COGME | Council on Graduate Medical Education

Webinar and Teleconference

Sponsored by the Health Resources and Services Administration (HRSA)

Meeting Minutes
March 24 –25, 2022

Council Members in Attendance
Appointed Members
Erin Fraher, PhD, MPP, Outgoing Chair
Peter Hollmann, MD, Incoming Chair
Thomas Tsai, MD, MPH, Vice Chair (part day)
Andrew Bazemore, MD, MPH
Ted Epperly, MD
R. Armour Forse, MD, PhD
Beulette Y. Hooks, MD
Warren Jones, MD
Byron Joyner, MD, MPA
John Norcini, PhD
Linda Thomas-Hemak, MD
Surendra Varma, MD, DSc (Hon)
Kenneth Veit, DO, MBA

Federal Representatives
Joseph Brooks (Designee of the Centers for Medicare and Medicaid Services)
John Byrne, DO (Designee of the Department of Veterans Affairs)
CAPT Paul Jung, MD, MPH (Designee of the Health Resources and Services Administration)
Leith J. States, MD, MPH, MBA (Designee of the Assistant Secretary for Health)

Health Resources and Services Administration Staff Present:
Shane Rogers, Designated Federal Officer, COGME
Kennita R. Carter, MD, Subject Matter Expert, COGME; Chief, Graduate Medical Education, Division of Medicine and Dentistry, HRSA
CAPT Curi Kim, MD, MPH, Senior Advisor, Division of Medicine and Dentistry
Raymond Bingham, MSN, RN, Writer and Editor, Division of Medicine and Dentistry, HRSA
Janet Robinson, Advisory Council Operations, HRSA
Zuleika Bouzeid, Advisory Council Operations, HRSA
Kimberly Huffman, Advisory Council Operations, HRSA

Thursday, March 24, 2022

Welcome and Roll Call

Mr. Shane Rogers, the Designated Federal Officer for the Council on Graduate Medical Education (COGME or the Council), convened the first COGME meeting of fiscal year (FY) 2022 at 10:00 a.m. ET on Thursday, March 24, 2022. The meeting was sponsored by the Health Resources and Services Administration (HRSA), Department of Health and Human Services (HHS), and was conducted virtually using a videoconference meeting platform. According to the provisions of the Federal Advisory Committee Act, the meeting was open to the public for its duration. Mr. Rogers turned the meeting over to the COGME chair, Erin Fraher, PhD, MPP.

Dr. Fraher conducted a roll call, and 16 of the Council's 18 members were present, meeting the requirement of a quorum and allowing the meeting to proceed. Dr. Fraher noted the need for the Council to continue to meet through a virtual platform in response to the ongoing COVID-19 pandemic. She expressed her gratitude for the hard work and contributions of front-line clinicians and acknowledged the stresses they faced in providing care during the pandemic. She also welcomed the efforts of HRSA in funding programs to promote resilience and reduce burn-out within the health workforce.

24th Report Update and Discussion

Dr. Fraher announced that the Council's 24th Report, *Strengthening the Rural Health Workforce to Improve Health Outcomes in Rural Communities*, was in its final draft form. She stated that the report represented a weaving together of three issue briefs that the Council prepared over the previous three years, focused on disparities in rural health and developing the rural health workforce to improve access to care.

Dr. Fraher noted the challenges faced in preparing the issue briefs and report, given the rapid changes in health care due to the COVID-19 pandemic. She also acknowledged the work of the Council in writing several letters to the HHS Secretary and Congress, including:

- A response to provisions of Section 126 of the 2021 Consolidated Appropriations Act, as they applied to changes in federal funding of graduate medical education (GME),
- Input into the HHS Health Workforce Strategic Plan, required under Section 3402 of the 2020 Coronavirus Aid, Relief, and Economic Security (CARES) Act,
- A recommendation regarding a proposed rule change on medical record documentation from the Centers for Medicare and Medicaid Services (CMS), and
- A request for increased funding for the Health Careers Opportunity Program (HCOP).

Discussion

A Council member encouraged the Council to continue its forward thinking in terms of the reports and recommendations, as opposed to reiterating issues from previous reports. There was further discussion on the report process, with a suggestion to ensure adequate coverage of the topic and any related concerns, rather than focus on brevity. There was a further recommendation to alter the process to create a full report, then to develop shorter issue briefs, infographics, or other documents to highlight the most significant and timely issues. Further discussion covered a proposal to create a mechanism, to include both metrics and a dashboard

that would allow the Council to track actions undertaken in response to its recommendations.

As the Council had already approved the recommendations of the report, no final vote was required. Since no further edits were offered, Mr. Rogers stated that the final manuscript would be posted to the COGME website within the next few weeks.

COGME Chair Handoff

Dr. Fraher stated that her term as COGME chair had ended, and she introduced Dr. Peter Hollmann, MD, as the incoming COGME chair. Dr. Thomas Tsai, MD, MPH, agreed to remain as vice chair.

Presentation: Health Careers Opportunity Program (HCOP): The National HCOP Academies

Tammy Mayo-Blake, MEd
Branch Chief, Health Careers Pipeline Branch
Division of Health Careers & Financial Support
Bureau of Health Workforce, HRSA

Brandon Rose, MPH, COR-II
Public Health Analyst, Health Careers Pipeline Branch
Division of Health Careers & Financial Support
Bureau of Health Workforce, HRSA

Audrey Adade, MSW
Public Health Analyst, Health Careers Pipeline Branch
Division of Health Careers & Financial Support
Bureau of Health Workforce, HRSA

The first speaker was Tammy Mayo-Blake, MEd, Branch Chief, Health Careers Pipeline Branch, Division of Health Careers & Financial Support (DHCFS). Ms. Mayo-Blake noted that DHCFS oversees the Health Careers Opportunity Program (HCOP), along with three other programs that are designed to assist students from disadvantaged backgrounds enter the health professions:

- Scholarships for Disadvantaged Students,
- Area Health Education Centers, and
- Centers of Excellence.

Ms. Mayo-Blake introduced the two main presenters, Brandon Rose, MPH, and Audrey Adade, MSW, to provide an overview of the National HCOP Academies. Mr. Rose said that the National HCOP Academies help individuals from economically or educationally disadvantaged backgrounds to enter and successfully complete allied health or health professions education. The program assists students to develop the academic and social skills that meet their needs and provides training opportunities in community-based health care settings. The target populations include high school juniors and seniors, undergraduate college students, and adult, non-traditional students, including veterans. Entities eligible to apply for funding include:

- Accredited health professions schools,
- Allied health schools that offer certain graduate programs, and

- Other public or private nonprofit health or educational institutions, such as community or tribal colleges.

Programs in the National HCOP Academies must plan for the recruitment and retention of students from disadvantaged backgrounds; develop structured programs that include curriculum development, training, and research projects; and demonstrate a plan for project sustainability after federal funding ends. Programs must establish a cohort of at least 25 students each year, leading to matriculation into a two- or four-year college program in the health or allied health professions or employment in a primary care setting. Students are eligible for stipends and scholarship support. The current project period of September 2018 to August 2023 includes 21 grantees from 15 states and the District of Columbia.

Ms. Adade stated that HCOP awardees offered structured and unstructured programs to over 3,500 students in the health professions pipeline in the 2020–2021 academic year, of whom over 1,500 completed their training. Several HCOP Academies include clinical sites in rural, tribal, or other underserved areas. Students from the HCOP Academies have received admission to medical, nursing, and other professional schools. The grantee programs have been very innovative during the pandemic in developing virtual and hybrid programming, increasing access to virtual tools, offering creative clinical exposure opportunities, and providing increased mental health support for trainees.

Q and A

There was a question about targeting undergraduate students at historically black colleges and universities (HBCUs), along with a comment that some of the eligibility requirements limit that participation of many HBCUs. Dr. Mayo-Blake replied that some of the HCOP grant recipients include health professions schools at an HBCU, and they are required to partner with the undergraduate program.

There was a question about the percentage of individuals who have successfully completed the program. Dr. Mayo-Blake replied that the HRSA National Center for Health Workforce Analysis (NCHWA) recently completed a five-year analysis of the HCOP program, which is still under review. The goal is to train students who are representative of the local communities and have them return to those communities upon completion.

There was a question about collaboration between the HCOP Academies and the Area Health Education Center (AHEC) program or federally qualified health centers (FQHCs). Dr. Mayo-Blake stated that most of the HCOP Academies have some collaboration with AHEC programs in their state, while many are working on building relationships with local FQHCs to provide clinical training sites.

Presentation: Advisory Committee on Training in Primary Care Medicine and Dentistry

Sandra M. Snyder, DO
Chair, ACTPCMD

Dr. Hollmann introduced Sandra Snyder, DO, Chair of the Advisory Committee on Training in

Primary Care Medicine and Dentistry (ACTPCMD). Dr. Snyder noted that ACTPCMD was authorized in 1998 and serves to provide advice to the HHS secretary and Congress on policy, program development, and other significant matters concerning the medicine and dentistry training activities authorized under Title VII, Sections 747 and 748 of the Public Health Service Act. Dr. Snyder noted that programs under Section 747 focus on medical training, including physician assistants, while programs under Section 748 focus on training and career development in dentistry and dental hygiene. The Committee has 17 members who are appointed by the HHS secretary and serve three-year terms. The Committee membership is balanced, with representation from allopathic and osteopathic medicine, including family medicine, general internal medicine, pediatrics, and physician assistants, along with dentistry, including general dentistry, pediatric dentistry, public health dentistry and dental hygiene.

Dr. Snyder shared the topics of the recent ACTPCMD reports, noting that their 18th Report, published in 2021, addressed improving care in underserved rural communities. She said that the 19th and 20th Reports are currently in development. For its 19th Report, the Committee is focusing on the preparation of medical and dental trainees in the care of patients with special healthcare needs, including those with intellectual and developmental disabilities, as well as on health equity and workforce diversity in the post-pandemic phase. Noting the success of the Teaching Health Center Graduate Medical Education (THCGME) program, which has achieved strong outcomes in improving primary care training and increasing health care access to underserved communities and vulnerable populations, the Committee plans to recommend a workforce analysis of all federally funded programs to track trainees who practice primary care.

The 20th Report concerns dental therapy, an emerging allied primary care oral health profession. Dental therapists deliver essential primary oral healthcare especially in communities often underserved by the dental profession, and provide access to oral healthcare to high-risk individuals who may have undetected and untreated oral health issues. The Committee is recommending that PHS Act section 748 be amended to include dental therapists and trainees under several scholarship or loan repayment programs, that funding for programs under Section 748 be increased to train more dental therapists, and that metrics be developed to evaluate the impact of dental therapy on improving oral health care.

Dr. Snyder also presented a letter that ACTPCMD submitted to the HHS Secretary regarding the Indian Health Service (IHS), with recommendations to address workforce shortages at health facilities serving Native Americans and Alaskan natives.

Q and A

Dr. Hollmann asked about the differences in the charges of ACTPCMD and COGME. Dr. Kennita Carter, the COGME subject matter expert, replied that ACTPCMD focuses on primary care and oral health programs specifically under Title VII of the PHS act. Meanwhile, the charge of COGME is broader, covering graduate medical education and the entire range of specialties within the physician workforce. She added that certain programs under the purview of COGME, including the THCGME and the Children’s Hospitals Graduate Medical Education (CHGME) programs, also fund dental residencies outside of Title VII, but are included in the GME space as a function of a team-based, interprofessional approach to health care.

There was a comment highlighting the potential benefit of dental therapy in the prevention of

dental carries, especially in young children. A follow-up comment focused on oral health promotion as a key area of focus for family physicians serving the African-American population and the role of maintaining oral health in preventing many chronic conditions.

Dr. John Byrne, the representative on COGME from the Department of Veterans Affairs (VA), stated that the Mission Act expanded care for veterans in the community, including a GME expansion program targeted at high priority areas of the IHS and other tribal organizations. He added that proposed federal regulations have been posted for public comment. Dr. Paul Jung, the HRSA representative on COGME and the director of the HRSA Division of Medicine and Dentistry (DMD), added that the Mission Act could have a significant impact for tribal sites because of the large number of veterans who are Native Americans or Alaskan natives and who need access to VA services. He reinforced the health workforce shortage issues affecting the IHS, despite the high number of medical officers within the PHS Commissioned Corps serving at IHS sites. He noted the potential of a joint action between ACTPCMD and COGME to highlight the shortage and provide suggestions on how the Federal Government may address it.

There was a question about sustainability of care within underserved areas such as rural and tribal communities. Dr. Snyder replied that building a sustainable system in primary care relies on interprofessional teams involving social work, community health workers, pharmacists, and others; recognizing the importance of establishing their roles and responsibilities; and aligning care with the needs of the community. Another vital piece involves workforce diversity, including efforts to recruit individuals from rural areas into the health professions needed in their communities and developing local programs.

A final comment addressed the need to track outcomes of training programs, noting the work of the National Health Service Corps (NHSC) in following their graduates to identify the return on investment. Dr. Snyder added that having better metrics to track the outcomes of federal funding for GME, especially related to primary care, could help shift funding to where it is most needed.

Council Discussion/Vote: Joint BHW Committee Telehealth Letter of Support

Dr. Hollmann moved to the next agenda item, a Council discussion on a proposed letter to the HHS Secretary and Congress, developed jointly by the five advisory committees under the Bureau of Health Workforce (BHW), expressing support of ongoing utilization of telehealth and continuation of certain changes and flexibilities in telehealth policies and regulations put in place during the pandemic response. Mr. Rogers provided some background on the letter's purpose and development. He noted that three of the five advisory committees had reviewed and approved the letter, with minor editing changes. He added that a workgroup of COGME members had reviewed the draft letter and had suggested some further edits. Dr. Leith States, a member of this workgroup, went through the text and the edits. There was some discussion on the topic of payment parity for all providers, the need for data collection, and concern about communicating the outcomes of a telehealth visit with the patient's usual source of care to prevent fragmentation of care. At the conclusion of the discussion, the letter was approved by a unanimous voice vote.

Presentation: Graduate Medical Education Branch Update

Kennita Carter, MD
Chief, Graduate Medical Education Branch
Division of Medicine and Dentistry, Bureau of Health Workforce, HRSA

Robyn Duarte, MPH
Public Health Analyst
Division of Medicine and Dentistry, Bureau of Health Workforce, HRSA

Kristin Gordon
Management Analyst
Division of Medicine and Dentistry, Bureau of Health Workforce, HRSA

The next speaker, Kennita Carter, MD, outlined the programs within DMD's Graduate Medical Education Branch. She introduced Robyn Duarte, MPH, to discuss the CHGME program. Ms. Duarte said that CHGME provides funding to freestanding children's hospitals to support the training of pediatric and other residents in GME programs, as well as residents in pediatric and adult dentistry, according to a legislatively mandated formula. For academic year (AY) 2019–2020, CHGME supported over 13,000 residents in over 900 generalist and specialist training programs, who conducted over 1.6 million patient encounters and provided 4.7 million hours of service in medically underserved communities (MUCs). In 2013, CHGME initiated a Quality Bonus System (QBS), with the goal to recognize and incentivize CHGME awardees with high quality training outcomes. In AY 2019–2020, the QBS provided around $1.5 million in supplemental funding to 29 children's hospitals. Ms. Duarte noted that roughly half of the pediatric residents trained in the United States received their training in CHGME-supported hospitals, and that over 60 percent continue to practice in the state where they trained.

Ms. Duarte turned the presentation over the Kristin Gordon, project officer in DMD, for an overview of the THCGME program. Ms. Gordon stated that THCGME encompasses three separate programs. The first and longest running is the THCGME program, which involves accredited residency programs for both medicine and dentistry within community-based primary care Teaching Health Centers (THCs). This program is currently supporting almost 800 residents in 59 programs across 24 states. Next, the THC Planning and Development (THCPD) program, made possible by the 2020 American Rescue Plan (ARP), provides up to $500,000 per recipient to support the establishment and development of new primary care residency programs in community-based settings. These are grantees that are developing new programs that have not yet been accredited. Awardees can use THCPD funds for program accreditation, faculty salaries, curriculum development as well as other program development activities. Lastly, there is a cooperative agreement with the University of North Carolina-Chapel Hill for a THCPD technical assistance center that assists THCPD recipients in getting their new community-based residency programs up and running.

Ms. Gordon said that the overall purpose of these THCGME programs is to support the training of residents in community-based THCs. The goal is to prepare the residents to provide high quality care, particularly in rural and underserved communities, and to have the residents stay and practice in these areas. To date, the THCGME program has been able to produce some

strong data demonstrating its value. Since its onset in 2011, over 1,400 new primary care physicians and dentists have graduated, with 65 percent currently practicing in primary care settings. A map of the distribution of the THCGME programs across the United States showed a gap of programs serving the middle regions of the U.S., which HRSA expects to address as the program expands with a new funding announcement released in FY 2022. THCGME funding may be used to support training in family medicine, internal medicine, pediatrics, internal medicine/pediatrics, obstetrics and gynecology, psychiatry, geriatrics, and pediatric and general dentistry.

Q and A

One COGME member commented on the results of a survey conducted by his research group and submitted for publication on the impact of the THCGME program over its first 10 years. Among the findings, THCGME graduates were more likely to practice in the communities where they trained and to care for medically underserved communities than their non-THCGME-trained peers.

Another member commented on the difficulties of retaining young professionals with families to provide care in rural areas, out of concern for finding higher-quality schools for their children than are available in many rural communities. Dr. Carter replied that some retention strategies would be discussed in a later presentation.

There was another comment on the absence of general surgery residencies from the THCGME program. Generalist practice is important when providing care for rural or other underserved communities. In particular, there is a need for general surgery to support primary care practices and provide services at rural or critical access hospitals. Dr. Carter replied that THCGME focuses on community-based primary care residency programs. DMD has partnered with the HRSA Federal Office of Rural Health Policy (FORHP) in developing the Rural Residency Planning and Development program, for which surgical residency programs are eligible to apply. There was a further comment on the need to broaden the HRSA designations of Health Professional Shortage Areas (HPSAs) to include general surgery and other needed specialties. Dr. Jung clarified that general surgery is not an eligible specialty in the THCGME program, according to its authorizing legislation from Congress.

Another member stated that the THCGME program provides a major lever to address primary care workforce development. The program is notable for its commitment to the local community and for supporting ambulatory care in community-based settings. Noting the need for a linkage between the needs of the population and the workforce development systems, as stated in the COGME 24th Report, a greater focus is needed on obesity and addiction, two epidemics impacting the health of millions of Americans. She added that the lack of consistent appropriations for the THCGME program impairs its ability to reach the neediest communities.

Presentation: Teaching Health Center Planning and Development–Technical Assistance Center

Emily Hawes, PharmD, BCPS, CPP
Associate Professor, University of North Carolina (UNC) Department of Family Medicine

Associate Professor of Clinical Education, UNC Eshelman School of Pharmacy
Deputy Director, Teaching Health Center Planning & Development–Technical Assistance Center

Judith Pauwels, MD
Professor Emeritus, Department of Family Medicine
University of Washington School of Medicine
Associate Director for Program Development and Accreditation
WWAMI Family Medicine Residency Network

Dr. Hollmann introduced Emily Hawes, PharmD, BCPS, CPP, and Judith Pauwels, MD, to provide an overview of the THCPD Technical Assistance Center (THCPD-TAC). Dr. Hawes noted that HRSA created the THCPD program to provide start-up funding to launch community-based residency programs that could reinforce the workforce pipeline to medically underserved areas. Given the many common challenges and barriers that new residency programs face, the THCPD-TAC was created to provide guidance, technical assistance, tools, and resources to current as well as future THCGME residency programs as they pursue or maintain program accreditation from the Accreditation Council for Graduate Medical Education (ACGME) or the Commission on Dental Accreditation (CODA).

HRSA selected 47 THCPD grant recipients. To support these programs, the THCPD-TAC has developed an infrastructure that involves regional hub programs at established institutions, along with content experts and advisors, key stakeholders, and external partners. As a result, the THCPD-TAC is developing a broad guiding coalition of stakeholders and collaborators for a shared purpose to expand the THC model.

Dr. Hawes turned the presentation over to Dr. Pauwels for an outline of the technical assistance process. Dr. Pauwels said that the road map for THC program development was adapted from previous work with the HRSA Rural Residency Program Development grant and focused on three domains:

- Community Engagement,
- Institutional Sponsorship, and
- Financial Planning

New THC programs need to assess the needs and expectations of the local community. Since many THCs involve consortiums that include FQHCs, they need to address the issues of institutional control and governance as well as how to best align the competing clinical needs of the FQHC mission to serve the public and the educational mission to teach and prepare resident physicians and dentists. In addition, structures are needed to maintain financial stability while developing strong relationships between local facilities and larger facilities that provide opportunities to train residents in procedural competencies. Dr. Pauwels outlined the five steps of program development:

1. Exploration, including community assessment, local leadership, and support.
2. Design, including appointment of a program director and completion of an initial program design with the sponsoring institution.

3. Development, including obtaining support staff and faculty, developing a financial plan, and undergoing the process for ACGME accreditation.
4. Start-up, including marketing and recruitment, developing program infrastructure, and establishing a budget.
5. Maintenance, including annual recruitment, maintaining staff and faculty, maintaining financial solvency, and tracking and reporting program outcomes.

Dr. Pauwels turned the presentation over Mark Koday, DDS, who introduced himself as a general dentist and director of a THCGME program in the state of Washington, to discuss some of the differences between medical and dental residencies. Dr. Koday identified three main areas of concern. First, CODA requires that all sponsors and cosponsors must be accredited by an accrediting body approved by CMS, which can be an issue for smaller programs. Second, pediatric residencies have further accreditation restrictions and must be sponsored by a hospital, not a community health center. Third, many procedures required to complete dental residency are not covered under Medicare and may require access to specialized equipment, meaning that the sponsoring institutions may have to draw on grant funding rather than patient revenues to provide the needed care. Dr. Koday pointed to the TAC website, THCGME.org, which provides a range of resources for both medical and dental residency programs.

Q and A

One Council member expressed concern about the lack of a THCPD-TAC hub institution located in a southern state, where there is a great degree of need due to higher levels of poverty, chronic illness, and poorer health outcomes than most other regions of the country. Dr. Hawes replied that the three TAC hubs are located in the states of Washington, Wisconsin, and North Carolina. In addition, the program has recruited advisors from all different states and is working to connect them with programs in their local area. Dr. Pauwels said that having advisors who understand the particular challenges in different communities is an essential part of the work of the THCPD-TAC.

Presentation: Teaching Health Center Graduate Medical Education (THCGME) Cost Evaluation Update

Marsha Regenstein, PhD
Professor, Department of Health Policy and Management
Milken Institute School of Public Health
George Washington University

Marsha Regenstein, PhD, provided an update on a cost evaluation study of the THCGME program. Dr. Regenstein recognized the support of HRSA for its leadership and vision in expanding the primary care workforce dedicated to community-based care in under-resourced and rural communities. She said that the current evaluation is the second review of THCGME costs. The first cost evaluation, completed in 2016, estimated the per resident amount (PRA) of support required for a successful THCGME residency program to be about $157,000. She noted, however, that the training environment had changed significantly. The current study covers twice as many programs as the first, the financial data reflects more years of operating experience and other features to sharpen the data. It also explores some of the early impacts of the COVID-19 pandemic. Of the 55 THCs in place in FY 2018, data from 50 programs were

included in developing the new PRA estimate. Taking into account both costs and revenues, the median PRA estimate for FY 2022–2022 is $209,623, a significant increase from FY 2018–19. Thus, THCs are likely to be paid only about 76% of the true median cost of training in 2022–2023. A shortcoming in THC funding as currently structured is the lack of an inflation or update factor to reflect market realities in terms of healthcare and workforce costs. She emphasized that the study explored direct medical education costs. Indirect medical education costs are harder to estimate. The study team at George Washington University is working to identify additional options that are consistent with HRSA's mission and priorities, including payment approaches that are based on performance, quality, and outcomes.

Q and A

There was a comment about the difficulty in estimating the indirect costs, noting that the Medicare Payment Advisory Commission has been exploring the issue with particular emphasis on handling the shift within the health care system from hospital-based acute care to outpatient settings.

Presentation: National Advisory Council on the National Health Service Corps

Keisha R. Callins, MD, MPH
Chair, NACNHSC

Dr. Keisha Callins, MD, MPH, provided an overview of the National Advisory Council for the National Health Service Corps (NACNHSC). Dr. Callins said that the NACNHSC provides advice to HRSA on the NHSC. She briefly discussed her background, stating she was an NHSC scholar and participated in its loan repayment program to help with her journey through medical school. These NHSC experiences helped to drive her passion for working in rural underserved areas.

Dr. Callins stated that the NACNHSC is a group of experienced healthcare providers and administrators who are experts in the issues that communities face in meeting their healthcare needs. It provides recommendations to the HHS Secretary and, by designation, the HRSA Administrator, about changes to the NHSC that could improve health access and outcomes. Noting the shortage of primary care providers, Dr. Callins mentioned that NHSC clinicians serve as the backbone of primary care across the nation. In addition, she said that the COVID-19 pandemic exposed many fault lines within the health care system. The responsibilities of the NACNHSC include:

- Serving as a forum to identify priorities for the NHSC,
- Reviewing proposed policy changes, and
- Developing and distributing white papers and issue briefs.

Dr. Callins listed several topics of current interest for the NACNHSC:

- Prepare the healthcare workforce to deliver telehealth, and build an infrastructure to increase patient and provider utilization of telehealth services.
- Prepare the workforce to deliver interdisciplinary team-based care.
- Train culturally competent healthcare workforce adequately prepared to meet the unique needs of rural and underserved communities.

- Encourage education and training plans that emphasize mentoring to support recruitment, retention, and resilience.
- Promote exposure to community-based practice settings.
- Ensure equity in maternal care and behavioral healthcare.

Dr. Callins noted two pending publications from the NACNHSC. One provides recommendations for priorities in developing the healthcare workforce. The other addresses the readiness-to-practice protocols for health care providers in underserved communities, looking at facilitators, barriers, and potential measures. She noted the many shared interests between the NACNHSC and COGME, and welcomed any opportunities for partnership.

Presentation: National Health Service Corps Updates

Israil Ali, MPA
Director, Division of National Health Service Corps
Bureau of Health Workforce, HRSA

Israil Ali, MPA, provided an update on the NHSC. Mr. Ali described the NHSC as serving the mission of BHW to connect skilled health care professionals to communities in need, as one part of HRSA's broader efforts to address health equity. He noted that NHSC is celebrating its 50th anniversary in 2022. It is dedicated to building healthy communities and improving access to care through scholarship and loan repayment programs that support health professional students and primary care providers committed to serving in high-need areas, or HPSAs. He noted that many of the individuals who come through the NHSC stay within these communities even after they complete their service obligation.

Mr. Ali said that the NHSC supported nearly 20,000 clinicians in 2021, including behavioral health providers (47 percent), nurse practitioners (19 percent), physicians (13 percent), and dentists (9 percent). These clinicians provided care to more than 21 million Americans. The NHSC offers three distinct loan repayment programs: a traditional program that offers loan repayment in exchange of two years of service in the primary care workforce; a substance abuse disorder workforce loan repayment program, launched in 2019, with a three-year service commitment in a HPSA; and a rural community loan repayment program, which also has a three-year service commitment. Other program under the NHSC include the:

- Students to Service Loan Repayment Program, which offers to up to $120,000 in loan repayment funds in exchange for three years of service in underserved communities for students who are in their last year of medical, nursing, or dental school;.
- State Loan Repayment Program, intended for states and territories to operate their own loan repayment program for primary care providers working in HPSAs; and
- Scholarship Program, which provides scholarships to students pursuing careers in primary care in exchange for at least two years of service in a high need area.

Mr. Ali provided a quick overview of the NHSC budget, noting that the NHSC received over $850 million in FY 2022, including additional funding through the American Rescue Plan Act. This funding allowed HRSA to award every eligible provider who applied.

Mr. Ali discussed the three FY2022 NHSC priorities. First is supporting the NHSC pipeline,

including improving the readiness of NHSC clinicians to serve in HPSAs, expanding the disciplines in the Students to Service program, and recognizing BHW-funded post-graduate trainings. Second is to optimize data utilization, including evaluating the applicants who apply to NHSC programs, establishing data dashboards to externalize NHSC data, and improving analysis of NHSC outcomes. Third is to improve outreach to other pathway and pipeline programs, including THCGME, the Addiction Medicine Fellowship, HCOP, the AHEC program, and other HRSA programs, and evaluating residency and fellowship programs in the NHSC pipeline.

Q and A

There was a question about including general surgery under the primary care specialties eligible for the NHSC as one way to help develop the workforce for rural and underserved areas. There was a supporting comment on the need for general surgeons as a component of the care team and in support of other primary care services. Mr. Ali replied that NHSC is prepared to administer anything under its statutory authority.

Presentation: Initiative to Strengthen Primary Health Care

Shannon McDevitt, MD, MPH
Federal Partner Lead, *Initiative to Strengthen Primary Health Care*
Immediate Office of the Assistant Secretary for Health

Shannon McDevitt, MD, MPH, presented an overview of the HHS Initiative to Strengthen Primary Care. Dr. McDevitt stated that the long-standing need to strengthen primary healthcare has taken on new urgency in light of the COVID-19 pandemic, which exposed the weakening link between primary care and public health and eroded trust in health care. She said that primary care remains the most common entry point into health care and promotes longer lives and greater health equity. Strengthening primary health care is essential to achieving the following HHS priorities:

- Ending the pandemic,
- Expanding healthcare coverage and access,
- Improving behavioral healthcare, including addressing the opioid epidemic, and
- Improving child health and well-being.

Dr. McDevitt pointed to the recent report from the National Academies of Science, Engineering, and Medicine (NASEM), *Implementing High-Quality Primary Care*. This report provided an update to the definition of primary care to focus on whole-person care, the integration of behavioral healthcare, accessibility, and health equity. She noted the emphasis that HRSA is putting on interprofessional education, along with moving beyond the diagnosis and treatment model to think about what makes an individual or community healthy. The report is broken up into five domains: payment, access, workforce, digital health, and accountability.

> High-quality primary care is the provision of whole-person, integrated, accessible, and equitable health care by interprofessional teams that are accountable for addressing the majority of an individual's health and wellness needs across settings and through sustained relationships with patients, families, and communities.
> NASEM, May 2021

Dr. McDevitt said that the Initiative was launched by the Office of the Assistant Secretary for Health (OASH) in September 2021. The aim is "to strengthen primary health care for our nation that will provide high quality primary health care for all, improve the health of individuals, families and communities, and advance health equity." The Initiative will develop a plan to highlight the HHS role in steering, coordinating, and overseeing the strengthening of primary care, with specific actions to be taken across HHS and other federal agencies. She noted that this work will not be completed in a single effort; rather, it should involve a consistent striving to improve quality. Since its launch, OASH has established a federal leadership advisory group with representation at the highest levels of senior leadership across 18 different agencies and offices, performed a landscape analysis, and met with many different stakeholder groups outside of the federal government. The office is moving into an agency action planning phase, using the NASEM report as a guide. Dr. McDevitt highlighted the guiding principles:

- Equity,
- Access, and
- Health Outcomes.

Dr. McDevitt discussed several of the recommendations from the NASEM report and steps that HHS is taking to address them. She noted that the task force had engaged in several listening sessions with representatives from:

- Advocates for patients and families,
- Professional societies/trade organizations,
- Centers for primary care and primary care coalitions,
- Academia,
- Provider organizations and foundations,
- Care transformation programs and technical assistance organizations,
- Payers, purchasers, and employer associations, and
- NASEM.

Dr. McDevitt said that the major objective for the HHS plan is to make sure the patient and community voice is prominent and integrated throughout that plan. She added that a Request for Information would be coming out shortly and asked to share the link with COGME or the individual members to disseminate and provide formal comment in response.

Q and A

Dr. Hollmann commented that the COGME 24th report contained recommendations consistent with the NASEM report. There was a further comment that the report was a compilation of three issue briefs on rural health care, so COGME had given a lot of thought to advancing primary care and the needs of underserved communities. There was a question about what more HHS might need to hear from COGME to inform and advance the HHS initiative. Dr. McDevitt replied that she had reviewed the COGME report and recommendations. Implementing the NASEM and COGME recommendations would require time and coordination among federal agencies, along with a significant amount of legislative action.

There was a comment that primary care medical homes and other community-based settings serve to coordinate community resources and provide the critical learning environments for the interprofessional workforce. One member asked about the potential barriers HHS might face in

moving the future of primary care forward. Dr. McDevitt noted the need to establish a coordinating body within HHS. Without such an entity, there is a risk to lose the momentum for action, along with fatigue and mission creep to stall progress before the next pandemic or natural disaster.

There was a question about developing information technology solutions through the Office of the National Coordinator for Health Information Technology (ONC) to advance team-based care. Dr. McDevitt replied that the ONC has a tremendous amount of expertise, but their role is not as a developer of new technology, but in creating the standards for interoperability. She noted that ONC has created the current road map for public-private partnership that reinforce the standards, which can accelerate information technology development in the private sector.

Consistent with the HHS Initiative, there was a comment that the healthcare system should: be designed around patients and populations; work to understand and address the critical health needs of population; and foster opportunities for interprofessional training, both with new students and within the current workforce. Dr. McDevitt replied that the Initiative task force centered its thinking around the right approach on supporting the health of both the individual and the community, so they feel empowered to take control of their own wellness.

There was a further comment on alternative payment mechanisms for both training and practice, recognizing the need for financial sustainability. The shift away from fee-for-service has helped some primary care centers bring on social workers and integrate behavioral healthcare with primary care services, or even develop community health teams. Different funding mechanisms may be needed to fully realize the NASEM recommendations. There was a further comment on the need to structure payment models to promote a team-based approach to healthcare. Putting in place an alternative payment model that would cover all patients engaged in the practice in the community could help advance quality outcomes, while saving money and decreasing provider burnout. There was a suggestion of the need for a central coordinating body for primary care.

Another member commented on the benefit of promoting a learning environment across the continuum of healthcare delivery and across all health professions. There is a need for continuing education of physicians and others, to promote lifelong professional development and remain joyful in practice by always learning and growing.

Dr. McDevitt noted the lack of a consensus definition for primary healthcare or a core set of measures to use, and advisory panels such as COGME could provide some recommendation. Without federal guidance, states are developing their own sets of measures, making it difficult to compare programs and outcomes across states.

Dr. McDevitt commented on a conversation she had with a nurse who suggested encouraging more RNs who are getting burned out in inpatient care settings, especially during the pandemic, to consider going into primary or ambulatory care and rediscover their love of nursing and helping others. Another COGME member said that nursing workforce data are showing an exodus from hospital-based nursing into community-based ambulatory care settings. However, the majority of nurse education and training remains focused on acute care.

There was a final comment on the need to address health literacy within communities to help individuals become better informed as healthcare consumers and participate more fully in maintaining their health. Dr. McDevitt agreed that there has been a loss of trust in the healthcare system, and improving health literacy could be one way to help individuals and communities participate in promoting their own health.

Public Comment

There was one public comment offered, noting that the cost of medical education can present a barrier to entry for many individuals from minority and underrepresented groups, while the process of taking advantage of opportunities such as the NHSC programs can be difficult to navigate. The commenter also stated that she appreciated the discussion on professional collaboration and the integration of care delivery with the education process, and expressed support for HRSA's efforts to promote interprofessional education and practice.

Wrap Up

Dr. Hollmann reviewed the events of the day and summarized the presentations the Council had received. He noted the opportunity presented to collaborate with ACTPCMD on a letter regarding the challenges at the IHS. He noted some common themes among the presentations and discussions regarding team-based care, sustainability of programs, incentives, and metrics. He noted that the Council would begin discussions during the second day of the meeting on potential topics for its next report.

Meeting Adjourn

Mr. Rogers adjourned the first day of the meeting at 4:30 p.m. ET.

Friday, March 25, 2022

Welcome/Roll Call/Agenda Review

Mr. Rogers welcomed the COGME members to the second day of the meeting and conducted a roll call. He confirmed the presence of a quorum and the meeting proceeded.

Presentation: Bureau of Health Workforce Updates

Luis Padilla, MD
Associate Administrator for Health Workforce
Health Resources and Services Administration

Luis Padilla, M.D., Associate Administrator for BHW, presented an overview of BHW's current programs and funding, upcoming initiatives, and research and resources. He stated that the workforce programs of BHW have four aims: increase access to care, balance the supply of healthcare workers with demand, improve the distribution of the health workforce, and enhance the quality of care. Over the course of the pandemic, the country has seen the dire need for more equitable access to care. The nursing workforce has been particularly hard hit. BHW has a strong focus on outcomes and remains intent on demonstrating the long-term impact of its

programs on enhancing healthcare access and quality.

Dr. Padilla discussed the focus across the federal government on the COVID-19 response and health equity, noting that several Executive Orders have influenced the current and future funding opportunities offered by HRSA. Within BHW, the areas of emphasis include behavioral health, community health, and maternal health. The Behavioral Health Workforce Education and Training (BHWET) program has expanded in size and incorporated community-based training and the integration of behavioral health in primary care. While the initial focus of BHWET was the opioid epidemic, Congress has shown greater interest in broadening the infrastructure of behavioral health and increasing both the supply and the diversity of the behavioral health workforce to support community health. In addition, he noted the pressing need for addressing maternal health and decreasing the significant and long-standing disparities in outcomes. Cross-cutting themes in healthcare include supporting provider resilience, enhancing the adoption and use of telehealth, and improving health equity by increasing the diversity of the health workforce.

Dr. Padilla explored some of the challenges of addressing community needs. He said that HRSA is developing tools and measures in identifying HPSAs that better characterize community need across the country. He noted that HHS is emphasizing the infrastructure to improve rural health centers and community health centers, while the Centers for Disease Control and Prevention is preparing to deploy $3 billion in public health and community health work infrastructure funds.

He noted the need to do a better job of bolstering educational and training pipeline. Some admission practices within schools of medicine and nursing, in particular, may result in the loss of talented individuals going into the health professions, so there is work to do in terms of identifying community members who are promising students, helping them prepare for admission into health professions schools, and supporting them during their education and after they complete their training.

Dr. Padilla said that HRSA received funding from the ARP to support resiliency among the workforce. Even before the pandemic, health professionals had a high rate of mental health conditions and suicide; the stresses of the pandemic has only made it worse. He pointed to a recent HRSA program, Promoting Resilience and Mental Health Among the Health Professional Workforce, that provided around $30 million to 10 awardee organizations to look at the culture of wellness to support the current and future workforce. The ARP also provided a significant increase in funding to the THCGME program, as well as the NHSC and Nurse Corps.

Dr. Padilla said that a survey of over 8,000 health centers across the country helped identify community needs in support of the Health Professions Education and Training Initiative. As a result, HRSA has encouraged these health centers to develop a workforce action plan, enhance their partnerships with academic institutions, and demonstrate the sustainability and the return on investment on community-based training models across the country. He added that HRSA has worked to make the health workforce data it collects more available and accessible to the public through the development of a number of data dashboards.

Dr. Padilla said that HRSA would be hosting a virtual all-grantee and stakeholder meeting and encouraged the COGME members to register. The key areas of discussion will focus on:

- COVID-19 Response,
- Health Equity and Diversity,
- Behavioral Health and Community Health, and
- Provider Resilience and Telehealth.

Looking ahead, Dr. Padilla said the key areas of emphasis in the recovery from the pandemic as the country enters the post-COVID phase includes:

- Advancing health equity and provider diversity,
- Expanding care teams,
- Encouraging careers in public health, and
- Expanding the workforce in primary care, behavioral health, and nursing.

Q and A

There was a comment that many areas of the country resist steps to achieve health equity, under the interpretation that if one person or group gains, another loses. A messaging approach should clarify that a more equitable system benefits everyone. Dr. Padilla replied that the root question focuses on what we mean by health equity and how we achieve parity. HHS and the White House have focused on addressing disparities and promoting an equal distribution of resources, not taking away services. The message is to "lift all boats" to address needs and reduce disparities in communities.

There was another comment highlighting the images in the presentation slides, which depicted many minorities in caring and professional roles. Such images used to be rare. This type of messaging can help policy leaders and others in thinking about issues of equity and serves to align with the images and the words. The country cannot achieve health equity without diversifying the workforce.

There was a question regarding how COGME can support BHW in promoting the sustainability of health equity efforts. Dr. Padilla agreed with the challenge of achieving long-term sustainability in any of the programs that rely on federal grant funding. BHW is pushing to be more intentional in its programs, meaning that expectations benchmarks for success are clearly stated. He noted that the BHW advisory councils, and COGME in particular, are very active in their support and recommendations, and their letters and other publications receive a lot of attention.

A COGME member addressed the stress and tension experienced by the current workforce, driving an increase in burnout and causing many to leave the health professions. Another member observed that patients seem to have lost respect for providers, to the point of physical or verbal abuse. There is a need to expand the narrative from strategies for wellness and resiliency and enhanced coping skills to focus on the experience of trauma and how to process it, recover, and continue in professional and personal growth. Dr. Padilla noted the need for changes in organization culture within the health care system to promote wellness in the workforce. As one example, he pointed to data showing that many physicians are forced to complete their charting after their work hours, taking time away from their family and contributing to burnout.

There was a comment about developing linkages between the THCs and other community health

centers and programs to promote training, such as Rural Residency Program Development. There was a follow-up question on the HRSA Readiness to Train (RTT) assessment tool. Dr. Padilla said that data from the RTT has been shared with health centers and can help them form the basis of a workforce development plan. He suggested having someone from the RTT development team speak at a future COGME meeting.

Another comment stressed the need to reach children at an early age in order to improve workforce diversity, as many children of color decide what they want to be by elementary school, from programs they see on television or elsewhere.

A Council member asked if HRSA had surveyed its grant recipients on how to promote grassroots sustainable action from its funding. Dr. Padilla replied that HRSA does survey its grant recipients on satisfaction, but there are limits to the types of questions HRSA can ask and types of data it can collect. However, HRSA is striving to improve the accountability of its programs, particularly in the areas of workforce diversity and health care access.

Discussion: 25th Report Topics and Publication Strategies

Dr. Hollmann moderated Council discussions focused on exploring topics for its 25th Report, along with other matters of concern. Dr. Hollmann suggested some initial criteria to follow in exploring a new report topic:

- What is the problem area that needs to be addressed?
- How will COGME help inform Congress and others on this topic?
- What role would COGME take—as a lead, or in support of another initiative?
- What other groups might take on this subject?
- What expertise could COGME bring to address the topic?
- Is the topic area an HHS or HRSA priority?
- Will COGME be able to create measures to evaluate whether its recommendations were successfully implemented?

In response to a request, Dr. Hollmann provided a brief review of the COGME charge:

- Supply and distribution of physicians;
- Current and future shortages related to medical specialties and subspecialties;
- Issues for medical school graduates, involving financing of undergraduate and graduate programs and changes in GME programs;
- Appropriate efforts to be carried out by hospitals, accrediting bodies, and related entities;
- Deficiencies in and needs for improvements in existing databases;
- Development of performance measures and longitudinal evaluations; and
- Appropriation levels of programs under COGME's charge.

There was a reminder the COGME has a legislative mandate to publish a report every five years. However, the topic and structure of the report are at the Council's discretion. COGME report and recommendations to Congress and the HHS Secretary have significant influence and should focus on areas where the Council can have its greatest impact. The strongest recommendations provide a specific and actionable change and state who it is addressed to and how it should be implemented and evaluated.

Dr. Hollmann stated that reports provide space for a broad and in-depth overview and understanding of a topic, but they take time to develop. In addition, COGME can employ other outlets on a shorter and more nimble basis, such as the preparation of letters to the HHS Secretary and Congress, issue briefs, infographics, and related documents. In exploring topics, one member suggested that COGME should emphasize looking toward the future rather than rehashing old problems.

Members discussed the planning process for developing the 25th Report. There was a suggestion to follow the process of the 24th Report, in writing a series of Issue Briefs, to be consolidated into a final report, along with a suggestion to reverse the process to prepare the full report and write Issue Briefs covering the main topics to promote dissemination.

The members explored several proposed report topics, including:
- Underrepresented Groups;
- Aging Demographic, both in the general population and in the physician workforce;
- Population Management/Value Based Payment;
- Team Healthcare;
- Augmented Intelligence;
- Performance Measurement; and
- International Medical Graduates.

The topic discussions centered on the areas of health equity and improving the recruitment and retention of minority and under-represented populations in the medical professions, including pipeline issues, and long-term retention. No final decision was reached and discussions are set to continue in the September 2022 COGME meeting.

Council Workgroups

The Council formed four workgroups (WGs) to address areas of immediate concern:
- WG1: 24th Report Recommendation Metrics, to include Drs. Epperly, Varma, Norcini, and Hollmann
- WG2: 24th Report Dissemination Strategies, to include Drs. Fraher, Jones, Veit, Bazemore, Hooks, and Thomas-Hemak.
- WG3: Draft a letter to the HHS Secretary and Congress in support of stable, long-term funding for the THCGME program, to include Drs. Bazemore, Joyner, Jones, and Thomas-Hemak. WG3 might also draft a letter of concern noting the significant loss of medical students of color or from minority backgrounds who fail medical school, are unsuccessful in the residency match process, or drop out of residency.
- WG4: Draft a letter to the HHS Secretary and Congress to recommend the inclusion of general surgery within the medical specialties eligible for primary care funding, to include Drs. Epperly and Tsai. This letter would examine the eligible specialties under THCGME, NHSC, and other programs. WG4 might look into coordinating with FORHP. There was also a suggestion to have the American College of Surgeons present at an upcoming COGME meeting.

There was further discussion on another WG to research information that COGME should review on an annual basis, such as residency match rates.

Business Meeting

Mr. Rogers reminded the COGME members that the next public meeting is scheduled for September 12, 2022. The meeting will be held virtually, but HRSA is exploring the process to resume in-person meetings. He reminded the members to complete their annual ethics recertifications.

Mr. Rogers noted that members of the public may reach out to COGME directly on certain topics that fall under the Council's charge. He stated the members should not engage and provided the following options:

- Ignore the contact;
- If the contact comes by email, forward it to the DFO, who will work with the individual or organization to make sure that the comments are received by the Council during the public comment session of a public meeting; or
- Similarly, if the contact is by phone, refer them to the DFO.

He also reminded the COGME members of the upcoming BHW all-grantee virtual meeting scheduled for April 5–6, 2022.

In planning for the September 2022 meeting, the Council members suggesting identifying a speaker from ACGME and/or CODA to discuss the accreditation process, as well as the high loss of minority residents. Two potential speakers were suggested from ACGME, Dr. Thomas Nasca and Dr. William McDade.

Adjourn

Mr. Rogers adjourned the meeting at 4:00 p.m. ET.

Acronym and Abbreviation List

ACGME	Accreditation Council for Graduate Medical Education
ACTPCMD	Advisory Committee on Training in Primary Care Medicine and Dentistry
AHEC	Area Health Education Center
AY	Academic Year
BHW	Bureau of Health Workforce
BHWET	Behavioral Health Workforce Education and Training
CHGME	Children's Hospitals Graduate Medical Education
CODA	Commission on Dental Accreditation
CMS	Centers for Medicare & Medicaid Services
COGME	Council on Graduate Medical Education
DMD	Division of Medicine and Dentistry
DHCFS	Division of Health Careers & Financial Support
FORHP	Federal Office of Rural Health Policy
FQHC	Federally Qualified Health Centers
FY	Fiscal Year
GME	Graduate Medical Education
HBCUs	Historically Black Colleges and Universities
HCOP	Health Careers Opportunity Program
HHS	U.S. Department of Health and Human Services
HPSA	Health Professional Shortage Areas
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
MUC	Medically Underserved Communities
NACNHSC	National Advisory Council for the National Health Service Corps
NASEM	National Academies of Science, Engineering and Medicine
NHSC	National Health Service Corps
OASH	Office of the Assistant Secretary for Health
ONC	Office of the National Coordinator for Health Information Technology
QBS	Quality Bonus System
RTT	Readiness to Train
THC	Teaching Health Centers
THCGME	Teaching Health Center Graduate Medical Education
THCPD	Teaching Health Center Planning and Development
THCPD-TAC	Teaching Health Center Planning and Development Technical Assistance Center
VA	Department of Veterans Affairs