

**COUNCIL ON GRADUATE MEDICAL EDUCATION (COGME)  
MEETING MINUTES**

**Rural Health  
June 5-6, 2019**

**Day 1: June 5, 2019**

**Council Members in Attendance**

**Lois Margaret Nora, MD, JD, MBA**

*Chair*

Immediate Past President  
American Board of Medical Specialties  
Chicago, IL

**Erin Fraher, PhD, MPP**

*Vice Chair*

Director  
Carolina Health Workforce Research Center  
University of North Carolina at Chapel Hill  
Chapel Hill, NC

**Peter B. Angood, MD, FRCS(C), FACS,  
MCCM**

Chief Executive Officer and President  
American Association for Physician Leadership  
Tampa, FL

**Andrew Bazemore, MD, MPH**

Director  
Robert Graham Center  
Washington, DC

**Ted Epperly, MD**

President and Chief Executive Officer  
Family Medicine Residency of Idaho, Inc.  
Boise, ID

**Kristen Goodell, MD, FAAFP**

Immediate Past Chair, COGME  
Assistant Dean for Admissions  
Boston University School of Medicine  
Boston, MA

**John J. Norcini, PhD**

President and Chief Executive Officer  
Foundation for Advancement of International  
Medical Education and Research  
Philadelphia, PA

**Beth M. Roemer, MPH**

Assistant Dean for Admissions, Outreach,  
Diversity and Inclusion  
Kaiser Permanente School of Medicine  
Oakland, CA

**Eric J. Scher, MD, FACP**

Chair  
Department of Medicine  
Henry Ford Hospital  
Detroit, MI

**Thomas C. Tsai, MD, MPH**

Surgery Fellow  
Brigham and Women's Hospital  
Boston, MA

**Ex-Officio Members:**

**Leith J. States, MD, MPH**

Deputy Chief Medical Officer  
Office of the Assistant Secretary for Health  
Department of Health and Human Services  
Washington, DC

**Monica L. Lypson, MD, MHPE, FACP**

Director, Medical and Dental Education  
Office of Academic Affiliations  
Veterans Health Administration  
Department of Veterans Affairs  
Washington, DC

### HRSA Advisory Committee Staff

**Kennita R. Carter, MD**

Designated Federal Official, COGME  
Senior Advisor, Division of Medicine and  
Dentistry, Bureau of Health Workforce (BHW)

**Samantha L. Das, MS**

Designated Federal Official Liaison, COGME  
Public Health Analyst, Division of Medicine and  
Dentistry, BHW

**Kim Huffman**

Director  
Advisory Council Operations, BHW

**Robin L. Alexander**

Management Analyst  
Advisory Council Operations, BHW

**Janet A. Robinson**

Management Analyst  
Advisory Council Operations, BHW

**Carl Yonder**

Public Affairs Specialist  
Division of External Affairs, BHW

**Heather Gorby, PhD**

Technical Contract Writer  
Global Evaluation & Applied Research  
Solutions (GEARS) Inc

### Presenters

**George Sigounas, PhD**

Administrator, HRSA

**Torey Mack, MD, FAAP**

Deputy Associate Administrator, BHW, HRSA

**Jemima Drake, MPH, RN**

Health Insurance Specialist, Federal Office of  
Rural Health Policy, HRSA

**CAPT Sophia Russell**

Division Director, Division of Nursing and  
Public Health, BHW, HRSA

**Miryam Gerdine**

Project Officer, Division of Nursing and Public  
Health, BHW, HRSA

**CAPT Paul Jung, MD, MPH**

Deputy Director, Division of Health Professions,  
Indian Health Service

**Laura Ridder**

Ethics Advisor, Office of Human Resources,  
HRSA

**Lucy Shafer**

Ethics Advisor, Office of Human Resources,  
HRSA

**CAPT Jacqueline Rodrigue, MSW**

Director, Division of Health Careers and  
Financial Support, BHW, HRSA

**CAPT Madelyn Reyes, MA, MPA, RN**

Deputy Director, Division of Health Careers and  
Financial Support, BHW, HRSA

### Members of the Public (In Person and Virtual Via Webinar)

Teresa Baker, American Academy of Family Physicians (AAFP); Emily Bassett, Robert Graham Center; Joy De Guzman, American Association of Colleges of Osteopathic Medicine (AACOM); Karen Mitchell, MD (AAFP); Dave J. Keahey, PA-C, BUS, MSPH Hope Wittenberg, Council of Academic Family Medicine

## **Introduction**

The Council on Graduate Medical Education (COGME, or the Council) held an in-person meeting at the headquarters of the Health Resources and Services Administration (HRSA), 5600 Fishers Lane, Room 5N76, Rockville, MD 20857. Dr. Kennita Carter, Designated Federal Official, called the meeting to order at 8:30 a.m. ET, and conducted a roll call. From the initial roll call, Dr. Carter informed the Council that a quorum was achieved, and the meeting could proceed.

Dr. Carter stated that the Council had held a series of small workgroup meetings that identified three rural health workforce issues: (1) special needs in rural America and implications for health care workforce education and training, (2) training needs to prepare the health care workforce for rural practice and, (3) the rural health care workforce: necessary investments. The workgroups were developing issue briefs on each topic, which would be discussed during the meeting. Dr. Carter and Dr. Lois Nora, the COGME Chair, provided an overview of the agenda. After a brief round of introductions, Dr. Carter introduced Dr. George Sigounas, the HRSA Administrator.

## **HRSA Welcome**

*Speaker: George Sigounas, PhD, HRSA Administrator*

Dr. Sigounas welcomed the COGME members. He stated that HRSA is the primary federal agency in the Department of Health and Human Services (HHS) that supports access to quality health care for vulnerable communities. HRSA oversees more than 90 programs, many of which provide health care to people who are geographically isolated, or economically or medically challenged. In 2018, HRSA supported around 27 million people in primary care and other integrated services. Overall, HRSA programs support an estimated 100 million Americans, almost 30 percent of the total population. The goal of HRSA is to ensure an adequate healthcare workforce prepared to meet the nation's current and emerging health care needs.

Dr. Sigounas said that addressing the health care challenges of rural communities is a priority for HRSA. He mentioned a rural health task force within HHS, charged with making recommendations for building capacity and increasing access to care through education, training, and the support of the existing workforce in rural communities. Many HRSA programs, like the Rural Residency Program, the Rural Technical Assistance Centers, the National Health Service Corps (NHSC), the Children's Hospital Graduate Medical Education program (CHGME), and the Teaching Health Centers Graduate Medical Education (THCGME) program, support the training of health professionals with a particular focus on distributing providers to areas where there is a significant need. During academic year 2017 - 2018, for example, THCGME supported the training of nearly 850 new physicians and dentists, of whom 55 percent practice in medically underserved or rural communities.

He stated that collaboration with federal partners like the Centers for Medicare and Medicaid Services (CMS), the Department of Veterans Affairs (VA), and the Indian Health Service (IHS) is a priority, as HRSA explores how to address crosscutting public health issues more effectively across HRSA's programs, and identify new ways to address the health-related needs of the population.

## **Presentation: Bureau of Health Workforce Update**

*Torey Mack, MD, FAAP, Associate Deputy Administrator, Bureau of Health Workforce (BHW), HRSA*

Dr. Carter introduced Dr. Torey Mack, Associate Deputy Administrator, Bureau of Health Workforce (BHW). Dr. Mack stated that the vision of BHW is to make a positive and sustained impact on health

## Rural Health

care delivery for underserved communities through education, training, and service. The mission of BHW is to improve the health of underserved and vulnerable populations by strengthening the health workforce and connecting these skilled professionals to communities in need. BHW priorities include:

- Transform the health care workforce by creating training opportunities, incentives, and sustained support for clinicians working in rural and underserved areas.
- Increase access to behavioral health services, including substance use disorder treatment.
- Use health care workforce data to inform HRSA's programs and policies.

To address the first point, Dr. Mack explained that creating training opportunities in underserved communities serves increase the number of health professionals serving in those communities. Over 60 percent of BHW-supported health profession trainees receive training in medically underserved communities. Dr. Mack outlined the BHW strategies to combat the nation's opioid crisis:

- Increasing access to treatment and enhancing substance use disorder prevention.
- Expanding workforce training to prevent addiction to opioids.
- Increasing the use of telehealth and medicine services to increase access to care, and
- Connecting stakeholders to resources to share best practices for opioid-related events.

She stated that HRSA had made significant investments for the Fiscal Year (FY) 2019 in the opioid crisis and mental health, including \$69 million for opioid-related expansion programs that go directly to training institutions. The NHSC investment in behavioral health resulted in about 10,000-11,000 providers currently serving in the field.

Dr. Mack discussed a \$225 million investment to improve access to quality opioid and substance use disorder treatment, which included two new programs, Substance Use Disorder Workforce Loan Repayment, and Opioid Response in Rural Communities. In addition, a loan repayment program specifically for rural communities was created in partnership with the Federal Office of Rural Health Policy (FORHP). These and all HRSA programs policies are informed by research and analysis from the National Center for Health Workforce Analysis (NCHWA).

Dr. Mack said that additional areas of focus include residency training, longitudinal training experiences in rural and underserved areas, and rural health. The Children's Hospitals Graduate Medical Education (CHGME) program provides federal funds to free-standing children's hospitals. During academic year 2017-2018, CHGME supported over half all pediatric residents trained in the U.S., and a new CHGME quality bonus program will incentivize children's hospitals that provide individual-level data about residents in a few key areas. In terms of rural health, more than 185,000 students and trainees from rural backgrounds have participated in BHW-sponsored programs, with more than 8,400 training sites in rural areas. The Rural Residency Planning and Development (RRPD) program is a collaboration with FORHP to expand the health workforce in rural areas. BHW also supports a nurse practitioner (NP) residency program that prepares new NPs to serve in rural and underserved communities. The Area Health Education Centers (AHEC) program enhances access to high-quality, culturally competent health care through academic-community partnerships.

Dr. Mack stated that HRSA developed the Clinician Tracking Initiative to measure retention through the NHSC and the Nurse Corp. The data are available through HRSA's new [Health Professions Training](#)

[Program Dashboard](#). BHW also created a Health Workforce Connector, a newsletter which helps to connect NHSC and Nurse Corps participants with job opportunities and virtual job fairs, as well as to connect health care facilities with job-seeking primary care providers interested in serving communities with limited access to care. Dr. Mack summed up by saying that HRSA awarded more than \$1 billion to more than 8,000 organizations and individuals through its 40+ workforce programs, and 46 percent of HRSA-supported graduates work in underserved areas.

## **Presentation: Federal Office of Rural Health Policy Update**

*Jemimah Drake, MPH, RN, Health Insurance Specialist, Federal Office of Rural Health Policy, HRSA*

Dr. Carter introduced Ms. Jemimah Drake, policy analyst, FORHP. Ms. Drake said that the FORHP was established to be the voice for rural health across HHS and to coordinate the Department's activities related to rural health care. Specifically, FORPH is charged with advising the HHS Secretary on the effects of CMS policies and proposed changes on the viability of small rural hospitals; the ability of rural areas to attract and retain physicians and other health professionals; and issues affecting access to quality health care in rural areas. The FORHP is made up of four divisions: state and hospital programs, community-based programs, telehealth programs, and policy and research. There are two new areas for 2018-2019, the Rural Community Opioids Response program and Rural Residency programs.

Ms. Drake informed the Council that 106 rural hospitals had closed since 2010, with another 93 at high-risk of financial distress in 2018. As a result, more than 20 percent of rural hospitals fall into the high-risk or mid-to-high-risk categories. These hospitals are more likely to serve minority populations and communities with higher rates of unemployment and poor health status. Of almost 2,000 counties in the U.S. classified as rural, over 170 did not have a critical access hospital, Federally Qualified Health Center (FQHC), or rural health clinic (collectively known as safety net providers) within their boundaries. In these counties, the travel time to the next nearest hospital or clinic could range from about 5 minutes to well over 2 hours.

In particular, Ms. Drake noted that women living in rural counties are disproportionately affected by the loss of hospital obstetric services. Between 2004 and 2014, 179 rural counties (9 percent of all rural counties) lost access to in-county hospital obstetric services. In the year after loss of services, most of these rural counties experienced significant increases in out-of-hospital births, births in a hospital without obstetric services, and pre-term births. As a result of closures, rural hospitals relied more heavily on family physicians to provide obstetric care. Training, recruitment and retention were identified as obstetric staffing challenges for rural hospitals. HRSA created the Rural Maternity and Obstetric Management Strategies (RMOMS) pilot program, intended to demonstrate the impact on access to and continuity of maternal and obstetrics care in rural communities.

Ms. Drake also explained the impact that pharmacy closures in rural areas have on the community's access to health services. Pharmacies not only provide access to medications, but many also deliver clinical services such as medication counseling, blood pressure and glucose monitoring, immunizations, patient consultation and treatment of mild illnesses, and other counseling and education services. Pharmacy closures result in residents having to travel further to get medications, or use mail order services that do not provide clinical services.

Ms. Drake added that county-level data from across the country show that there are fewer physicians (5.5 vs. 7.9), primary care providers (11 vs. 15.2), dentists (3.6 vs. 5.9), and dental hygienists (4.5 vs. 5) per 10,000 people in rural areas compared to urban or metropolitan areas. Since rural hospitals are significantly less likely than rural hospitals and urban hospitals to employ respiratory therapists, rural patients with chronic obstructive pulmonary disease may need to travel to larger urban hospitals or

## Rural Health

completely forego respiratory services. Researchers at the University of Kentucky's Rural Health Research Center found that rural family physicians engaged in a broader scope of practice than urban family physicians and may provide services such as pediatric mental health and women's health care.

Ms. Drake noted that HRSA's RRPD program has a grants program component, and a technical assistance center component. The focus of the RRPD grant program is on developing new, accredited, and financially sustainable rural residency programs or rural training tracks in family medicine, internal medicine, or psychiatry. Grantees are required to demonstrate an ability and structured plan to track retention in rural communities after the program.

Ms. Drake informed the Council that FORPH supports the [Rural Health Research Gateway](#) and a [Rural Health Information Hub](#) programs, and sends weekly announcements that provide rural-focused funding opportunities, as well as policy developments and research findings with a rural perspective.

### Council Discussion

*Moderator: Lois Margaret Nora, MD, JD, MBA, Chair, COGME*

Dr. Nora opened the floor for discussion. Dr. Peter Angood commented that he appreciated the breadth of activity within HRSA, and wondered how the Council could best provide its support. Dr. Sigounas responded that HRSA has three main areas of focus regarding the health workforce: education, training and residency, and health care services. HRSA uses statistical modeling to project trends in the health workforce over the next 5 or 10 years. However, there is concern about whether HRSA is collecting the appropriate data for this modeling. In addition, HRSA is working to determine if the main problem is shortage versus maldistribution of providers, with too many providers concentrated in urban regions.

Dr. Nora reminded the members that the previous COGME report had recommended a national strategic plan on graduate medical education and training. She asked participants to weigh in on whether that topic should be revisited with a specific focus on rural health. Dr. Ted Epperly discussed the success his home state of Idaho had in retaining physicians by increasing their training in rural areas. He suggested including a requirement for training in rural or underserved places as part of the HRSA grant process.

Dr. Epperly also commented on the difficulties faced by the THCGME program. He described the program as very valuable for training medical and dental residents in primary care and rural health. However, it faces constant uncertainty around funding levels as the funding is renewed every two years, which is inadequate to fund a 3-year residency program. As a result, program administrators are cautious in taking on new residents. Dr. Sigounas reported that he and his team have met with members in Congress and the Office of Management and Budget to advocate for five years of funding for THCGME.

Dr. Monica Lyson added that the Veteran's Choice and Accountability Act of 2014 provided a good example for how to handle the problem of short funding cycles. The stakeholders had asked Congress for a ten-year funding horizon, and spent a lot of time educating the Doctors' Caucus within the House of Representatives on the problems caused by short-term episodic funding.

Dr. Scher mentioned that data projections suggest many rural areas are becoming more rural, and asked whether workforce planning was accounting for this demographic shift. He also asked if HRSA was considering any programs using telehealth and biometric data along with electronic health records. He discussed his experiences with two telehealth programs that helped providers monitor the glycemic control and blood pressure of patients. Dr. Sigounas responded that telehealth is an area of priority, and HRSA has an office of telehealth that oversees more than 1500 projects. HRSA is expanding investment in this area and created two Centers of Excellence in 2018 for telehealth. He reiterated that HRSA is

looking into how to use telehealth for reaching out to patients and addressing different challenges, such as opioid use disorders, behavioral health, diabetes, and other areas.

Dr. Erin Fraher raised the issue of interprofessional education and training. The diverse health needs of rural populations often need to be addressed through health care teams. However, the make-up of these teams may look different in Idaho versus North Carolina. To meet rural health care needs, the focus needs to shift away from specific professions and towards funding future health care needs and recognizing that grantees will need to put together teams that vary between communities. HRSA officials stated that they are open to engaging with the GME community to meet the needs of the future.

Ms. Miryam Gerdine, a project officer with the Behavioral Health Workforce Education and Training (BHWET), Division of Nursing and Public Health (DNPH), talked about creating a future workforce with a focus on interprofessional, multidisciplinary training environments. She said that the BHWET awardees focus on the integration of behavioral health in primary care through didactic learning and experiential field placements. Behavioral health trainees complete their experiential learning field assignments in a variety of locations, including FQHCs, school-based programs, hospitals, and other residential and community-based organizations. The trainees complete interdisciplinary training with two or more disciplines such as dentists, psychiatrists, psychologists, nurses, social workers, counselors, and paraprofessionals. Currently around one-quarter of training sites are in rural settings. She also mentioned that many trainees have been trained in telehealth activities in the last year. She encouraged Council members to explore the NCHWA [database](#) for HRSA-funded program activities in telehealth.

### **Council Discussion: Rural Health Workforce Issues Overview**

*Lois Margaret Nora, MD, JD, MBA, Chair, COGME*

Dr. Nora reviewed the process to develop the 24<sup>th</sup> report. The topic of rural health was chosen because evidence has shown that the health needs of the individuals, families, and communities in rural areas were not being met. Dr. Nora urged the Council members to consider what the workforce for rural health in the U.S. should look like. While physicians are a core segment, the workforce extends well beyond physicians to include other providers. In addition, physicians located in urban medical centers might be at the other end of a telehealth consultation and need to understand rural issues and consider appropriate solutions. The Council will need to identify the necessary steps to create an adequate workforce equipped to provide better care in rural communities, and look at financial investment and how to measure outcomes. The report has three areas of focuses to be discussed in three separate Issue Briefs: workforce, training, and investment and measurement.

### **Issue Brief 1: Special Needs in Rural America and Implications for Healthcare Workforce Education, Training and Practice**

*Erin Fraher, PhD, MPP, Vice Chair, COGME*

Dr. Carter turned the meeting over to Dr. Erin Fraher. Dr. Fraher opened by stating that one of the key points for the report to stress is that rural populations are less healthy on almost every measure than urban populations. In terms of reframing GME policy, there is a need to have investments and training centered around patients and populations and not individual health professions. Dr. Fraher highlighted the shift of financing and care delivery models towards community-based care and care outside of the hospital. One approach would be to identify the “bright spots” of success in rural health, and scale them to address rural health needs and build the rural workforce.

Dr. Fraher noted that some specific causes of death are higher in rural areas, including motor vehicle accidents, other non-transportation accidents, suicide by gun, and acute myocardial infarction. These factors point to specific workforce implications, such as the need for trauma and emergency medical services, general surgery, behavioral health care, and primary care. Services like obstetrics and gynecology, prenatal care, general surgery, trauma, and procedural care need strengthening, while the aging of the population places an emphasis on long-term care and home health. The American Hospital Association identified that essential services needed in rural communities to promote health must balance access to traditional health care services with other social services such as nutrition and transportation.

Dr. Fraher explained that focus on essential health-care services also highlights the need for different teams of providers across health professions. From 2004-2014, 9 percent of rural counties lost access hospital obstetric services, and more than half of rural counties in the country are now without a single local hospital where women can get prenatal care and deliver babies. The critical need for obstetric care highlights the need for cross-professional services in rural communities.

Dr. Fraher added that social workers have not traditionally been included in health care teams. However, they can serve as behavioral health specialists, as well as care managers to connect patients to community resources. Most rural communities use an “asset-based” approach and adjust team structures and services to make use of local providers. Providers in rural communities are typically more “plastic,” meaning that the scope of services overlap and are dynamic. Dr. Fraher reminded the Council that regulation is critical. For example, hospitals that employ NPs determine their practice authority or scope of practice, although the practice authority for NPs may be broader at the state level.

### **Issue 2: Training Needs to Prepare/Encourage Health Professionals for Rural Practice**

*Kristen Goodell, MD, FAAFP, Immediate Past Chair, COGME*

Dr. Carter turned the meeting over to Dr. Kristen Goodell to review Issue Brief 2. Dr. Goodell stated that Issue Brief 2 will discuss the specific training needs for the rural health workforce. Dr. Goodell recommended that all three issue briefs should support one another and share background information, including a statement of the problem, followed by policy recommendations and a summary.

Dr. Goodell said there are three overarching policy recommendations: (1) New or existing assessments need to be used to clarify the specific health care services needs and the potential resources that exist within of rural communities; (2) Use those needs assessments to create individualized programs that can train cohorts of different types of providers together, working as teams; (3) The majority of these providers should be already living in or hailing from these communities and should be financially incentivized to train or return. HRSA has programs in place intended to attract providers to rural areas, but research suggests that the best predictor of a providing working in a rural community is that they were from a rural area to begin with. This suggests that training should occur within the local community.

Additionally, the varying needs of different communities should be addressed in a flexible manner. Residency program requirements should be tailored to the needs of individual communities, and not nationally mandated. Programs need to emphasize team-based care. Other key issues for rural areas are the idea of generalism/plasticity, lifelong multi-modality learning, and faculty development.

### **Issue Brief 3: The Rural Healthcare Workforce: Necessary Investments**

*Andrew Bazemore, MD, MPH, Member, COGME*



## Rural Health

Dr. Carter turned the meeting over to Dr. Bazemore to discuss Issue Brief 3. Dr. Bazemore started the discussion by stating that there is a mismatch between what rural populations and communities need and what they are currently getting from the GME system with public financing. Rural communities have tremendous assets, but also face multiple disparities. The brief will start with an introduction on GME financing. One critical issue is the misalignment between GME financing and current rural health needs. Current “bright spots” such as THCGME and rural training tracks are hindered by uncertain funding.

Dr. Bazemore reminded the Council of bills under consideration that need to be addressed, such as S.289 and others in the pipeline, so that the Issue Briefs and the final report are alignment with other federal efforts. The goal is a GME system that best serves the needs of rural populations.

The first policy recommendation is to improve strategic planning and governance over the public investment in GME for rural health, by addressing the issues of workforce sufficiency and distribution, and team-based health care. One part of this recommendation will address the need to foster interagency coordination, at both the federal and state levels.

The second policy recommendation is to identify and reduce environmental and regulatory barriers that limit effectiveness in addressing rural health. There are different proposals to Congress to open the “cap on GME” to increase residency slots provide more flexibility for rural GME.

The third policy recommendation is to create sustainable and increased investment in community-based rural training in place. The Council should applaud agency efforts, HRSA in particular, to seed expansion and pilot and innovation ideas like community-based training models, rural training tracks, and teaching health centers. However, the sustainability of these programs is in jeopardy due to insecure funding. Congress should consider alternate reimbursement models for resident payments that promote place-based training in rural areas, with the recognition that the current CMS formula does not compensate rural training adequately and fails to create stable and sustainable rural training programs.

The fourth policy recommendation is to proactively foster innovation in rural GME, to advocate for big and sustainable ideas and not just pilot projects.

The fifth policy recommendation is to ensure measurement and accountability for any GME investments going forward. Congress should tie financing of these and other programs to some form of measurement or outcome-based approach to financing. The current administration has placed an importance on value and return on investment. Having access to performance metrics will help to define the best and most sustainable programs.

### **Council Discussion**

To start the discussion, Dr. Nora observed that the ideas discussed were bold strokes and go beyond how COGME has traditionally seen its role in terms of adding value to workforce and training. Dr. Fraher requested further input from HRSA staff on accreditation or training efforts already underway. Dr Carter responded that the Council should request what kinds of information or questions they would like addressed, and she would direct the questions to the appropriate HRSA staff. Dr. Carter also encouraged the Council to think beyond the typical sources of funding to build the necessary rural infrastructure.

Dr. Epperly wanted to make sure that a diverse set of stakeholders would review the report, including residents currently in training. Dr. Tsai mentioned that residents typically work in very specialized areas, and that training should match the available jobs. Dr. Scher mentioned that the Council needs to build a model that is relevant not just for today, but for 20 years from now. He also advised the Council to avoid recommending a redistribution of existing funds, which was likely to upset stakeholders losing funding.

## Rural Health

Other federal agencies are critical to building infrastructure in rural communities, such as the Department of Energy. The Council can recommend appropriations levels for Title VII funding not covering parts C and D, which means Part B, which covers the Health Career Opportunities Program (HCOP).

Dr. Lypson mentioned that training people from the rural areas they are meant to serve requires a diverse pipeline. There are resources needed outside of GME funding to train the health professionals, not just physicians, for the jobs that already exist in rural communities.

Ms. Roemer stated that the group should shift away from thinking about residency programs towards broader health care services. Dr. Tsai mentioned that there should be recommendations to train residents for rural practice (i.e. team-based services) and not just rural residencies. Dr. Angood mentioned that there is a trend for increasing sub-specialization, but physicians going to rural areas need a broader and more generalist scope, as well as knowing how to identify their limits. He added that team-based care needs to consider nurses, pharmacists, and other health professionals.

Dr. Carter challenged the Council to consider ways to retool the existing workforce, including specific changes that could provide short-term solutions. Dr. Lypson stated that faculty development is key, mentioning one approach where both faculty and learners receive simultaneous training.

### **Council Policy Brief Development and Small Group Discussion**

The members broke into three small groups for one hour of discussion. After reconvening the full Council,

### **Rural Health Workgroup Report Out**

#### **Main Points of Discussion:**

#### **Issue 1: Special Needs in Rural America and Implications for Healthcare Workforce Education, Training and Practice**

*Erin Fraher, PhD, MPP; Monica L. Lypson, MD, MHPE, FACP; Thomas C. Tsai, MD, MPH; and Ted Epperly, MD*

Dr. Fraher stated the group discussed adding a section on “reframing towards patients and populations.” The group decided to broaden the section to include both essential health care and social services. In the brief, they will add examples of community health workers as important contributors to health. They also recognized telehealth as a key component of team-based care. Team-based care includes physicians with a broad scope of practice. The group also defined how they were using the term “plasticity.” Dr. Tsai stated that the rural health infrastructure needs to be plastic and able to adapt to local needs, which can vary across different communities. However, the providers themselves may need to be generalists within a plastic or adaptable health care infrastructure.

#### **Issue 2: Training Needs to Prepare/Encourage Health Professionals for Rural Practice**

*Kristen Goodell, MD, FAAFP; Peter B. Angood, MD, FRCS(C), FACS, MCCM; Eric J. Scher, MD, FACP; and Beth M. Roemer, MPH*

Dr. Goodell stated that the group solidified their thinking on the current recommendation: “We recommend that existing assessments be used to clarify specific health care services needs of individual communities and the potential of resources that exist within such communities. Individualized programs

can then be created to train cohorts of different types of providers working together as teams. Most of these providers should be already living in or hailing from these communities and should be financially incentivized to train or return.”

She stated there is a need for flexibility to decrease physician burnout. The role of generalism in provider training promotes plasticity, on both an individual and team level. She mentioned the need to establish ongoing training opportunities for faculty, such as the Project Extension for Community Healthcare Outcomes ([ECHO](#)) model. The group also recommended investing in people living in rural communities to expand the health professions pipeline. The next step would be to find successful program examples to discuss within the chapter. Dr. Angood mentioned that connectivity to a center of excellence is important to providing a continuum of care. Dr. Goodell also requested that the groups determine the structure of the report to help make it a cohesive document.

### **Issue 3: The Rural Healthcare Workforce: Necessary Investments**

*Andrew Bazemore, MD, MPH; John J. Norcini, PhD; Lois Margaret Nora, MD, JD, MBA; and Leith J. States, MD, MPH*

Dr. Bazemore stated the group worked on narrative alignment with the other two groups. One of their top recommendations is now “a strategic plan for investing in health professional workforce planning and education across the professional continuum for rural populations.” There continues to be conversations on centers of learning and telehealth for rural communities. The group is developing a set of measures for accountability, but decided against language around shaping governance. The group also focused on reducing existing environmental and regulatory barriers that limit effectiveness in addressing rural health needs. Finally, there needs to be a link between investment and innovation. He stated a need to look at learning at scale and moving away from pilot programs that rarely move forward.

### **Ethics Training**

*Laura Ridder, Ethics Advisor, Office of Human Resources, HRSA*

Dr. Nora introduced Ms. Laura Ridder, HRSA ethics advisor for COGME. Ms. Ridder presented a brief update on the ethics requirements for the members as special government employees. Members were reminded to reach out to the office with any ethics-related questions. Ms. Ridder described a new secure portal for submitting documents and participating in training. A member asked for clarification on how to handle certain situations such as speaking and writing engagements. Mr. Ridder advised that members should make it clear that they are not representing COGME, but they should reach out directly with specific questions for advice.

### **Presentation: Department of Veterans Affairs, Office of Academic Affiliations Update**

*Monica L. Lypson, MD, MHPE, FACP, Ex-officio Member, COGME*

Dr. Nora handed the meeting to Dr. Monica Lypson, current COGME member and Director, Medical and Dental Education, at the Department of Veterans Affairs (VA). Dr. Lypson provided an update on the Veterans Health Administration. She said that the MISSION Act of 2018 would help the VA provide more services to veterans in the community. The VA funds about 11,000 physician trainees and about 300 dental trainees, with a priority for mental health and primary care providers because of the challenge staffing for those positions within the VA.

Dr. Lypson observed there are staffing shortages in rural VA facilities, and the VA is focused on retaining trainees in the VA system to combat these shortages. She noted that VA practitioners who engage in either research or education have demonstrated high satisfaction levels. The VA is making efforts to direct trainees into sites with less than 20 full-time employees. The Office of Rural Health within the VA has developed a rural faculty development program to promote training of not only physicians, but of all types of health professionals through an interprofessional program.

One part of the MISSION Act aims to combat the problems with the VA scholarship program for physicians. Originally the program only had a 2-year authorization, and will now be a more robust program with a service commitment to the VA. There is also a loan repayment fix in the MISSION Act, as the original loan repayment cap was too low. The MISSION Act has clear priorities on loan repayment for physicians, particularly in specialty areas of high need within the VA.

Dr. Lypson stated that the VA has 32 NP residency programs, specifically developed with a focus on mental health and primary care. The VA also has 25 post-baccalaureate registered nurse (RN) residency programs to help RNs adapt to practice more quickly in the field and deploy into areas of high need.

Dr. Bazemore brought up the VA's Expansion in Rural Areas program, currently in the planning phase. This program would provide startup costs for establishing training programs, and serves as a good example of overcoming environmental barriers such as financing and startup costs. The program was delayed because it involves the creation of an extramural platform that did not exist at the VA.

Dr. Epperly asked about a mechanism to allow VA trainees to train offsite in rural areas, to help with workforce issues. Dr. Lypson responded that is the intent of the MISSION Act to allow trainees within federally covered facilities, such as the IHS.

Dr. Fraher asked about the cost and potential return on investment nurse practitioner residency programs. Dr. Lypson responded that the VA has that information and the data is very favorable, and could help to inform much of the work that the Council has been discussing in terms of team-based care. Dr. Carter asked for additional information on other residency programs such as chiropractors in the VA. Dr. Lypson replied that the VA is one of only a few chiropractic residency programs, which provide health care practitioners the skillset that they need to immediately deploy into the health care system.

### **Presentation: IHS Overview**

*CAPT Paul Jung, MD, MPH, Deputy Director, Division of Health Professions, Indian Health Service*

Dr. Carter introduced CAPT Paul Jung, Deputy Director of the Division of Health Professions Support at the IHS, to provide an overview of the agency and how they are addressing health care workforce issues. CAPT Jung stated that the IHS provides comprehensive health care to 2.2 million beneficiaries, all of whom are members of federally recognized tribes. The mission is to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives through direct patient-care services and other programs. The IHS appropriation is approximately \$5.5 billion, or approximately \$4,000 per capita. By comparison, CAPT Jung stated the VA budget is about \$10,000 per capita. There are around 15,000 staff members across IHS, of whom about a third are clinicians or other providers.

CAPT Jung said that IHS facilities serve about 40,000 inpatient admissions, and about 14 million outpatient visits, per year. Within the IHS are both federal-owned and tribal-owned facilities. The tribal facilities are completely independent and people who work at these facilities are not federal employees. Tribal facilities do not report data nor are overseen by the IHS. Most IHS facilities are in rural regions of America, and include hospitals and health centers, Alaskan village clinics, and health stations.

## Rural Health

The IHS has a vacancy rate of around 30 percent for medical officers. The vacancy rate for pharmacists is much lower (15 percent), perhaps because of the vibrant and active pharmacy resident program in the IHS. Council members raised questions on the availability of behavioral services within IHS. Dr. Jung stated that these services were available throughout the IHS, and that psychologist prescribing privileges depend on the individual health facilities and the individuals training. The scope of practice for NPs is similar and depends on state and local authorities.

Dr. Tsai asked about the breakdown of the types of vacancies that exist for the medical officer positions. Dr. Jung responded that there was not a detailed breakdown, but most are primary care practitioners. Facilities can transfer patients out if they need specialty services.

To extend the reach of the IHS, the Community Health Aide Program (CHAP), which started in Alaska, has been expanded to the lower 48 states. CHAP includes community health aides, behavioral health aides, and dental health aides. All providers are trained and certified by the program. The purpose is to improve health and increases access, and not replace professional providers.

To increase recruitment and retention, IHS has several programs including Title 38 pay scales; housing subsidies; recruitment at conferences and schools; relationships with universities, training programs, and associations to recruit from tribal communities; student rotations at IHS and tribal sites, IHS externship program; IHS grant programs (InMed, InPsych, and InNursing); and the IHS scholarships and loan repayment program. For example, the University of North Dakota InMed program offers students from tribal communities the opportunity to shadow a physician. The scholarship and loan repayment programs are modeled after the NHSC and are meant to produce more American Indian and Alaska Native health professionals. There are no requirements for a selecting a specialty, but participants must be an Alaska Native or American Indian student. The IHS is requesting a part-time payback and teaching payback like NHSC. The program is not restricted to physicians, but is open to dentists, NPs, nurse midwives, physician assistants, podiatrists, pharmacists, optometrists, and others.

The IHS loan repayment program is similarly open to a variety of providers. However, it lacks options for part-time payback or teaching credit for payback. Another large hurdle is that the awards are taxable, which results in additional funds being given to the student to pay the tax burden. The NHSC Loan Repayment program is not taxable, and the IHS has requested this status as well. The budget for the loan repayment program is approximately \$36 million. This has been a successful program, and the number of qualified applicants is more than double the budget. The average service obligation is three years, and recipients tend to stay three additional years beyond this obligation.

The IHS also funds two students per year at the Uniformed Services University of the Health Sciences to attend medical school as public health service officers with a 10-year service obligation within IHS following their residency. These graduates often become leaders within the IHS. While there are no medical residency programs at federal IHS sites, there are two at tribal facilities. Dr. Jung stated that the lack of residency programs is a missing piece of the pipeline, as graduates end up wherever they find funding, instead of staying within IHS after training. He mentioned that creating residency programs at IHS federal sites is a priority for retaining physicians within IHS.

Dr. Epperly asked a follow-up question on how COGME can help the IHS. Dr. Jung reiterated the request for creating residency programs within the IHS to increase the number of providers, but also training providers that have knowledge about Indian health. He also suggested removing the cap on residency programs when they are at IHS sites. Another suggestion was to create a funding formula for training residents at facilities that are primarily outpatient.

The IHS appropriation comes from the Department of the Interior. The Council discussed this issue from various angles. Dr. Carter reminded the members that the Council does not have any mechanism to make recommendations to the Department of the Interior. Dr. Nora stated that there is a need to for the committee to have a thorough examination of this issue.

Dr. Epperly asked about how the IHS is providing care. Dr. Jung stated that IHS is implementing team-based care, although there is a lot of room for improvement. One example is the Improving Patient Care Program, designed to modify operations to match the health needs of the population. This includes using team-based care to reach the community, and not making the community come to the provider.

### **Public Comment**

Dr. Carter opened the floor for public comment.

Ms. Hope Wittenberg, Council of Academic and Family Medicine, had several comments on the day's discussion. She noted that the Department of the Interior appropriates funding for the IHS, but there are several authorizing committees, such as the Department of Energy, Commerce, and others that COGME could contact. Also, the bill for reauthorizing the THCGME program asks for funding for 5 years, but there is a lot of concern on how to pay for it. She recommended that the Council determine the definition of "rural," and suggested looking at the definition in S.289 to make sure that it was not too open ended. This bill also would also remove residency caps for all rural areas, which would apply to the IHS as well. She added that the Title VII reauthorization includes the establishment of a rural workforce commission. She noted the enthusiasm for establishing a rural residency program, but there is concern with how to provide long-term financial stability for the program. She also cautioned that while there are some state-funded GME programs, these are often cut during times of budgetary constraints. Ms. Wittenberg advised the members to avoid the use of the term per-resident amount (PRA), as the term is used differently by CMS and teaching health centers, which can cause confusion.

Ms. Karen Mitchell, American Academy of Family Physicians (AAFP), commented on faculty development and long-term training related to plasticity, such as programs offered by the Society of Teachers and Family Medicine. The American Board of Family Medicine has a pilot program to give credit for performance improvement. She added that the AAFP Division of Continuing Medical Education (CME) is changing the way learners can connect to CME to provide more opportunities for specific topics needed by rural providers.

There were no further public comments.

### **Council 24<sup>th</sup> Report Discussion**

Dr. Carter turned the meeting over to Dr. Nora to discuss the 24<sup>th</sup> report. There was some discussion on how the three briefs should relate to each other to form specific chapters of the report. Dr. Goodell stated the report itself needs background on why rural health is important, followed by one paragraph introducing each issue brief. She suggested that the rest of the meeting should focus on creating the recommendations, to serve as the guideposts for writing the report. Dr. Fraher recommended cross-referencing the report, to point the reader to look for more information in other areas of the report.

Dr. Carter agreed that having shorter issue briefs would be informative for members of Congress, and the full report would allow a deeper dive into the recommendations. She suggested that the Council consider the necessary investments to support the entire rural healthcare workforce.

## Rural Health

Dr. Nora stated that during the 2<sup>nd</sup> day of the meeting the group should gather core principles and recommendations to start making the issue briefs consistent. They should also decide on the definition of rural that will be used. Developing and strengthening the healthcare workforce in rural communities may happen in multiple sectors. Creating a unique policy or issue brief may resonate with Congress to connect with them to get care to the people that need it.

Dr. Nora asked the members if they wanted to discuss funding in terms of opportunities for rural health that either exist and need to be increased or additional innovations as opposed to revisiting funding that already existed. Dr. Bazemore acknowledged that there is tension with the financing issue to not upset key stakeholders. Dr. Carter asked the Council to consider the existing physician workforce and addressing other sources of money outside of GME only. She stated that there would be a presentation on Title VII Part B funding on the following day, and this funding pool addresses medical students and other allied health professions, but also community health workers and paraprofessionals that the Council has discussed. COGME can make appropriation recommendations in that space.

Dr. Goodell mentioned that the Council needs to think about the larger picture and avoid just funding pilot programs, which rarely create meaningful change.

## **Conclusion**

Dr. Carter adjourned the meeting at 5:00 PM.

## Day 2: June 6, 2019

Dr. Carter called the meeting to order at 8:30 a.m., and turned the meeting over to Dr. Nora.

Dr. Nora opened the floor for comments on any new ideas that had come to mind during the previous day's discussions. Dr. Epperly proposed developing a focus on services provided at a community level by the healthcare team, and creating a payment source, such as a global capitated payment, that would honor and value this integrated teams' performance and service to the community.

Dr. Tsai mentioned that the Center for Medicare & Medicaid Innovation (CMMI) has an advanced practice primary care initiative, called [primary care first model options](#), that provides a funding structure to primary care practices to help promote team-based care. This model could be used as an example of how to provide funding for team-based care. He added that the existing rural GME grant program has focused on primary care. The Council could recommend expanding this program to cover general surgery and other healthcare specialties needed in rural areas, as well as to providers such as social workers or community health workers.

Dr. Goodell mentioned that helpful examples should be included in the report to illustrate the main points. Needs will vary by community and geographic region, and there is no one-size-fits all approach for improving rural health across the nation. Dr. Fraher emphasized the importance of using examples that will get the attention of Congress.

Dr. Tsai mentioned that there seemed to be a question of whether the Council should write policy briefs or issue briefs. Dr. Carter replied that the group is considering issue briefs, but should choose the best format to provide information on improving rural health. Dr. Scher asked for a clarification between the two types of documents. Dr. Bazemore stated that policy briefs tend to be more structured and formal, and provide specific recommendations, whereas issue briefs are less specific and rigid and allow for the communication of broader ideas. Dr. Fraher stated that the committee will likely end up with a hybrid type of document that contains a description of the problem along with a list of recommendations.

### *Discussion on Definition of Rural*

Dr. Nora asked the committee to discuss the definition of rural for the purposes of the report. Dr. Tsai stated that he had a report that compared the various definitions of rural that he would send to the group. Dr. Bazemore stated that there were over 15 different definitions, and most agencies have their own established definitions of rural. Dr. Fraher mentioned that the group should be strategic in the choice of definition such as the one in S.289 or the one used by the residency development grant program. Dr. Carter suggested that the Council use the FORHP [definition of rural](#), and that the Council may wish to talk to FORHP about how the analyzer works and take into consideration the discussion at the meeting.

### **Public Comment**

Dr. Nora opened the floor for public comment.

Ms. Wittenberg commented on the definition of rural. One consideration is to include communities that are within 10 miles of a sole community hospital. Current definitions might eliminate certain areas.

There were no other public comments.



## **Issue Brief Recommendations Workgroups**

Dr. Nora instructed the Council members to divide into the three workgroups to discuss and develop the key recommendations for the each issue brief. At the conclusion of this session, Dr. Carter reconvened the meeting for a report out from the workgroups.

### **Issue Brief 1: Special Needs in Rural America and Implications for Healthcare Workforce Education, Training and Practice**

*Erin Fraher, PhD, MPP; Monica L. Lypson, MD, MHPE, FACP; Thomas C. Tsai, MD, MPH; and Ted Epperly, MD*

Dr. Fraher summarized the group's prior discussion by saying group felt that efforts to reform physician GME training will only occur with radical reframing to put patients and their health care needs at the center of GME policy discussions. Such an approach will highlight the need for a diverse workforce made up of a team of professionals from various health professions needed to address patient health and social service needs throughout the life course from prenatal, maternity to end of life and palliative care. They want to highlight team-based training and the integration of health and social services.

The group proposed three recommendations:

1. New health and payment incentives are shifting care upstream to outpatient, community, and home settings yet most GME funding goes to hospitals. These trends suggest the need to enhance GME training in community-based setting.
2. Health workforce investments need to leverage the natural plasticity or flexibility of rural providers practice. Providers in rural communities generally have more comprehensive scopes of practice with generalism as their focus. Health workforce investment needs to support and enhance the generalist approach in both initial and ongoing training.
3. There is a need to expand existing funding categories for rural GME beyond typical primary care specialties to include general surgery as well as non-physician providers.

### **Issue Brief 2: Training Needs to Prepare/Encourage Health Professionals for Rural Practice**

*Kristen Goodell, MD, FAAFP; Peter B. Angood, MD, FRCS(C), FACS, MCCM; Eric J. Scher, MD, FACP; and Beth M. Roemer, MPH*

Dr. Goodell stated that the workgroup added to their overarching recommendations. New or existing assessments can be used to clarify the specific health services needs of individual communities, as well as the potential resources that exist within the communities. Individualized programs should then be created to train cohorts of different types of providers to work together as teams. These teams should include public health officers wherever possible. Programs should encourage partnerships between training programs and community institutions and resources. Many of these providers should already be living in, or hailing from, these communities and should be financially incentivized to train or return. Infrastructure, including transportation, broadband internet services, and other factors must support connections between rural areas and advanced specialty services.

The workgroup stressed the importance of public health services to make sure that patients requiring inpatient care have that option available. One more point was the need to have structures in place to ensure full access of care including tertiary care, referrals, and consults.

### **Issue 3: The Rural Healthcare Workforce: Necessary Investments**

*Andrew Bazemore, MD, MPH; John J. Norcini, PhD; Lois Margaret Nora, MD, JD, MBA; and Leith J. States, MD, MPH*

Dr. Bazemore stated that the previous day's discussions suggested that the group wants recommendations that are immediate, actionable, and visionary. The THCGME program and the IHS are both areas to bring attention to, because they have actionable paths to team-based training. Additionally, the group stressed the value of crafting rural-specific regulatory language. Institutions that are creating new residency programs in rural areas should not be affected by the residency cap. There is a need to create or revise regulations to permit rural hospitals to establish fair "total resident amounts" for funding. The workgroup wanted to retain recommendations on strategic planning, and planning and value.

The group recommends are:

- Expand and extend and make sustainable, successful place-based training initiatives including access to rural communities.
- Identify and eliminate regulatory barriers to help professional education expansion and innovation in rural areas.

### **The COGME 24<sup>th</sup> Report: General Discussion**

Dr. Nora opened the floor to a general discussion of the COGME 24<sup>th</sup> Report. Dr. Tsai mentioned that there is a new theme emerging around how to support the current workforce along with the issue of how to develop the pipeline. Dr. Fraher agreed that by only addressing the pipeline, meaningful change cannot happen, and they needed to stress the issue of retooling in issue 1.

Ms. Roemer stated that the charge of COGME relates to the workforce and that ultimately the Council is trying to promote broader access to care. Currently, there are financial barriers for both providers and patients. The Council should consider acknowledging other barriers to care.

Dr. Epperly brought up the issue of payment for rural providers, adding that there needs to be a mechanism and recommendation on payment change, in particular a form of payment that rewards team-based care. Without a payment mechanism, this type of care will not happen.

Dr. Nora asked for further comment on each of the recommendations for each of the issue briefs.

#### *Issue Brief 1 (Special Needs in Rural America and Implications for Healthcare Workforce Education, Training and Practice)*

Dr. Goodell recommended that a statement should be added that both GME funding and training are hospital-based, and changes are needed to promote community-based healthcare. Dr. Nora suggested broadening the introductory statement to focus more on the health workforce, and not just GME. Dr. Carter suggested using the term "radical reframing."

#### *Issue Brief 2 (Training Needs to Prepare/Encourage Health Professionals for Rural Practice)*

## Rural Health

Dr. Lypson brought up the fact that hospitals with 501(3)(c) not-for-profit status are required to perform community needs assessments. Dr. Carter mentioned that assessment could be interpreted in different ways. Dr. Epperly suggested developing a community score, similar to the APGAR score for newborns, that assesses the community's ability to provide and maintain healthcare services.

Dr. Fraher questioned why public health is singled out when the idea is to broaden the workforce. Ms. Roemer replied that public health has infrastructure that could be leveraged to help shift resources to rural communities. There was a great deal of discussion among the members on how to frame the discussion on public health.

### *Issue Brief 3 (The Rural Healthcare Workforce: Necessary Investments)*

Dr. Lypson mentioned that there should be a recommendation that when residency slots are reallocated, rural communities should be prioritized. Dr. Fraher recommended expanding rural training tracks to include all health professionals. She also recommended looking at New Mexico as an example of payments for team-based care. Dr. Epperly recommended that the Council should consider methods to attract more providers to rural health. Dr. Fraher stated that she would investigate finding some non-claims-based funding models to promote team-based care. Dr. Scher suggested the addition of interprofessional training to this issue brief.

## **Presentation – Division of Health Careers and Financial Support**

*CAPT Jacqueline Rodrigue, MSW, Director, Division of Health Careers and Financial Support*

*CAPT Madelyn Reyes, MA, MPA, RN, Deputy Director, Division of Health Careers and Financial Support*

Dr. Carter introduced CAPT Jacqueline Rodrigue, Director of the Division of Health Careers and Financial Support, and CAPT Madelyn Reyes, Deputy Director of the Division of Health Careers and Financial Support, to present on HRSA's the workforce diversity and pipeline programs. CAPT Rodrigue stated that research shows that health professionals who come from rural areas and underserved communities are more likely to return to those same communities to practice after completing their training. HRSA has 13 workforce programs, and these include scholarships, loans, as well as pipeline and diversity programs. The rest of her talk discussed the workforce pipeline programs. These programs funded 119 grantees, mostly at academic institutions across the U.S., which resulted in the training of almost 21,000 students and faculty. More than 5,000 of these students came from pipeline programs. Additionally, 25 percent of scholarship recipients came from rural areas.

CAPT Rodrigue gave a brief overview of the Centers of Excellence Program, authorized under Title VII Section 736, which is designed to strengthen the national capacity to produce a quality health care workforce whose racial and ethnic diversity is representative of the U.S. population. The program has three primary goals:

1. Serve as an innovative, educational resource to recruit, train underrepresented minority students and faculty.
2. Improve the clinical education and cultural competency of minority-health issues on social determinates of health.
3. Facilitate faculty and student research on minority-health issues.

## Rural Health

There are 6 legislative requirements of the Centers of Excellence Program:

1. Develop a competitive applicant pool
2. Enhance academic performance of underrepresented minority students
3. Focus on recruitment and training retention for underrepresented minorities
4. Clinical education and cultural competency development
5. Focus on minority-health disparities research
6. Build strategic partnerships with school districts, community colleges, and four-year academic institutions and other community-based partners

CAPT Rodrigue mentioned that the legislation requires that these programs offer stipends, but due to lack of funding, these stipends are often unavailable. Schools of medicine, dentistry, pharmacy, veterinary medicine, public health and allied health and behavioral health are eligible for these programs. There are four legislatively designated Centers of Excellence located within historically black colleges and universities. In addition, there are Hispanic serving institutions and Native American serving institutions, among other minority serving institutions.

CAPT Reyes provided an overview of the National HCOP Academies and scholarships for disadvantaged students. The purpose of the National HCOP Academies is to assist and support individuals from disadvantaged backgrounds to enter a health profession. The National HCOP Academies are expected to:

1. Promote the recruitment of qualified individuals from economically or educationally disadvantaged background into health professions including allied health programs.
2. Improve retention, matriculation, and graduation rates by implementing tailored enrichment programs designed to address the academic and social needs of economically or educationally disadvantaged students.
3. Provide opportunities for community-based health professionals training in primary care settings, emphasizing experiences in rural and underserved communities.

The HCOP Academy program targets rising high school juniors and seniors. In addition, eligible applicants include accredited schools of medicine, osteopathic medicine, public health, dentistry, veterinary medicine, optometry, pharmacy, allied health, chiropractic medicine, podiatry, and public and non-private/private schools that offer graduate programs and behavioral and mental health, including programs for the training of physician assistants and/or other public or private nonprofit health or educational entities, including community colleges, technical colleges, or tribal colleges. The National HCOP Academies also have an ambassador program with a goal towards matriculation into the applicant or partner organizations two- or four-year college, university, health, or allied health professions school, or employment in primary care setting in rural and underserved communities. Curriculums must be defined to help students prepare for meeting the admissions requirement for the next level of the educational pipeline trajectory and integrate training and research on clinical areas of opioid abuse and mental and behavioral health when applicable.

CAPT Reyes also described another pipeline program, the Scholarships for Disadvantaged Students (SDS). The SDS Program increases diversity in the health professions and nursing workforce by

## Rural Health

providing grants to eligible health profession schools for use in awarding scholarships to students from disadvantaged backgrounds with financial need, including students who are members of racial and ethnic minority groups. Participating schools are responsible for selecting scholarship recipients, making reasonable determinations of need, and providing scholarships that do not exceed the allowable costs, which include tuition, reasonable educational expenses, and reasonable living expenses with a cap of the total scholarship award of \$30,000. SDS has many eligible disciplines, including nursing, allied health, public health, behavioral health, mental health, and physician assistant.

CAPT Rodrigue discussed some opportunities for collaboration and challenges. The ability to increase the number of training sites in rural and underserved communities is a priority. HRSA would also like to strengthen the pipeline activities by partnering with other governmental entity programs that have historically focused on science, technology, math, and education. Some examples are Gaining Early Awareness and Readiness for Undergraduate Programs and the federal [TRIO](#) programs from the Department of Education. Another area is incorporating interdisciplinary (team-based) models into training. Currently, it is difficult to track the career trajectories of these awardees because they are very early in their careers. HRSA would like to find a mechanism to track these students, to see if the program is helping to fill hard-to-fill vacancies.

Dr. Tsai asked if there had been thought to expanding the language around the qualifying specialties to be tailored towards the specific needs of the communities. CAPT Rodrigue responded that the categories are broad, and not limited to single areas.

Dr. Nora asked what about the top priorities for these programs. CAPT Rodrigue stated that the biggest challenge is competing for preceptorships in rural and underserved communities. These programs often do not have any financial incentives for the students, and other programs have these benefits. Another priority would be funding for curriculum development that is focused on rural and underserved communities, as well as the social determinants of health applicable to rural health.

Dr. Angood asked how these programs are advertised to the communities where they would like to recruit. CAPT Rodrigue replied that HRSA is working on branding the different programs, such as the HCOP Academy. Grantees are also required to publish their work. These opportunities will also be listed in the HRSA publication, the Health Workforce Connector.

Dr. Lypson asked how participants are tracked through these programs. CAPT Rodrigue mentioned that the National Provider Identifier (NPI) number is being used to track some participants. The health workforce connector will also be used to track former participants.

Ms. Roemer commented that COGME is considering a recommendation for a homegrown scholar's program where the student is sponsored or supported by the community and wanted to know if a similar program already existed. CAPT Rodrigue replied that there is an area health education incentive program, that recruits' students from rural and underserved communities and exposes them to health professions careers early in the pipeline, but this could be expanded.

Dr. Fraher mentioned that much of the discussions from COGME have focused on programs similar to the Area Health Education Centers (AHEC) program. AHEC has struggled with funding over the years. Dr. Fraher asked how COGME can highlight the important and innovative role that AHECs play in bolstering the rural community health workforce. CAPT Rodrigue stated that there is a need for more preceptors, along with continued support for clinical positions in rural and underserved communities.

## Rural Health

Dr. Tsai asked about how many applicants to the HCOP Academy program receive funding. CAPT Rodrigue replied that this is the first year of funding for the program, so the exact data has not been looked at yet. However, the programs have been very popular and there are waiting lists to participate.

Dr. Carter asked about the appropriation for the AHEC programs, and what percentage of students receive stipends. CAPT Rodrigue stated that the appropriation is \$86.8 million. She also replied that the stipend funding percentage is very low. This kind of funding is particularly important for students from disadvantaged and rural backgrounds. These students often work part time to support their education and do not have the time to participate in other opportunities. Dr. Carter asked about the costs related to preceptors. CAPT Rodrigue replied that the costs are \$1,500 per year per student.

Dr. Carter suggested that the Council should work to finalize the recommendations.

Dr. Epperly supported enhancing the workforce diversity and pipeline programs that already exist. He suggested increased appropriations around 25 percent for Title VII Part B Programs to enhance HRSA's efforts to train the rural workforce.

Dr. Nora summarized the three elements that the Council had agreed on: 1) a recommendation of about 25 percent increase in funding; 2) the specific targets of that funding will be worked out upon the advice of COGME staff and other HRSA colleagues; 3) Any funding should also be associated with measurements and feedback. Dr. Goodell cautioned that many of these resources go to students from a wide range of disadvantaged backgrounds, and that the Council should be careful to not take away funding from these students to shift to a rural focus. Dr. Carter suggested that an additional workgroup should develop recommendations to look at this. Dr. Nora stated that writing a letter would be the best form of communication. A subgroup of volunteers, Dr. Epperly, Dr. Bazemore, Dr. States, Dr. Lyphon, Dr. Fraher, and Dr. Nora will work on this issue.

### **Council Discussion: CMS Student Documentation Letter**

Dr. Nora reviewed a letter to Congress supporting the rule change allowing documentation provided by medical students to be entered into the electronic health record. However, the Council also advocated that this rule change should also apply to nurse practitioners and physician assistants to use the student notes without re-documentation. Dr. Nora moved to approve the letter as written. Dr. Scher seconded the motion and the letter was approved.

### **Council 24<sup>th</sup> Report Discussion**

The Council members discussed some wording changes to Issue Brief 1 and added that most GME funding and health workforce training occurs in hospitals, while emerging trends suggest the need to enhance training in community-based settings. Dr. Fraher stated that the one piece that is missing is linking the existing workforce.

The revised recommendations for Issue Brief 1 were:

- New health and payment incentives are shifting care upstream to outpatient, community, and home settings, yet most GME funding flows to hospitals and most health workforce training occurs in the hospital. These trends suggest the need to enhance GME training in community-based settings.
- Health workforce investments need to leverage the natural plasticity, or flexibility, of rural providers' practice. Providers in rural communities generally have more comprehensive scopes of

## Rural Health

practice, with generalism as their focus; and health workforce investments need to support, and enhance, the generalist approach in both initial and ongoing training.

- Expand existing funding categories for rural GME to expand beyond typical primary care specialties to also include general surgery as well as non-physician providers.
- Supporting existing rural providers to deliver team-based care through alternative payment models.

Dr. Nora moved the discussion to Issue Brief 2.

Dr. Goodell stated that the group incorporated the comments from previous recommendations, and revised some of the language to emphasize providing support for change. Dr. Goodell asked the group to weigh in on ideas that would support rural health infrastructure and did not relate to training specifically such as telehealth capabilities. Dr. Scher suggested adding some language on supporting community needs and the training needs of students. The revised recommendations for Issue Brief 2 were:

- Health profession training programs in rural areas should be created to address individual community needs.
- Individualized programs should be created that train cohorts of different types of providers together, working as teams.
- Training programs will optimally integrate multiple local institutions, both public and private, which are invested in the health of the local population.
- Most rural providers should have close ties and be reflective of these communities.

The members also discussed some sub-recommendations. Many of the changes suggested were to make the recommendations like other briefs. Dr. Fraher mentioned a [report](#) from the Bipartisan Policy Council that would make a good reference for addressing varying needs among rural communities. There was some discussion among the members on making requirements more flexible for rural communities.

- Existing competencies must be flexible and tailored to the needs of rural communities.
- Programs must emphasize the following key issues in rural health training:
  - Team-based care allows for flexibility, decreases burnout, and expands care access.
  - Generalism in provider training is necessary in rural areas; more so than in urban places with a large cohort of specialists.
  - Lifelong multi-modality learning must be emphasized.
  - An interprofessional faculty will need continuous faculty and preceptor development because they will have to practice differently.
  - Structures like connection to a tertiary care center or center of excellence, for both treatment purposes and training purposes.

## Rural Health

Dr. Fraher mentioned that the members should tie workforce investments to workforce needs. Ms. Roemer commented that there should still be high standards for excellence while at the same time some ability to customize to individual community needs. Dr. Nora advised the group to take this under advisement and revise the language as necessary.

Dr. Nora then moved the discussion to Issue Brief 3.

Dr. Bazemore commented that adding a reference to a global payment model by CMS to promote team-based care would reinforce many of the recommendations in the report. Dr. Epperly advised removing mention of community health boards, as this may not sit well with individual practices. Dr. Lybson stressed the importance of interprofessional training as well as practice. Dr. Bazemore also talked about the measurement and value recommendation.

The Council discussed the recommendation for the strategic plan on rural health. Ms. Roemer suggested that “strategic” should be changed to “investment” to reflect that this is related to the financial recommendation. There was also some discussion on how to recommend increased appropriations for Title VII programs. Dr. Fraher suggested that the group should avoid the term “strategic plan” as it may suggest a central authority. Dr. Lybson suggesting adding some language on responding to the individual needs of the community. The revised recommendations for Issue 3 were:

- Expand and extend successful place-based training initiatives that promote access to care for rural communities.
- Identify and eliminate regulatory barriers to health professional education expansion and innovation in rural areas.
- Test sustainable financing for team-based rural delivery.
  - CMMI should immediately develop and deploy pilot testing for alternative payment models to support team-based rural interprofessional training and practice.
- Create an investment plan for a more “plastic” rural health workforce.
- Develop a set of measures consistent with the strategic plan and any other COGME-recommended actions to ensure value and return on investment in rural health education.

## Meeting Adjourn

Drs. Nora and Carter thanked the members for their participation and adjourned the meeting at 2:00 p.m.

## Acronym and Abbreviation List

AACOM	American Association of Colleges of Osteopathic Medicine
AAFP	American Academy of Family Physicians
ACO	Accountable care organization
AHEC	Area Health Education Centers
BHW	Bureau of Health Workforce
BHWET	Behavioral Health Workforce Education and Training
CHAP	Community Health Aide Program
CHGME	Children’s Hospital Graduate Medical Education



CME	Continuing Medical Education
CMMI	Center for Medicare & Medicaid Innovation
CMS	Centers for Medicare and Medicaid Services
COGME	Council on Graduate Medical Education
DMD	Division of Medicine and Dentistry
DNPH	Division of Nursing and Public Health
ECHO	Extension for Community Healthcare Outcomes
FORHP	Federal Office of Rural Health Policy
FQHC	Federally Qualified Health Center
FY	Fiscal Year
HCOP	Health Career Opportunity Programs
HHS	Department of Health and Human Services
HRSA	Health Resources and Services Administration
HIS	Indian Health Service
NCHWA	National Center for Health Workforce Analysis
NHSC	National Health Service Corp
NP	Nurse Practitioner
NPI	National Provider Identifier
PRA	Per-resident amount
RMOMS	Rural Maternity and Obstetric Management Strategies
RRPD	Rural Residency Planning and Development
SDS	Scholarships for Disadvantaged Students
THCGME	Teaching Health Centers Graduate Medical Education
VA	Veterans Affairs