# COGME
## Council on Graduate Medical Education

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June 30, 2020

The Honorable Alex M. Azar II
Secretary of Health and Human Services
200 Independence Ave S.W.
Washington, DC 20201

The Honorable Lamar Alexander
Chair, Committee on Health, Education,
Labor and Pensions
United States Senate
Washington, DC 20510

The Honorable Patty Murray
Ranking Member, Committee on Health, Education,
Labor and Pensions
United States Senate
Washington, DC 20510

The Honorable Frank Pallone
Chair, Committee on Energy and Commerce
House of Representatives
Washington, DC 20515

The Honorable Greg Walden
Ranking Member, Committee on Energy and
Commerce
House of Representatives
Washington, DC 20515

Dear Secretary Azar, Chairman Alexander, Ranking Member Murray, Chairman Walden, and Ranking Member Pallone:

In its over 30 years of service, the Council on Graduate Medical Education (COGME) has provided advice and recommendations on federal policy and investments in graduate medical education (GME), physician training and medical practice, and a broad range of health workforce issues. However, in the course of its history, the Council has not faced a public health emergency of the scope, magnitude, and threat to the nation as the current COVID-19 pandemic.

Section 3402 of the *CARES Act* calls on the Secretary, in collaboration with the Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD) and COGME, to "develop a comprehensive and coordinated plan with respect to the health care workforce development programs of the Department of Health and Human Services, including education and training programs." In keeping with this charge, and COGME's longstanding role in health workforce policy in the United States, the Council has developed several direct and actionable recommendations to bolster the nation's health workforce responding to the pandemic. These recommendations cover five high-priority areas (outlined in more detail in the attached Appendix):

- Bolster telehealth accessibility, usage, and infrastructure
- Stabilize/provide financial relief for vulnerable practices and critical access hospitals
- Strengthen and modernize the public health workforce
- Address workforce stress, fatigue, and burnout
- Continue to support and accelerate federal program flexibilities to sustain, prepare, and strengthen the existing, entering, and returning health workforce

COGME's recommendations arise from the deep and diverse expertise of Council members. Many of us are practicing physicians on the frontlines of the crisis at hospitals and clinics across the nation. Others are researchers, educators, and expert advisers working tirelessly with local and state policy makers to surge and sustain the health workforce responding to the pandemic. We work in academic teaching hospitals and health systems and community-based training programs, in rural and urban settings, around the U.S. These experiences have helped drive the Council's desire to inform and advise on the national pandemic response.

The Council supports and applauds the federal response to the pandemic, often led by the Centers for Medicare and Medicaid Services (CMS), the Health Resources and Services Administration (HRSA), and several other Operational Divisions of the Department of Health and Human Services (HHS), including efforts to:

- Ease restrictions on the use of telehealth to broaden access to care
- Improve reimbursement for video and telephonic visits
- Encourage states to relax and remove regulatory barriers to surge the workforce
- Ease or eliminate scope of practice restrictions

Cognizant of these important efforts already underway, COGME convened a virtual advisory committee meeting on April 29, 2020, to gather the perspectives of invited experts from a wide range of stakeholders. Representatives from the American Medical Association, American Nurses Association, National Governors Association, Accreditation Council for Graduate Medical Education, Association of American Medical Colleges, American Association of Colleges of Osteopathic Medicine, Educational Commission for Foreign Medical Graduates, Federation of State Medical Boards, National Council of State Boards of Nursing, and a nationally recognized physician assistant workforce subject matter expert provided expert testimony on current efforts and needed actions in three areas related to the COVID-19 response – 1) sustaining the existing healthcare workforce, 2) training and accelerating the entering healthcare workforce, and 3) preparing and integrating the returning healthcare workforce.

The COGME recommendations outlined in the Appendix to this letter emerged from extensive deliberations of Council members before and during the April meeting and the testimony of the interprofessional experts who attended the meeting. At the meeting, we noted that the pandemic is having a disproportionate impact on rural areas and within minority and vulnerable populations. The recommendations reinforce our commitment to diversity, inclusion, and the reduction of health care disparities in these populations.

We also discussed the fact that the pandemic will be felt long into the future along these five phases:

1. Immediate mortality and morbidity of COVID-19 patients.
2. Impact of resource restriction on patients with urgent, non-COVID conditions.
3. Impact of interrupted care of patients with chronic conditions.
4. Psychological trauma and burnout in the health workforce and within our communities; economic injury to health care practices and the communities they serve.
5. Post-acute care, including long-term acute care, rehabilitation, and home health care.

As such, COGME will continue to develop recommendations to address the workforce challenges associated with each of these phases. We stand ready to partner with the Secretary and HHS to develop the strategic plan called for in Section 3402 of the *CARES Act*. We believe that HRSA is exceptionally well-positioned, in partnership with COGME and ACTPCMD, to develop performance measures to assess the extent to which the nation's health workforce training programs are strengthening the nation's health care system; identify gaps between projected health care workforce supply and needs; and identify barriers to addressing these gaps.

COGME would be happy to provide any further information or clarification needed on its recommendations and on any other matters related to mitigating the pandemic. We are deeply committed to working with you to protect and improve the health of the nation.

Sincerely,

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| Erin Patricia Fraher, PhD, MPP | Thomas Tsai, MD, MPH |
| Chair, COGME | Vice Chair, COGME |

## APPENDIX: COGME's COVID-19 Recommendations with Rationale

In keeping with its charge and COGME's longstanding role in health workforce policy in the United States, and to bolster the nation's health workforce responding to the pandemic, the Council has developed five (5) actionable **recommendations:**

### The Charge of COGME

Title VII of the *Public Health Service Act*, as amended, requires COGME to provide advice and recommendations to the HHS Secretary and Congress on the following issues:

1. The supply and distribution of physicians in the United States.
2. Current and future shortages or excesses of physicians in medical and surgical specialties and subspecialties.
3. Issues relating to foreign medical school graduates.
4. Appropriate federal policies with respect to the matters specified in items 1-3 …
5. Appropriate efforts to be carried out by hospitals, schools of medicine, schools of osteopathy, and accrediting bodies with respect to the matters specified in items 1-3 …

Section 3402 of the *Coronavirus Aid, Relief, and Economic Security (CARES) Act*, passed by Congress in March 2020, calls on the Secretary, in collaboration with the Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD) and COGME, to "develop a comprehensive and coordinated plan with respect to the health care workforce development programs of the Department of Health and Human Services, including education and training programs."

**1. Bolster telehealth accessibility, usage, and infrastructure**

- Broaden access to patient-centered telehealth services through public-private partnerships
- Change temporary waivers covering telehealth reimbursement to permanent policies where appropriate
- Implement reimbursement parity for all telehealth and telephone visits
- Invest in community-based telehealth services and accelerate transformation of telehealth and distance learning infrastructure by broadening flexibility of grant programs
- Remove regulatory barriers to the provision of telehealth in different settings and across state lines

Rationale: Advances in the use of telehealth technology as a result of the COVID-19 pandemic will likely change both the delivery of care and the training of new clinicians. Many hospitals, clinics, and other health systems have had to rapidly expand telehealth capabilities. In particular, rural county governments need to upgrade and strength their connections and infrastructure for telehealth. Temporary changes implemented by the Centers for Medicare and Medicaid Services (CMS) to allow reimbursement parity between in-person and telehealth video visits should be made permanent, and broadened to include payment parity for other forms of virtual care, such as telephonic visits. To promote clinical training, regulatory and accreditation changes are needed to encourage tele-precepting for medical residents working in hospitals, community clinics, and remote locations by faculty who are not on site.

**2. Stabilize/provide financial relief for vulnerable practices and critical access hospitals Provide GME funding support to clinicians and clinical practices, not just hospitals**

- Bolster support for ambulatory practices in rural areas
- Mitigate financial strain for the workforce within the graduate medical education enterprise, to support current faculty and providers as well as future physicians

Rationale: The COVID-19 pandemic has had a devastating impact on the revenues of many hospitals, subacute and long term care facilities, clinics, and other healthcare delivery entities, which have seen a precipitous drop in patient visits and elective or non-emergent procedures. This drop has disproportionately affected primary and ambulatory care practices and hospitals, especially those serving rural or other underserved populations. Funding is needed to support these providers through the stresses induced by the pandemic, help maintain the viability of these vulnerable practices, prevent or reduce staff furloughs and layoffs, and prevent the collapse of the primary care and ambulatory care provider network. Providing funding to keep rural and other vulnerable practices from closing reduces the potential of creating more Health Professional Shortage Areas and worsening access to health care for many Americans. In addition, it is important to relax medical student loan repayments for practicing physicians, faculty, and resident physicians during this crisis, to decrease the financial strain on front-line providers and physicians in the workforce at this crucial time.

**3. Strengthen and modernize the public health workforce**

- Invest in the public health/preventive medicine workforce and infrastructure
- Modernize public health education and preventive medicine residency training
- Identify novel ways to incorporate unmatched medical school graduates and other healthcare professionals into public health service that supports community and national public health needs
- Expand capacity to support public health functions

Rationale: A strong public health system and workforce is vital to addressing pandemics and other national public health emergencies efficiently and effectively. Identifying novel ways to incorporate unmatched medical students into public health service may be linked to student loan forgiveness. Rapid response to new outbreaks of COVID-19 infections are crucial to reducing the stress on local hospitals and improving population health outcomes. Investments in the public health infrastructure can support the network of outbreak detection and contact tracing workers needed to slow the spread of COVID-19 and promote stability. Investments in recovery planning for the healthcare system should begin at the time as the initial response, and include the public health workforce.

**4. Address stress, fatigue, and burnout among healthcare providers**

- Strengthen and expand the behavioral health workforce
- Provide access to mental health services
- Institute hazard pay or other reimbursement for frontline healthcare workers
- Promote interdisciplinary, team-based care and training
- Provide sick pay, remote monitoring, and related support when self-isolation or self-quarantine is required

Rationale: Personal safety, the safety of others in the workplace, and the safety of all patients are fundamental concerns shared by all healthcare personnel. The pandemic response is creating great emotional strain, as healthcare workers on the front lines are facing an unprecedented level of disease response and management under rapidly shifting circumstances, while often having to isolate themselves for fear of spreading infection to their family members and other loved ones. The mental health and wellness of physicians, physician assistants, nurses, and other healthcare providers must be a priority. This is imperative to avoid having providers leave the health professions due to stress, fatigue, and burnout. Programs are needed to promote a healthcare team where every member is working at the top of their education and training. Now is a time to promote interdisciplinary, team-based care and training models and payment programs to help accelerate care integration and workload distribution, and reduce provider stress, fatigue, and burnout.

**5. Continue to support and accelerate federal program flexibilities to sustain, prepare, and strengthen the existing, entering, and returning health workforce**

- Accelerate health workforce strategic planning
- Allow flexibility and extend the 5-year GME cap period for new GME programs during the pandemic in high priority and needed specialties
- Accelerate visa approval and clearance for international medical graduates

Rationale: Section 3402 of the *CARES Act* calls on the Secretary, in collaboration with the Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD) and COGME, to "develop a comprehensive and coordinated plan with respect to the healthcare workforce development programs of the Department of Health and Human Services, including education and training programs." COGME stands ready to take part in the plan development, and the Council believes that HRSA is exceptionally well-positioned, in partnership with COGME and ACTPCMD, to develop performance measures to assess the extent to which the nation's health workforce training programs are strengthening the nation's healthcare system; identify gaps between projected healthcare workforce supply and needs, and identify barriers to addressing these gaps.

Of particular note, many rural hospitals with new GME programs are struggling to adapt in the COVID crisis, and may lack the necessary resources to fully focus on and develop their residency programs within the mandated 5-year cap period. These hospitals may need regulatory flexibility regarding the cap period to better allow for full implementation of their programs and address the health needs of rural America.

International medical graduates (IMGs) make up a significant proportion (approximately 20-25%) of the physician workforce, and thus will be significant contributors within both the current crisis and the post-pandemic health care recovery phase.[1] However, visa restrictions and delays may impact their ability to come to the U.S. and enter practice. Regulatory barriers may need to be eased to facilitate the processing and clearance of visas for IMGs.

[1]Association of American Medical Colleges (2018). *Physician Specialty Data Report.* Retrieved from: https://www.aamc.org/data-reports/workforce/interactive-data/active-physicians-who-are-international-medical-graduates-imgs-specialty-2017