COUNCIL ON GRADUATE MEDICAL EDUCATION (COGME)
Minutes of Meeting – November 8 & 10, 2011

Council Members Present:

Russell G. Robertson, MD, Chair
Thomas E. Keane, MD
Jerry E. Kruse, MD, MSPH
Spencer G. Nabors, MD, MPH
H. David Reines, MD
Mary Ellen Rimsza, MD
Keya Sau, PhD
Gamini S. Sooriyaarachchi, MD, MBA
David Squire
Donald Keith Watson, DO
Daniel J. Winn, MD
Tzvi M. Hefter, Designee of the Centers for Medicare & Medicaid Services

Others Present:

Kathleen Klink, MD, Director, Division of Medicine and Dentistry
Janet Heinrich, DrPH, RN, Associate Administrator, Bureau of Health Professions
Jerilyn K. Glass, MD, PhD, Deputy Executive Secretary, COGME

Tuesday, November 8, 2011

The Council on Graduate Medical Education (COGME) convened its meeting at the Georgetown University Hotel and Conference Center, 3800 Reservoir Road NW, Washington, DC 20057. Russell G. Robertson, MD, Chair, welcomed attendees and asked members to introduce themselves. He then invited Kathleen Klink, MD, Director of HRSA's Division of Medicine and Dentistry (DMD) to provide remarks.

Dr. Klink welcomed COGME members and provided a brief synopsis of COGME's mandated objectives. She summarized recent DMD activities such as development of program performance measures, primary care residency expansion, and physician assistant training. Dr. Robertson then introduced the first of a number of speakers for the meeting.

Jason Hwang, MD, MBA, Executive Director of Healthcare, Innosight Institute, stated that health care issues posed by an aging population, an increase in chronic disease, and an inequitable ratio of specialists/generalists require solutions beyond increasing the number of GME positions. He added that focusing on health care costs as a percentage of gross domestic product (GDP) is not the issue; rather, it is the *insufficient value* obtained from our health care dollars that is the issue. He also advocated applying the economic concept of *disruptive innovation* to health care, exemplified by the innovation of computers from mainframes to laptops. Translating this concept to health care involves the delegation of care for less complex health conditions to new care providers in new venues (e.g., nurse practitioners in retail clinics, team-based care in a medical home, and telehealth

services. This plan would allow doctors, surgeons, and specialists to care for the sickest of the sick at the top of their licensed scope of practice. Dr. Hwang stated that technology is a key component in this transformation, and he encouraged health care providers to participate in social media to ensure that information "out there" is accurate.

Linda E. Fishman, MBA, Senior Vice President for Public Policy Analysis and Development, American Hospital Association (AHA), provided information concerning federal deficit reduction efforts and their impact on GME. Her synopsis began with the Budget Control Act of August 2011 and subsequent bi-partisan congressional "Super Committee" created to locate budget savings and provide recommendations to Congress. She saw three possible outcomes: (a) the Super Committee's recommendations are adopted, (b) Congress passes a balanced budget amendment, or (c) automatic, across-the-board cuts begin in January 2013. If across-the-board cuts ensue, funding for indirect medical education (IME) could be affected. IME could be drastically cut and/or consolidated with direct funding. Ms. Fishman concluded by stating that AHA has been working to protect both indirect and direct GME funding and that a paper on *Deficit Reduction Alternatives in Healthcare* is included on its website.

Bob Phillips, MD, MSPH, Director, The Robert Graham Center, discussed the role of Critical Access Hospitals (CAHs) in residency training, part of a larger study by the Macy Foundation on CAHs and teaching health centers. CAHs have a location of at least 35 miles from the nearest hospital (15 miles in mountainous areas), contain 25 beds or less, include 24-hour emergency services, and provide no more than a four-day average length of stay. Dr. Phillips commented that CAHs, with a residency retention rate of 43 percent, can serve as an important factor in addressing the maldistribution of physicians. Based upon the study, Dr. Phillips concluded that CAHs could expand training for GME by participating in affiliations, similar to a consortia model.

Thomas J. Nasca, MD, MACP, Chief Executive Officer, Accreditation Council on Graduate Medical Education (ACGME), described milestones and competencies for a new accreditation system. The goals of such a system are to: (a) establish outcomes-based accreditation, (b) permit the innovation of good programs, (c) provide assistance to poor programs, (d) reduce the administrative burden of accreditation, (e) enhance institutional responsibility for quality and safety, and (f) present accountability outcomes to the public. The milestones provide observable steps for the education of future physicians by listing six clinical competencies:

1. Medical knowledge
2. Patient care and procedural skills
3. Interpersonal and communication skills
4. Professionalism
5. Practice-based learning and improvement
6. Systems-based practice

Dr. Nasca stated that the six competencies encourage the development of national, specialty-specific evaluation tools to measure outcomes, both formative and summative. He added that up to seven specialties may implement the next accreditation system by July 2013. He presented the results of an ACGME study that assessed the impact of reductions in GME financing on residency programs. Using three scenarios (stable funding, 33 percent reduction, 50 percent reduction), the study revealed that 6 percent of respondents would close GME programs under the stable funding

scenario, 88 percent would reduce programs under the 33 percent scenario, and 95 percent would reduce programs under the 50 percent scenario.

Malcolm Cox, MD, Chief Academic Affiliations Officer, Veterans Health Administration (VA), provided three case studies that illustrated how the VA is enhancing primary care through workforce expansion, program redesign, and practice redesign. He commented that the VA has completed a five-year initiative to increase GME positions by 2,000 full time equivalents. He acknowledged that increasing GME positions is not enough; rather, new learning models and approaches/incentives are needed to make careers in primary care more attractive. In program redesign, the VA has engaged in clinical education reform to restructure internal medicine residencies to include greater continuity in patient care and allowing residents to learn new skills through systems-based practice. Internal medicine residents have been satisfied with the continuity, and more studies are needed to determine if patient outcomes are improved. Dr. Cox explained that the VA is engaged in practice redesign through educational reform. The VA Centers of Excellence program includes educational goals such as shared decision-making with patients, continuity in relationships, interprofessional collaboration, and quality performance improvement.

Debra Weinstein, MD, Vice President for GME, Partners Healthcare System, discussed the reformation of GME by sharing recommendations from two Macy Foundation conferences in 2010 and 2011. The 2010 conference, covering GME regulation and finance, recommended aligning GME with the public's need for physicians through funding and innovation. The 2011 conference detailed GME content, recommending: (a) expansion of public representation and reporting; (b) expansion of GME training sites and content, with an increase in interprofessional education; and (c) use of competency and systems-based training with nationally endorsed, specialty-specific standards. Dr. Weinstein stated that broad-based competency standards, faculty development, and regulatory revision would allow innovation and facilitate implementation of these recommendations. She concluded that GME could be aligned with public need by eliminating preliminary and transitional year positions, decreasing the duration of core specialty training, providing financial incentives for targeted specialties, and regulating the number of GME positions according to specialty.

A panel discussion on *Graduate Medical Education: Will the Supply Meet the Demand?* was moderated by Edward Salsberg, Director of HRSA's National Center for Health Workforce Analysis. Panelists included Paul H. Rockey, MD, MPH, Director, Division of GME, American Medical Association; Stephen C. Shannon, DO, MPH, President and CEO, American Association of Colleges of Osteopathic Medicine; and Atul Grover, MD, PhD, Chief Advocacy Officer, Association of American Medical Colleges.

Dr. Salsberg began by acknowledging that the National Center for Health Workforce Analysis was established by the Affordable Care Act of 2010 to collect and analyze health workforce data. The data indicate that increased enrollment in medical and osteopathic schools necessitates an increase in residency positions. A study of total workforce needs requires knowledge of which can be met by U.S. versus international medical school graduates. Dr. Salsberg stressed that it is important to plan undergraduate and graduate capacity together. Otherwise, U.S. citizens may be forced to attend medical schools overseas before returning to the U.S. for GME.

Dr. Rockey stated that primary care is crucial with the changing demographics of an aging population, an increase in chronic disease, and an increase in unhealthy lifestyles that lead to obesity. However, the term "primary" is a misnomer; rather, the term "generalist" best describes a physician who has the broad skills for overall patient care. Just as the professions of business and education promote generalists, medicine should promote generalist skills. These skills include: (a) knowing the patient in the context of the social milieu; (b) leading teams and advising amid competing interventions; and (c) engaging in collaborative care and teamwork in a number of settings. Dr. Rockey stated that the AMA has joined a total of 40 organizations in writing a strong letter to the bi-partisan Congressional "Super Committee" requesting that funds for GME not incur a reduction at a time when it is apparent that expansion in GME programs is needed.

Dr. Shannon described conditions in osteopathic GME remarkably similar to allopathic GME: more applicants than matriculants; demographic changes in patient populations; and concerns over proposed reductions in funding health care and health professions education, including GME. He added that schools are searching for creative ways to finance programs, such as working with public health departments to fund a preventive medicine program. However, such efforts are *not* an answer to the GME funding issue. Dr. Shannon stated that a Blue Ribbon Commission, working in conjunction with foundations, is examining ways to restructure the educational process through competency-based training and length of training—adding that incremental changes could have a big impact on the future.

Dr. Grover commented that it was important to properly present data and avoid extremes in workforce planning because projections are dependent upon the context in which data are presented (e.g., ratio of 1 doctor to 300 patients vs. 1 doctor for 1,000 patients). He noted that at present there is a projected shortage of 90,000 physicians for the next decade, half in family and internal medicine and the remainder divided among all other specialties. Dr. Grover said that it is important to think about the efficient use of health care teams and to increase the number of primary care doctors.

Dr. Salsberg concluded the panel discussion by stating that HRSA, over the next several years, will be examining scope of practice to ensure health care professionals are allowed to work at the top of their license.

Dr. Robertson asked for public comment. Dr. David Sklar, Health Policy Fellow from the Robert Wood Johnson Foundation, commented that the shortage of physicians presents an opportunity to encourage current physicians to continue practicing instead of retiring. In addition, Dr. Sklar also stated that it was important to bring people into medicine interested in managing chronic disease and providing care for patients at end-of-life.

The meeting was adjourned at 5:26 pm.

Thursday, November 10, 2011

Dr. Robertson began the day's agenda by introducing Songhai Barclift, M.D, Chief, Community Based Training Branch, DMD. She provided information on training within teaching health centers (CHCs) which is a new model for community and academic partnerships to support community-based training of residents. She noted studies which concluded that residents exposed to CHCs during residency are more likely to practice in underserved areas than those not exposed to CHCs. She noted two themes that emerged from the studies: (a) a shared mission of service and education, and (b) an offset of training expenses due to lower recruiting costs. Dr. Barclift stated that HRSA

developed and received approval to institute a consortium model to accredit residents serving at CHCs.

Louis Coccodrilli, MPH, Chief, Area Health Education Centers Branch, provided insight into public health, diversity, and preventive medicine programs newly placed under COGME oversight by the Affordable Care Act. Mr. Coccodrilli provided an overview of these programs to familiarize COGME members and enable COGME to give feedback on performance measures for these programs. These programs include the Health Careers Opportunities Program (HCOP) for economically/educationally disadvantaged students, the Centers of Excellence (COE) to assist underrepresented minority groups to become faculty, and the Public Health Training Centers (PHTC) program.

COGME discussed, reviewed, and approved seven suggestions regarding performance measures for the programs under their purview covering such topics as: (a) the longitudinal tracking of students from pipeline entry to practice, (b) determining barriers to pipeline programs for disadvantaged and underrepresented minority students, (c) assessing factors that impede student admission into health professions programs (e.g., perceptions, attitudes, and ideas), (d) encouraging mentorship from both disadvantaged and non-disadvantaged health professionals, (e) educating students about health professions career options, (f) determining factors behind the "gap" that exists when students transition from pipeline programs into health care programs, and (e) supporting BHPr's efforts to review the content of preventive medicine residency programs.

Dr. Robertson requested Mr. Patrick Stephens, technical writer, to assist COGME in compiling a letter on GME to be sent to the Secretary of HHS; the Senate Committee on Energy and Commerce; and the House of Representatives Committee on Health, Education, Labor, and Pensions.

This letter, assessing the present environment for GME, stated that COGME recognized the necessity for:

- fundamental change in the continuum of medical education, from pre-medical undergraduate training through GME;
- major innovations in health care education, health care, and payment methodologies that improve health and health care;
- preservation of GME funding; and
- fundamental change that occurs within the current education model.

Based on these conclusions, COGME proposed the following recommendations to the Secretary and Congress:

1. Preserve the current level of GME funding, to prepare for the imminent increase in demand for health care and to recognize the implications of the Affordable Care Act.
2. Operationalize recommendations from COGME's 19th and 20th Reports (*Enhancing Flexibility in Graduate Medical Education* and *Enhancing Primary Care*), which included a recommendation to create 3,000 new entry-level GME positions.
3. The Association of Medical Colleges (AAMC) and the American Association of Colleges of Osteopathic Medicine (AACOM) jointly convene a meeting of accrediting agencies, licensing boards, and associations for a comprehensive review and development of new approaches for medical education and training.

COGME believes that implementing these recommendations could result in a substantial reduction in the overall cost of medical education and GME while retaining the standards and quality of our Nation's medical care. Topics covered in this letter will also serve as a foundation for COGME's upcoming Twenty-First Annual Report.

There was no public comment. The meeting adjourned at 2:25 pm.