, Deputy Director, Division of Policy and Shortage Designation (DPSD), Bureau of Health Workforce (BHW), HRSA. Ms. Stuckey said that DPSD works to strengthen the health workforce and connect skilled professionals to rural, urban and tribal underserved community across the nation. Ms. Stuckey provided an update on the BHW programs, priorities, and initiatives. She briefly reviewed the *BHWise* portfolio-driven collaborative approach to managing the BHW programs, citing the behavioral health workforce pilot program as an example.

Ms. Stuckey reviewed the FY 2021 budget for BHW, including provisions of the 2021 American Rescue Plan, which allocated additional funding for:

- The National Health Service Corp and Nurse Corps,
- The THCGME program,
- Behavioral Health Workforce Education and Training, and
- Mental and behavioral workforce training.

Ms. Stuckey also discussed several Executive Orders related to COVID-19 and the health workforce intended to:

- Improve and expand access to care and treatment for COVID-19,
- Establish the COVID-19 Pandemic Testing Board,
- Promote a data-driven response to COVID-19 and future public health threats, and
- Ensure equitable pandemic response and recovery efforts.

Lastly, Ms. Stuckey listed the BHW focus areas for 2021-22, including the COVID-19 response, health equity, behavioral health, and community health. Major themes cutting across all programs included supporting provider resilience, telehealth, and diversity in the workforce.

## *Q and A*

In the question and answer session, two COGME members mentioned the need to recruit and train nursing faculty, and specifically minority nursing faculty, because of the struggles many nursing schools are having in recruiting sufficient faculty members to train more nurses and address the national nursing shortage. There was a further comment about the need for educators in healthcare across the board. Some health professions training initiatives have had to shrink or shut down for a lack of adequately prepared faculty. Ms. Stuckey replied that several BHW programs provide training opportunities geared toward increasing the number of nurse faculty, as well as faculty and educators in other health professions.

Dr. Beulette Hooks asked about the HRSA pipeline programs to attract students from minority or under-represented populations into the health professions. Dr. Warren Jones shared that one HRSA-sponsored Area Health Education Centers (AHEC) offered opportunities to reach students as far back as elementary school. Ms. Stuckey replied that most HRSA programs start at the undergraduate level, although some can reach back into high schools or middle schools. Another member asked about the HRSA programs regarding diversity and inclusion. Ms. Stuckey said that HRSA had several programs targeting diversity, including the AHECs, the Health Careers Opportunity Program (HCOP), Centers of Excellence, and scholarships targeting rural, underrepresented, or disadvantaged students.

There was a question about the challenges of the HRSA scoring process to identify communities as Health Professions Shortage Areas (HPSAs). Ms. Stuckey replied that HRSA had posted a request for information on HPSA scoring, and was in the process of reviewing the comments and preparing a public response. There has been a challenge in determining how to balance all the competing needs, to make sure that any revisions or changes take into account the diverse needs of the population and the healthcare system.

There was a comment that part of the Council's third rural health issue brief would include discussion on areas such as maternal care, and a question about workforce projections for women's health providers. Ms. Stuckey said that the projections were anticipated, and would come from HRSA's National Center for Health Workforce Analysis (NCHWA).

There was concern expressed that the temporary increase in funding for national health care resources related to the COVID-19 pandemic response and other legislation could lead to problems of program stability and sustainability in the long-term. Ms. Stuckey acknowledged that the current funding represented a one-time infusion of funds. HRSA would be taking steps to help balance the immediate needs with long-term planning and sustainability.

## **Presentation: Health Careers Opportunity Program: The National HCOP Academies**

*CAPT Cory Palmer, Branch Chief, Health Careers Pipeline Branch, Division of Health Careers and Financial Support (DHCFS), BHW*

*Ms. Kim Evans, Health Careers Opportunity Program Lead, Division of Health Careers and Financial Support (DHCFS), BHW*

*Ms. Audrey Adade, Health Careers Opportunity Program Co-Lead, Division of Health Careers and Financial Support (DHCFS), BHW*

Dr. Fraher introduced three members from the BHW Division of Health Careers and Financial Support (DHCFS), CAPT Cory Palmer, Ms. Kim Evans, and Ms. Audrey Adade, to provide an overview of the Health Careers Opportunity Program (HCOP), specifically the National HCOP Academies. In their presentation, the speakers identified the purpose of Academies as “to assist individuals from economically and educationally disadvantaged backgrounds with entering and graduating from an allied health or health professions program.” They discussed the efforts of the Academies in developing the health careers pipeline for a variety of health professions to improve workforce diversity, in part by recruiting and supporting high school, undergraduate, and non-traditional (i.e. adult students, veterans) students from underrepresented minorities and rural or disadvantaged populations. They noted that the HCOP Academies emphasize community-based training and the use of clinical sites in rural and other medically underserved areas. In responding to the COVID-19 pandemic, programs became creative in their use of technology to provide virtual and hybrid interactions, develop on-line tools for academic and mental health support, and prepare clinical simulations that expose students to the health care environment. HCOP also provided grants to help trainees from disadvantaged backgrounds obtain the necessary communications tools and access to the internet.

### *Q and A*

Dr. Fraher noted that the Council is very interested in issues of health workforce diversity, and had written a [letter to the HHS Secretary](#) in August 2020 to support increased funding for HCOP.

Dr. Hooks related that she had participated in a summer study program through HCOP at Chapel Hill, North Carolina, in the summer of her senior year in college, and that experience changed her career path. She wanted to express her thanks for the program and the opportunity it had provided for many minority students. Dr. Fraher shared that she had participated in an evaluation of the Chapel Hill program two years ago, which found that graduates of the program were more likely than most medical school graduates to go into primary care, serve in rural communities or other HPSAs, and serve Medicaid populations. Thus, the program had a significant impact on the workforce in North Carolina, with real, tangible, long-lasting results. Dr. Jones added that HCOP had facilitated an increase in the number of African American students matriculated through the University of Mississippi.

Dr. Karen Sanders noted that Congress had passed an omnibus bill for the Department of Veterans Affairs (VA) in January 2021. As part of this legislation, the VA will conduct a pilot program for minority students at the graduate level to rotate through different VA facilities and learn about healthcare professions and workings of a healthcare system. The leaders of the program are working to collaborate with HCOP in the program’s implementation.

## **Presentation: Teaching Health Center Graduate Medical Education Program Update**

*Kristin Gordon, Project Officer, Division of Medicine and Dentistry, BHW*

Dr. Fraher introduced Kristin Gordon, a project officer in the Division of Medicine and Dentistry, to provide an update on the Teaching Health Center Graduate Medical Education (THCGME) program. Ms. Gordon noted that the program makes payments to community-based

settings such as rural health clinics or community mental health centers to sponsor a primary care residency program. The goal is for THCGME-funded residents to continue to practice primary care in community settings and other areas of need after the completion of their training. The program was initially authorized under the Affordable Care Act for five years, from 2011 to 2015. Since that time, it has received piecemeal appropriations that have allowed it to continue, typically in two-year increments. Ms. Gordon added that the American Rescue Plan Act has provided funds for the THCGME program for FYs 2021-23, to establish new THCGME primary care residencies, expand current programs, increase the per-resident-amount, support the development of community-based programs, and provide technical assistance to help programs achieve accreditation. HRSA planned to release new notices of funding opportunities for the THCGME program in the coming months.

### ***Q and A***

Dr. Fraher welcomed the potential to expand the THCGME program, and asked about the timeline to apply for developmental grants. Ms. Gordon replied that HRSA is working to prepare the grant applications as quickly as possible, with the expectation that the first notices of funding opportunities would be published in Summer 2021. There was a question about the how many development grants would be available, and Ms. Gordon said that number had not been determined.

Dr. Forse noted the opportunity to form a consortium under the THCGME program, which might help to serve rural areas, and asked if there were any specific examples. Ms. Gordon replied that roughly one third of the current 60 THCGME grantees are consortia, with some operating in a federally qualified health center (FQHC) or other facility in a rural setting.

### **Adjourn**

Mr. Rogers adjourned Day 1 of the meeting at 4:00 p.m.

## ***Day 2: Thursday, April 15, 2021***

### **Welcome and Roll Call**

Mr. Rogers convened the second day of the meeting at 10 a.m., and took a roll call to confirm the presence of a quorum. He turned the meeting over to Dr. Fraher, who offered a brief review of the discussions from Day 1.

### **Presentation: Rural Medicare Beneficiaries' Access to Care**

*Dr. James Mathews, Executive Director, Medicare Payment Advisory Commission*

Dr. Fraher introduced Dr. James Mathews, Executive Director, Medicare Payment Advisory Commission (MedPAC). Dr. Mathews provided an overview of MedPAC, and discussed its current work on improving access to care among rural beneficiaries and addressing rural hospitals closures. He stated that the purpose of MedPAC was to “provide independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program.” In response to a request from the congressional Ways and Means Committee, MedPAC reviewed several measures of rural health care access. From an annual survey, rural and urban beneficiaries reported similar levels of satisfaction with care, but rural residents had more difficulty obtaining specialty visits or care on nights and weekends. Meanwhile, claims data showed similar inpatient hospital use among urban and rural beneficiaries, but those in rural areas had higher outpatient department use and fewer specialty visits.

Dr. Mathews noted a national concern over rural hospital closures. He said that claims data indicated that most hospitals that closed had experienced years of decline in inpatient census. However, many continued to serve as an important source of emergency and outpatient care. After a hospital closure, care tended to shift to hospitals in adjacent areas, and to community sites such as federally qualified health centers and freestanding emergency departments. While Medicare pays most rural hospitals above standard rates, these higher payments do not always prevent closures, and they may reduce cost control incentives and distort local competition for services. As a result, MedPAC has recommended allowing outpatient-only hospitals in rural areas. Consistent with this recommendation, Congress has created a new category for rural emergency hospitals, which will not provide inpatient services but which must provide 24/7 emergency care and can offer other outpatient services. Dr. Mathews stated that a full report on access to care for rural Medicare beneficiaries is due out from MedPAC in June 2021.

### ***Q and A***

Dr. Fraher noted that COGME had been examining rural access to health care, as well as the overall shift in health care from acute to ambulatory settings. This shift would likely result in an increase in patient volumes for community clinics and other outpatient facilities. However, federal indirect medical education (IME) payments to support graduate medical education (GME) are generally based on inpatient volumes. She asked Dr. Mathews about the work within MedPAC to support the shift of training from acute to outpatient care and the calculation of IME payments, which might then influence the Council's recommendations for the THCGME program. Dr. Mathews replied that discussions had begun in 2010 related to the role of Medicare in doing workforce evaluations, assessing local community health care needs, and

supporting team-based care care. The commission recently approved a recommendation to have Congress direct the Medicare program to redistribute current levels of IME dollars on both an inpatient and an outpatient basis, to have these funds track where care is being provided.

Dr. Jones asked if the MedPAC survey on the impact of rural hospital closings took into account the travel time and distance for individuals in the rural areas in accessing care. Dr. Matthews answered that the survey results indicated Medicare beneficiaries were still able to access ambulatory care at a different facility, such as an FQHC, as well as inpatient care at a more distant hospital, but MedPAC did not have data to determine changes in travel.

Dr. Sanders asked about the omission of the VA in the MedPAC analyses of rural care access, noting that veterans over 65 are dual eligible for both Medicare and VA health benefits. Dr. Matthews replied that MedPAC must stay within the confines of Title 18, as it relates to Medicare and interactions between Medicaid and other payors, and the VA health system is outside of the MedPAC purview. Dr. Carter added that the VA has a large health system and has strongly promoted telehealth, and some lessons learned from the VA might apply to Medicare.

Dr. Ted Epperly asked about efforts of MedPAC revise payment policies to support the provision of primary care in rural settings, and efforts to bring medical specialists into rural care through telehealth. Dr. Matthews replied that MedPAC was concerned about the access of beneficiaries to primary care and supported policies to improve the financial viability of primary care practices. Going back to 2015, MedPAC recommended a partial capitation approach to primary care that would move away from fee-for-service based reimbursement and provide primary care practices with funds that could be used to cover the full range of activities needed in managing a patient population, to include enhanced telehealth capabilities. The arrival of the COVID-19 pandemic brought a rapid rise in telehealth and a broadening of the regulatory and payment policies around its use. However, MedPAC also had to be aware of the potential for fraud and abuse, and so maintained a relatively guarded approach to telehealth.

Dr. Hollmann asked about the potential impact of redistributing IME and other GME funds on physician workforce balance and distribution, noting that more residents will opt to go into specialty practice as long as specialists receive higher compensation. Dr. Matthews replied that as long as the income differential exists, especially over a long-term career, changes in IME distribution would only influence the workforce in the margins. MedPAC still believed that shifting more IME payment to ambulatory care settings was a worthwhile effort. However, as long as IME remained an exclusively inpatient adjustment, a hospital administrator would be very conscious of the financial considerations of inpatient versus outpatient care.

### **Council Discussions: Issue Brief 3 (Days 1 and 2)**

*Moderators:*

*Dr. Erin Fraher, COGME Chair*

*Dr. Surendra Varma, COGME Member*

Dr. Fraher and Dr. Varma moderated two Council discussions on the COGME rural health issue brief 3. In the first discussion on Day 1, Dr. Fraher reminded the members that the Council decided to address the topic of rural health for its 24<sup>th</sup> Report, with recommendations intended to

strengthen rural health workforce training and improve access to health care in rural communities. The Council approached the topic through a series of issue briefs to be combined into the final product. The decision to initially work on shorter, more focused publications allowed the Council to be more agile and responsive to the shifting needs of the evolving health care system. When the COVID-19 pandemic struck in the spring of 2020, the Council shifted some of its work to produce a recommendations to the HHS Secretary addressing some of the immediate needs of the health care workforce in the pandemic response. While the work on the issue briefs slowed, the Council continued to explore the topic.

Dr. Fraher stated that the first two issue briefs were intended to set the stage for the third brief:

- Issue Brief 1 (published July 2020) proposed the need to redesign rural health workforce investments to place patients, their families, and community needs at the center.
- Issue Brief 2 (published February 2021) called for policy action to advance sustainable financing of rural training and practice, and develop strategic planning to build a more flexible, dynamic, and interprofessional rural workforce that meets rural needs.

Dr. Fraher reviewed Issue Brief 3, titled *Training Needs to Prepare the Healthcare Workforce for Rural Practice*. The key principles from the previous Council discussions included:

- Developing training that is specific, adaptable, and flexible to meet community health needs.
- Supporting team-based training and practice.
- Promoting generalism.
- Recruiting individuals from rural communities.
- Developing new funding sources.
- Leveraging Area Health Education Centers (AHEC) Programs.
- Identifying resources to help health professionals transition to, and sustain, rural practice.

She summarized the three recommendation from Issue Brief 3 to have HHS:

- Fund a mid-career professional retraining program to help clinicians adapt their existing skills to meet the evolving rural health needs.
- Promote and expand integrated care by interprofessional teams.
- Invest in sustainable solutions that focus on building a stable healthcare workforce in rural communities.

The Council members reviewed the draft text and recommendations, making several recommendations related to specific wording of the recommendations, and to the placement of different sections. There were suggestions to:

- Cite model programs as examples, where possible.
- Discuss community access to telehealth, and the need to improve broadband infrastructure.
- Protect current flexibilities introduced in the pandemic response, such as Medicare payment for telephone consults.
- Address geriatrics and end-of-life care, along with care across the lifespan
- Define interprofessional team-based care in text.



In the Day 2 discussion, the Council reviewed edits made to the draft in response to the previous day's suggestions. There was also discussion on what topics to include the issue brief, and what topics might best reserved for more in-depth review in the full Report. At the end of this discussion, Dr. Varma moved to approve Issue Brief 3, pending minor edits to be incorporated by the technical writer and the workgroup. Dr. Warren Jones seconded the motion. The motion was approved by voice vote, with no votes opposed.

## **24<sup>th</sup> Report Workgroups**

The Council divided into two workgroups to discuss the development of the 24<sup>th</sup> Report.

### ***Workgroup 1 Report Out***

*Discussant: Dr. Fraher, COGME Chair*

Dr. Fraher summarized the Workgroup 1 discussion by saying that end goal was to create a succinct and readable report, with a target length of roughly 20 to 25 pages of text, excluding the opening material, appendices, references, and other supplementary material. The report format would follow the order of the issue briefs:

- Introduction – highlighting the consolidated information from across the three briefs on rural health disparities, along with a summary of current administration priorities and legislative priorities around health disparities.
- Three sections or chapters:
  - Section 1 – Summarizing Issue Brief 1 to provide an overview of rural health disparities and workforce needs
  - Section 2 – Summarizing Issue Brief 2 on investments needed to improve the physician and health workforce training in rural areas.
  - Section 3 – Summarizing Issue Brief 3 on the principles of rural health training.
- Updates on new initiatives and legislative actions.
- Recommendations with brief rationale.

The body of the report would include call-out text lines, text boxes, bolding, and similar devices to highlight the significant points, since many of the readers may only skim through the main sections.

Dr. Fraher noted that the three issue briefs contained a total of ten recommendations, which would likely be too many to include in the final report. There was discussion on having each Council member rank-order the most urgent or significant recommendations. The goal would be to pare the list down to a maximum of five, to increase the likelihood that the recommendations will be acted on.

For a timeline, Dr. Fraher suggested that the main body of the report should be completed by the time of the August COGME meeting, to allow the Council to review and discuss the draft manuscript, and provide time for public comment. After this discussion, final edits should be completed, with the COGME technical writer reviewing the report to put the text into a clear and consistent voice. It is planned for the final report to be submitted by the end of September 2021.

## ***Workgroup 2 report-out***

*Discussant: Dr. Bazemore, COGME member*

Dr. Bazemore said that Workgroup 2 discussed the need to develop the flexibility in the health workforce. There was discussion of using case studies to illustrate main points of the report, or of adapting a central theme to use as a vehicle to explain and connect the main points. Making significant changes requires a strong central authority with the necessary tools to act, an infrastructure that supports the change process, and relevant metrics to identify the needed changes and measure the success of any change efforts or initiatives. He noted that the need for a central authority on workforce issues was discussed in a letter from the Council addressing the health workforce strategic plan under development within HRSA.

Dr. Bazemore said that the workgroup identified some main themes to address:

- Advancing health equity.
- Diversifying the health workforce.
- Addressing disparities in rural communities.

The workgroup discussed several points to emphasize. The first is the need for community-based training. One approach may be to emphasize finding physicians and other health care providers who can function well in rural settings, and then provide training in additional skills to meet community needs. A second point is team-based training, and the related need for workforce diversity, to build interprofessional collaboration. A third point is to integrate behavioral health care into primary care. A fourth point is the role of international medical graduates in enhancing the rural health physician workforce.

Lastly, there is a need to explore the growing role of telehealth, which should be broad enough to cover emerging technologies. Educational models need to prepare physicians and other providers in telehealth modalities, and payment system need to be adapted to cover telehealth services. In addition, the system has to provide for flexibility in both training and payment, as technology is rapidly changing and it is not possible to perceive how training, usage, payment models, and measurement may change, even in the next five years.

## ***Council Discussion***

In exploring common ground between the two workgroup discussions, Dr. Fraher noted that Workgroup 2 discussion expanded the theme of rural health from the Council's issue briefs into a broader look at health equity. The COVID-19 pandemic had helped to reveal other structural forces, such as a lack of health workforce diversity, that relate not only to rural areas but to other underserved communities. These forces have a tremendous impact on health disparities, and exploring them might open the door to taking the rural health issues briefs and giving them broader context. As a result, the 24<sup>th</sup> Report could focus on rural health within the broader issues of health equity for the nation to consider.

Dr. Fraher noted that the emphasis on community based training to encourage more health practitioners to work where they are needed can apply not just in rural areas, but in health professional shortage areas (HPSAs) in urban areas as well. Similarly, the need for telehealth and for flexibility in the use of technology can apply to any areas where residents may lack

access to transportation, or when travel to a health facility may be burdensome. Given current legislative efforts and new health care appropriations, there is a need to improve the overall health care infrastructure and develop a strategic plan as a coordinating framework, as reflected Council's recommendations.

Dr. Hollmann said that Workgroup 2 adopted the approach of the case study, in which a particular case presented in a "grand rounds" forum can be used as a teaching point to illuminate broader themes. In this context, rural health disparities can help shed new light on the broader issue of health inequities. Topics addressed in the rural health issue brief such as longitudinal learning, team-based care, supporting people in their communities, and health care measurement apply across the health care system. They concern both decreasing health inequities and improving the overall quality of care.

A question was raised about the title of the 24<sup>th</sup> Report. There was a suggested approach to prepare the draft text of the report first, and then decide on a title to succinctly reflect the contents. This approach might be needed especially in the Council decided to reframe the thrust of the report from a compilation of the three rural health issue brief to the broader theme of health equity.

There was a general discussion on the feasibility of integrating more the broader themes raised by the Workgroup 2 discussion into the existing recommendations from the three rural health issue briefs. There was further discussion that the priorities of the current administration on health equity and infrastructure, as reflecting in the need to address the COVID-19 pandemic and other pressing health needs such as the opioid crisis, present a huge opportunity for the Council to provide its advice. However, concern was expressed that shifting the focus of the 24<sup>th</sup> Report to a broader topic risked diluting the work the Council had already done. There was a proposal to create two writing committees, one to complete work on the 24<sup>th</sup> Report retaining the theme of rural health, and the other to begin preparation of the 25<sup>th</sup> Report on the topic of health equity. There was further discussion on the importance of framing the issues clearly, to capture the attention of policymakers and have the greatest impact.

Dr. Fraher suggested forming a small subcommittee of members from each workgroup to brainstorm on how best to move forward. The volunteers for this group included:

- Dr. Bazemore,
- Dr. Forse,
- Dr. Fraher,
- Dr. Hollmann, and
- Dr. Varma.

## **Public Comment (Day 1 and Day 2)**

There were multiple public comments offered. Mr. Rogers noted that the Council had received two written comments in advance of the meeting, which were distributed to the full membership and will become part of the official record. He summarized the two written comments received:

- Concern about the training of medical students in vaccination safety.
- Discussion related to graduate medical students who do not receive a residency match.

The meeting also included several oral public comments:

- Hope Wittenburg, Director of Government Relations at the Society of Teachers of Family Medicine, supported COGME's efforts on behalf of THCGME, but added that lack of consistent, long-term funding inhibits the full development of the program.
- Dr. Linda Thomas-Hemak, Chief Executive Officer of the Wright Center for Community Health, spoke in support of the Council's efforts to address the workforce shortage in primary care.
- Dr. Karen Mitchell, Education Division Director for the American Academy of Family Physicians, discussed the need to promote a diverse workforce and address the issues of health inequities for rural areas.
- Three commentators from the organization "Unmatched and Unemployed Doctors of America," Dr. Caleb Atkins, Dr. Kristy Cromblin, and Dr. Mimi Oo, discussed several issues impacting medical school graduates in the United States who do not match into a residency program (over 7,400 in 2021), and are thus unable to complete the final stage of their medical training.

## **Business Meeting**

Mr. Rogers said that the next COGME meeting would be held on August 19, 2021. It was expected at that meeting that the Council would review the 24th Report, and begin discussions for a 25<sup>th</sup> Report, to be due within two years.

Mr. Rogers informed the Council that there were currently two open slots on the Council. Two individuals had been identified, to fill the legislatively mandated categories of a representative from a public teaching hospital, and a representative from a school of medicine. The nomination packages had been submitted for approval and appointment by the HHS Secretary. He noted, however, that the change in administration could slow the approval process, but he hoped to that the new members on board for the August 2021 meeting.

Lastly, Mr. Rogers provided a quick update on the COGME consultation letter provided to HRSA in response to the health workforce strategic plan required under the 2020 Coronavirus Aid, Relief, and Economic Security (CARES) Act. The plan was initially due to Congress in March 2021. However, with the change in administration, the deadline had been extended to September 2021. Thus, the Council could have the opportunity to update the letter, if needed.

## **Meeting Adjourn**

Dr. Fraher thanked the members of the public for their comments and their engagement in this meeting, underscoring the importance of the Council's work. She also thanked the HRSA staff for their support of the Council.

Mr. Rogers adjourned the meeting at 3:45 p.m.

## Acronym and Abbreviation List

AHEC	Area Health Education Center
BHW	Bureau of Health Workforce
BHwise	Behavioral Health Workforce Investments to Support Equity
CARES Act	Coronavirus Aid, Relief, and Economic Security Act
CMS	Centers for Medicare & Medicaid Services
COGME	Council on Graduate Medical Education
DHCFS	Division of Health Careers and Financial Support
DPSD	Division of Policy and Shortage Designation
FQHC	Federally Qualified Health Centers
GME	Graduate Medical Education
HCOP	Health Careers Opportunity Program
HHS	U.S. Department of Health and Human Services
HPSA	Health Professions Shortage Areas
HRSA	Health Resources and Services Administration
IME	Indirect Medical Education
MedPAC	Medicare Payment Advisory Commission
NCHWA	National Center for Health Workforce Analysis
THCGME	Teaching Health Center Graduate Medical Education
VA	Department of Veterans Affairs

The COGME Rural Health Issue Brief series:

Issue Brief 1 (IB1) [published July 2020]: [\*Special Needs in Rural America: Implications for Healthcare Workforce Education, Training, and Practice\*](#)

Issue Brief 2 (IB2) [published February 2021]: [\*Investing in a Health Workforce that Meets Rural Needs\*](#)

Issue Brief 3 (IB3) [in press]: *Training Needs to Prepare the Healthcare Workforce for Rural Practice*