COUNCIL ON GRADUATE MEDICAL EDUCATION (COGME)
Minutes of Meeting – July 23-24, 2012

Council Members Present:

David Goodman, MD, MS, Vice Chair
Kirk Calhoun, MD
Carol Carraccio, MD, MA
Erin Corriveau, MD
H. David Reines, MD
Mary Ellen Rimsza, MD
Kenneth I. Shine, MD
Gamini S. Sooriyaarachchi, MD, MBA
Donald Keith Watson, DO
Daniel J. Winn, MD
Judy Brannen, MD, Designee of the Department of Veterans Affairs

Others Present:

Mary K. Wakefield, PhD, RN, Administrator, Health Resources and Services Administration
Janet Heinrich, DrPH, RN, Associate Administrator, Bureau of Health Professions
Kathleen Klink, MD, Director, Division of Medicine and Dentistry
Juliette Jenkins, RN, MSN, Deputy Director, Division of Medicine and Dentistry
Jerilyn K. Glass, MD, PhD, Designated Federal Official, COGME

Monday, July 23, 2012

The Council on Graduate Medical Education (COGME) convened its meeting at 8:30 a.m. at the Hilton Washington DC/Rockville Executive Meeting Center, 1750 Rockville Pike, Rockville, MD 20852. David Goodman, MD, Vice Chair, welcomed attendees and invited members to introduce themselves. Kathleen Klink, MD, Director of HRSA's Division of Medicine and Dentistry, introduced Mary Wakefield, PhD, RN, HRSA Administrator, who provided introductory remarks.

Dr. Wakefield thanked COGME members for their service and their expertise in informing the work of the Agency. She stated that the health care workforce is central to HRSA's $8 billion-plus portfolio of programs. One of the Agency's core goals is to strengthen the workforce to better meet the health needs of the Nation. This goal requires a focus on the supply, diversity, and competence of physicians. She highlighted the importance of community-based training in underserved communities, collaborative training in teams, and use of technological advances such as telemedicine and medical records. Dr. Wakefield described a number of initiatives resulting from the Affordable Care Act of 2010, including HRSA's National Center for Health Workforce Analysis and a partnership with Centers for Medicare and Medicaid Services to award grants for health care delivery system innovations.

Further remarks were provided by Janet Heinrich, DrPH, RN, Associate Administrator of the Bureau of Health Professions. She described the Bureau's efforts to expand training of primary care providers, including physicians, physician assistants, and nurse practitioners; enhance diversity in the workforce; and increase workforce distribution across the country. She highlighted the Bureau's Coordinating Center for Interprofessional Education and Collaborative Practice, which will leverage efforts across government, and the Bureau's development of evaluation tools to measure short-term and long-term outcomes for its grant programs. Dr. Klink also gave remarks, focusing on current changes in the health care system and the evaluation of provider competencies.

Voting was held for officers of COGME. Dr. Goodman was elected Chair and H. David Reines, MD was elected Vice Chair.

Dr. Goodman began the discussion on the content of COGME's 21st report on restructuring graduate medical education (GME). He stated that the physician workforce will need to populate a new kind of health care delivery system and it should be trained to influence change in that system. Unfortunately, as change has occurred, GME funding has been stagnant. As he reviewed various GME funding recommendations from both public and private sectors, Dr. Goodman reiterated COGME's call for greater accountability of GME. Given that COGME is the only Federal advisory committee looking broadly at the physician workforce, it is important that its work be added to the National dialogue relatively quickly. Some themes discussed were: 1) the significant demands placed on GME by the sizeable increases in the number of medical school graduates in the next several years, 2) the need to evaluate GME outcomes, 3) the importance of competency-based team education, and 4) the need for change to the accreditation system for GME programs.

Dr. Goodman reviewed the work done so far on the report's preamble which begins with the premise that GME is a public good. The report points out the challenges to GME posed by an aging population, patients who widely differ in terms of access to care, a rapidly evolving health care system, and the public's lack of awareness of what GME is and a reluctance to invest funds without seeing a clear benefit to patients and populations. The key will be to demonstrate the value of GME by establishing a concordance between physician training and public need. The members suggested adding the following to the list of challenges: providing a clearer notion of what "value" in health care means, training physicians (along with faculty) in skill sets needed to practice in the 21st century, and developing innovative ways to address training costs. Dr. Goodman also reviewed the main ideas presented by speakers at the November 2011 COGME meeting, the letter COGME sent to Congress after that meeting, and the list of interest areas for the 21st report generated since then.

COGME members received ethics training by HRSA staff in a session that was closed to the public.

The afternoon agenda focused on report recommendations. Discussion centered on promoting innovation in GME, regardless of the funding environment. Some ideas were: incentivizing innovation in GME through competition, focusing on a set of principles by which GME has to change; moving primary care training away from a hospital-centric model; advancing new directions in training such as care coordination; and making evaluation of outcomes a funding requirement. Also discussed were curricular issues of population management and safety and the relationship between accreditation standards and the nature of competency-based training.

COGME discussed the topic of public accountability, asking the question: what are quality programs? Public accountability may be thought of as "measurable transparency." Possible practice outcomes to measure are the percent of residents who serve underserved populations and the number of services to the community. Accountability can reside in GME as an entire entity, in institutions, and in programs. However, it was pointed out that GME does not have total control over outcomes. For example, residents' massive medical school debt is an obvious contributing factor.

It was suggested that the report describe the overall size of the physician workforce; delineate workforce needs going forward, including a more diverse workforce; discuss how the workforce should be organized and which disciplines should be given priority; present the need for increased GME slots; and delineate how innovation in GME should be stimulated. All such recommendations will enhance the value of the health care system.

It was pointed out during the public comment period that program directors tend to be cautious about time-limited pilot projects and that it is not possible to use the fourth year of medical school as the first year of GME because of current ACGME requirements. One commenter urged COGME to come up with bold proposals on the future investment of human capital in health care delivery systems. He suggested that an additional metric for evaluating "accountable care organizations" could be the extent to which they are training the next generation of physicians while they provide care to populations. A final comment was that COGME should define the word "public" because the word can be interpreted in multiple ways. After the public comment period the meeting was adjourned.

Tuesday, July 24, 2012

Dr. Goodman re-convened the meeting at 8:10 a.m. and asked Dr. Klink to begin the discussion on performance measures. She reviewed COGME's new responsibilities for performance measures and longitudinal evaluation of grant programs under Parts A, B, and E of Title VII of the U.S. Public Health Service Act. Many of these programs are within the Division of Public Health Interdisciplinary Education and two staff members from that Division, Michelle Menser, MPH, and Kyle Peplinski, MA, gave an informational presentation on the performance measures developed by HRSA for three public health workforce programs and three diversity programs. Also included were two new programs funded for the first time: the Integrated Medicine Program and the National Coordinating Center for Integrated Medicine.

Because of the volume and complexity of the information presented, Dr. Goodman suggested that the process may be more productive if members are first given two or three examples of programs, along with performance measures and results, and then they would be better able to provide substantive comments. Dr. Klink pointed out that data collection will start in September 2012.

The Council discussed the maldistribution of GME slots and the notion of recommending a redistribution of existing slots to underserved areas or to places where physician supply is low. Additional funds might go for programs that advance population-based training and quality improvement. A redistribution of residency training would need to consider areas of need, quality of

education, and the extent of integration between medical education and health care systems. One important challenge will be to scale up innovative programs.

In terms of GME funding, COGME supported funding such that all new medical school graduates have residency slots and that the slots are distributed to states with the greatest workforce shortages. As a result of the Balanced Budget Act of 1996, the bulk of growth in GME in this country has gone to subspecialty training areas. This trend should be reversed and funds redirected to core residency training. An important recommendation to the Secretary and Congress would be that GME should be part of the overall expenditure of a whole host of new health care delivery models, such as accountable care organizations, medical/health homes, and collaborative care models.

The Council discussed funding partners for GME. In addition to the Federal government, other sources might include philanthropy, third party insurance, and paid residencies. The members recommended that a significant portion of the GME money be distributed to ambulatory settings, that a certain percentage of new slots go to new programs, and that money should follow residents. They requested more information be provided at the next meeting by the Council's CMS representative, Mr. Tzvi Hefter.

The Council broke into small working groups in the afternoon. Dr. Goodman led the preamble group. The group led by Dr. Reines focused on GME funding. This group will need some information from Mr. Hefter on how Medicare actually funds direct GME, what the restrictions are on IME, how funding supports outpatient care, and what changes in funding have occurred recently. The members felt that Children's Hospital GME should also be addressed by this group. Dr. Carraccio's group focused on outcomes for GME. Topics discussed included the educational system embedded in service and experiential learning; the continuum of education from undergrad through maintenance of certification (including six ACGME domains, plus two added ones by AAMC on interprofessional collaboration and personal and professional development); individualization of the learning process; better assessment tools for competency-based training; and sustainable mechanisms for ongoing innovation in medical education. Dr. Goodman requested that each group send its draft outline to his assistant, Ms. Elizabeth Bryan, within two weeks after the meeting.

One public comment cautioned that there are pitfalls to using external sources and non-traditional sources of funding.

The meeting adjourned at 3:15 p.m.