COGME | Council on Graduate Medical Education

Webinar and Teleconference

Sponsored by the Health Resources and Services Administration

Meeting Minutes
September 12, 2022

Council Members in Attendance
Appointed Members
Peter Hollmann, MD, Chair
Erin Fraher, PhD, MPP, Immediate Past Chair
Andrew Bazemore, MD, MPH (part-day)
Ted Epperly, MD
R. Armour Forse, MD, PhD
Beulette Y. Hooks, MD
Warren Jones, MD
John Norcini, PhD
Ashruta Patel, MD, MS
Linda Thomas-Hemak, MD
Surendra Varma, MD, DSc (Hon)

Federal Representatives
Allison Bramlett (sitting in for Joseph Brooks, Designee of the Centers for Medicare and Medicaid Services)
John Byrne, DO (Designee of the Department of Veterans Affairs)
Leith J. States, MD, MPH (Designee of the Assistant Secretary for Health)

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

Monday, September 12, 2022

Welcome and Roll Call

CAPT Curi Kim, the Designated Federal Officer for the Council on Graduate Medical Education (COGME or the Council), convened the second COGME meeting of fiscal year (FY) 2022 at 10:00 a.m. ET on Monday, September 12, 2022. The meeting was sponsored by the Bureau of

Health Workforce (BHW), 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. CAPT Kim turned the meeting over to the COGME chair, Peter Hollmann, MD.

Dr. Hollmann conducted a roll call, and 12 of the Council's 17 members were present, meeting the requirement of a quorum and allowing the meeting to proceed.

Presentation: Current State of Underrepresented in Medicine Groups in GME

William McDade, MD, PhD
Chief Diversity and Inclusion Officer
Accreditation Council for Graduate Medical Education

Dr. Hollmann introduced the first speaker, William McDade, MD, PhD, Chief Diversity and Inclusion Officer of the Accreditation Council for Graduate Medical Education (ACGME) and adjunct professor of anesthesiology at Rush Medical College. Dr. McDade said that his presentation would cover a wealth of information collected and analyzed by ACGME on underrepresented in medicine (UIM) groups within graduate medical education (GME), with a particular focus on Black medical residents. He noted the importance of diversity within the healthcare and physician workforce. Disease burden and health inequities are strongly concentrated in minority communities, and studies have shown that people tend to seek healthcare services within their own community. In addition, practitioners from minority populations tend to practice in minority and other underserved areas. Data suggests that Black, Latinx, and Asian physicians will disproportionately serve patients of their same race and ethnicity. Despite the increasing diversity of the U.S. population, though, the percentage of physicians from minority or other marginalized groups has not changed significantly in the last 15 years. ACGME saw the need to emphasize diversity, equity, and inclusion (DEI) in GME and formed a task force to look at four different areas: diversity data, GME accreditation, the GME learning environment and safety, and educating the GME community on issues of diversity. Out of these efforts, ACGME created its Office of Diversity, Equity, and Inclusion.

Dr. McDade outlined the societal benefits in collecting and analyzing demographic data on medical residents; these efforts may:

- Demonstrate fairness in the process of allocating residency positions;
- Recognize the role of diversity in improving the quality of education for all learners;
- Build a physician workforce that better reflects the population it serves to improve healthcare access and health outcomes;
- Obtain broader input for problem solving in clinical care, scholarship, and advocacy; and
- Promote inclusive clinical environments to improve both work and patient care conditions.

He further noted the documented benefits of racially concordant care, in which providers come from a similar background and share the same racial identity as their patient population, in improving patient satisfaction, adherence to medical advice, and trust. As a bottom line, racially

concordant care "improves access to care for individuals who would rather forego care than to receive it in an environment that dehumanizes them, discriminates against them, and fails to communicate effectively with them."

Despite its importance, Dr. McDade added, racially concordant care alone cannot eliminate all health disparities. He discussed the 2002 report from the Institute of Medicine, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* (available at: https://nap.nationalacademies.org/catalog/12875/unequal-treatment-confronting-racial-and-ethnic-disparities-in-health-care). This report detailed the extent of racial and ethnic differences in health outcomes outside of factors such as access to healthcare. Disparities were found across a wide range of clinical settings and were associated with excess morbidity and mortality among minority populations. In addition, there are too few physicians from minority backgrounds to meet the demand for racially concordant care.

Dr. McDade noted that ACGME developed four foundational principles for DEI: society should view health disparities as deficiencies in healthcare quality; health equity is one of the ways to eliminate health disparities; increasing workforce diversity can serve as a means to achieve health equity; and inclusion is a tool to ensure the success of promoting diversity. He briefly reviewed several action steps taken by ACGME:

- Changing its mission and vision statements to add DEI as key elements;
- Modifying program elements and requirements;
- Developing new assessment tools to address DEI; and
- Creating learning communities to continuously improve DEI practices.

Dr. McDade briefly outlined a new ACGME program called Equity Matters, with the goal of increasing physician workforce diversity and creating safe, equitable, and inclusive learning environments. Under this program, ACGME developed a number of video presentations as learning modules focused on improving DEI within GME programs. In addition, ACGME recently initiated a new DEI Award, named in honor of Dr. Barbara Ross Lee, the first African American woman to serve as dean of a U.S. medical school. Honorees have included a program offering summer research opportunities for pre-college students and a holistic review process for evaluating medical school applicants' experiences and attributes alongside their academic achievement. Materials from award-winning programs are included in the Equity Matters resource collection.

Dr. McDade discussed the sources of DEI data collected by ACGME and identified some of the challenges to accurate data collection, including missing data, lack of standard definitions of racial categories, and differing collection methodologies. To improve data collection, ACGME started working with the Association of American Medical Colleges and the American Medical Association to form the Physician Data Collaborative. He presented some of the data on minority representation in different medical specialties, noting that many of the percentages have changed little over the last 10 years.

Dr. McDade said that ACGME collects data on residents who leave or fail to complete their residency program, under five different categories: withdrawal, either voluntary or involuntary; transfer to a different program or specialty; dismissal; failure to complete the residency program;

and death. While the percentage of Black residents leaving a program is higher compared to Whites, the actual number is very small. ACGME does not report this information because the relatively small numbers could lead to misinterpretation or inadvertent breach of confidentiality.

Dr. McDade noted the outsized role that medical schools at historically black colleges and universities (HBCUs) play in the training of black medical students and residents. However, the ranges of residency programs available through these schools is often limited, making the expansion of HBCU programs a high priority, along with efforts for all residency programs to increase their diversity.

In conclusion, Dr. McDade noted the multiple challenges to improving diversity within GME programs, including a lack of diversity in GME faculty and other leadership positions, and insufficient resources devoted to growing the number of UIM individuals in the educational pipeline. Improving educational equity will require increased outreach to young learners and greater exposure to biomedical career options. In addition, selection criteria are often grounded in dominant historical or cultural norms, which may inhibit or exclude some applicants from minority backgrounds. Lastly, the disproportionate dismissal and withdrawal of minority residents once in training may be rooted in unconscious bias in training and evaluation, impacting both the learning environment and the patient care space.

Q and A

Dr. Hollmann opened the floor to questions from the Council members.

Noting that the National Medical Association's House of Delegates had expressed concern on the number of dismissals of Black residents and understanding the difficulty of publishing the raw numbers of residency dismissals, there was a question about sharing the comparative dismissal rates between Black and White residents. Dr. McDade replied that this data can be difficult to interpret in proper context, given the small numbers in absolute terms and the differences in the number of White and Black residents in many programs. He noted the risk of discouraging some individuals from entering a career in medicine or pursuing a particular residency if the data on dismissals were misinterpreted.

There was a question on how to recruit and support more residents from minority and other underrepresented groups into programs in rural areas and smaller states where residents have been predominantly white. Dr. McDade responded that he will often advise minority medical graduates to look into programs that have not historically taken many minority students, as these programs are often working to increase their diversity and may be more willing to take steps to accommodate an underrepresented resident. For program directors looking to increase diversity, he suggested attending national recruitment fairs sponsored by organizations like the Student National Medical Association, or the Latino Medical Student Association, and emphasizing the benefits or special characteristics of rural residencies.

Dr. Hollmann noted that COGME had drafted a letter addressing issues of diversity in GME, with a particular emphasis on the disparity in dismissals from residency programs. The current draft included recommendations for Congress to appropriate funds for a data repository, authorize federal agencies involved in GME financing to use this data in funding priorities, and convene a panel of experts to help define reporting and database requirements; Dr. Hollmann

asked for any specific recommendations to improve, strengthen, or refocus the letter. Dr. McDade noted that a central theme of the letter was to connect GME financing to diversity efforts. Some of these efforts are already in place, as ACGME is working to include more diversity measures in the accreditation process and accreditation is required for a GME program to receive federal funding. A vital element, though, is the need to expand the pathway into medicine because having a sufficient supply of fourth year medical students from diverse backgrounds depends on the flow of students into colleges and entering schools of medicine. He also cited the need for diverse faculty members to help draw more students from a variety of backgrounds.

There was a comment about the importance of collecting longitudinal data on the healthcare education pipeline from early entry into practice, to better understand how to attract diverse learners into medical careers and see how these careers evolve. Dr. McDade referenced a paper on race-conscious professionalism that explored why minority physicians tend to practice in minority communities and the career paths they navigate. He also noted a darker side in that minority physicians may have difficulty establishing a practice in a majority community if other physicians will not send them referrals or if they cannot establish a patient base. However, he also related a favorite experience in medical school: He had the opportunity to take care of his kindergarten teacher because his medical school was located near where he grew up and attended elementary school. He noted the attraction for many physicians of serving their local community.

Presentation: The HRSA Data Warehouse (HDW)—BHW Revamp Project

Elizabeth Kittrie
Senior Advisor
Office of the Associate Administrator, BHW

Michael Arsenault
Director
Division of Business Operations, BHW

Dr. Hollmann introduced Michael Arsenault, Director of the Division of Business Operations, BHW, and Elizabeth Kittrie, Senior Advisor in the Office of the Associate Administrator, BHW, for an update and demonstration of the new HRSA Data Warehouse (HDW) website and data presentation and analysis tools. Ms. Kittrie provided some examples from the data dashboards on diversity in HRSA training programs, noting that in 2021, 14 percent of medical residents in the National Health Service Corps (NHSC), and about 10 percent of residents in the Teaching Health Center Graduate Medical Education (THCGME) program, self-reported as Black.

Mr. Arsenault noted that he and Ms. Kittrie had presented an overview of the HDW web pages (data.hrsa.gov) to the five BHW Advisory Councils over the past year, as well as to several primary care associations and other stakeholders around the country. In response, HRSA had received a significant amount of valuable feedback, spurring further changes and improvements. Many users had commented on the wealth of information and data available from HRSA. However, the data were often poorly organized and hard to find or search, and users would report trouble finding grant information on specific programs or workforce data about different health professions. He described efforts to improve the searchability and accessibility of BHW's health

workforce data and make the web pages more user friendly. Mr. Arsenault provided a brief live demonstration of the HDW site and the different analysis and visualization tools available.

Ms. Kittrie discussed some new tools that would soon be available, including the BHW Health Workforce map, an interactive map allowing users to plug-in any location and see all the BHW- and HRSA-supported assets in their local area, and the nursing workforce tool dashboards, derived from the National Sample Survey of Registered Nurses, the largest workforce survey of registered nurses and nurse practitioners in this country. She encouraged the Council members to explore the HDW pages and continue to provide feedback.

Q and A

There was a comment that HRSA could help to reduce the amount of effort needed to track results in workforce development programs, as well as aid in longitudinal tracking of trainees and graduates. Mr. Arsenault noted that HRSA encourages clinicians to obtain a National Provider Identifier (NPI) number, which aids with data collection and long-term tracking. He noted that in the latest cycle, around 98 percent of clinicians supported through the NHSC had provided an NPI, and HRSA is collecting NPIs for other trainees, including those in the THCGME and the Children's Hospitals Graduate Medical Education (CHGME) programs.

HRSA Welcome

Carole Johnson
HRSA Administrator

To kick off the afternoon session, HRSA Administrator Carole Johnson offered welcoming comments to the Council, noting the difficulties faced by the health workforce in the face of the COVID-19 pandemic. She outlined three priority areas:

- Federal programs and tools to combat the pandemic,
- Integration of behavioral health care into primary care, and
- Efforts to reduce maternal health inequities.

Ms. Johnson noted that HRSA ran the program for the uninsured to pay for COVID-19 vaccine administration, testing and treatments, until the program closed in April 2022 due to lack of funds. That program served as a critical resource for underserved communities across the country.

Ms. Johnson discussed the historic investments from the 2021 American Rescue Plan (ARP), providing for an all-time high of 20,000 clinicians participating in the NHSC, additional funding for the THCGME program, and resources to develop new programs focused on workforce resilience and retention.

Q and A

There was a comment that rural areas in particular struggle with accessing mental health services due to a lack of providers. Ms. Johnson noted that the recently passed Bipartisan Safer Communities Act included new funding for investments in training more mental health providers. HRSA is using this funding to integrate mental health training into primary care training and to build out mental health training with a focus on pediatricians.

There was another comment on the impact of the HRSA-funded Area Health Education Centers program and the Health Careers Opportunities Program in helping more individuals from rural and underrepresented communities develop the educational foundation to pursue careers in medicine, dentistry, nursing, and research. Ms. Johnson agreed with the importance of these and other pipeline programs but noted there is great variability from state to state. HRSA is working to strengthen the programs and help individual programs support and learn from each other.

There was a comment recognizing the long-term impact of the pandemic on mental health and the importance of integrating mental health services into federally qualified health centers (FQHCs) and other sources of primary care as well as supporting HRSA's long-term investments in telehealth. It was noted, though, that current accreditation standards for FQHCs call for a certain number of behavioral health services to be provided face-to-face, which may limit access to behavioral health or mental health care provided through telehealth.

Presentation: BHW Updates

Luis Padilla, MD
Associate Administrator for Health Workforce
HRSA

Dr. Hollmann introduced Dr. Luis Padilla, Associate Administrator for Health Workforce, HRSA, for an update from BHW. Dr. Padilla noted that the ARP provided funds to expand several existing programs and launch new ones, enabling HRSA to:

- Increase the number of Teaching Health Centers (THCs),
- Add more clinicians to the NHSC and Nurse Corps programs,
- Create a new public health scholarship program,
- Expand the number of community health workers, and
- Initiate programs to support the health and wellbeing of the health workforce.

He highlighted several new programs that seek to support more students going into behavioral health and then serving in rural and underserved areas after graduation.

Dr. Padilla noted that the THCGME program provides a model for community-based primary care training. However, most THCs are in urban areas. The ARP funding will expand THCs through the creation of the Teaching Health Center Planning and Development (THCPD) program. In FY 2022, THCPD provided awards to programs in 26 states, including nine states that will have their first THC.

Q and A

There was a comment that one factor impeding several primary care or community-based residency programs from moving forward is the ebb and flow of federal funding. Dr. Padilla replied that HRSA is aware of the difficulties in establishing new programs in the absence of reliable, long-term funding. He noted that both the THCGME and the CHGME programs often face short-term reauthorization, placing residencies that rely on this funding in a precarious situation. Both BHW and the HRSA Federal Office of Rural Health Policy are making efforts to push for long-term reauthorization to place these critical programs on more stable ground.

There was another comment on the need for emergency medicine residency programs in rural areas, where the distance to a major hospital or trauma center is a challenge and can result in of loss of life, noting the development of programs to train family physicians to fill some of the void for emergency services.

COGME Discussions

Dr. Hollmann briefly reviewed the COGME charter. There was a comment that the term "foreign medical graduate" is used; the currently accepted term is "international medical graduate." Dr. Carter replied that the older term is in statute.

The Council reviewed and approved two writing group deliverables with the voting facilitated by CAPT Kim:

1. Dr. Andrew Bazemore led the discussion about a letter to the HHS Secretary and Congress in support of H.R. 3671 and its companion bill S. 1958 (the Doctors of Community Act) to provide long-term funding for the THCGME program. The Council voted to approve this letter, pending minor editing.
2. Dr. Erin Fraher led the discussion about a package of materials, including a one-page summary and other resources, intended to promote dissemination of the Council's 24th Report. The Council voted to approve this package, pending some minor formatting modifications.

Dr. Hollmann briefly reviewed the discussions of a COGME writing group convened to discuss how to measure outcomes of the 24th Report recommendations. Concerns were expressed that not all recommendations lend themselves to measurement or may be written very broadly to allow flexibility in implementation. Thus, developing precise metrics might change the intent of the recommendations or the report. The writing group concluded that measuring the recommendations was not feasible, and HRSA should have processes in place to evaluate the implementation of advisory council recommendations. In its future work products, the Council should consider if a recommendation could be written with a very specific goal and metric.

The Council also continued early discussions on its 25th Report. There was a consensus to focus the report on developing and enhancing team-based care in medical education and practice.

UIM Letter

Following up from Dr. McDade's session, Dr. Linda Thomas-Hemak led a discussion on the draft COGME letter in development concerning issues facing UIM individuals in GME. She summarized the three recommendations:

- Appropriate funding for an HHS-wide repository of GME data.
- Authorize federal agencies responsible for the distribution of GME financing to collect and report on the composition of residents in each program and sponsoring institution they finance, including the number of UIM residents entering and completing training.
- Authorize a panel of experts from multiple federal agencies involved in GME financing to develop and define the reporting and database requirements, including the reason for the dismissal of any residents during training.

There was a comment on revising the recommendations to focus on enhancing data collection on the pipeline of minority physicians, standardizing data collection on race and ethnicity, and investing in the collection of longitudinal data to track physician career development over time. Other comments noted the possibility of aligning federal data collection efforts with ACGME, and funding data collection to track both the front-end development of the pipeline and the back-end outcomes of career pathways. The Council agreed by consensus to broaden the scope of this letter and prepare a revised draft for consideration at the March 2023 COGME meeting.

General Surgery Letter

Dr. Ted Epperly, with the support of Dr. R. Armor Forse, led a discussion on a draft COGME letter in development regarding the vital role of general surgery in supporting primary care in rural areas. Dr. Epperly referenced the comment of Ms. Johnson that part of the COGME charge is to identify early warning signs or shortages within the physician workforce. He noted growing concerns about an emerging national crisis regarding the shrinking availability of general surgeons serving rural and frontier areas. Dr. Forse added that a lack of general surgeons to perform procedures and support family physicians also erodes the financial stability of rural critical access hospitals. Dr. Epperly summarized the three recommendations in the letter:

- Funding implementation of a rural health team concept, emphasizing general surgery as a vital component of the team;
- Restructuring NHSC programs to support general surgeons who chose to practice in rural and underserved areas; and
- Funding the creation and maintenance of training programs for general surgery residencies at community-based rural hospitals.

There was a comment on the need to build connections between the rural critical access hospitals and regional academic medical centers. There was another comment on the need to create a geographic shortage area designation for surgery, to make surgery residents eligible for NHSC programs. Dr. Andrew Bazemore alerted the Council to a bill before Congress, H.R. 5149, which would require HRSA to study access to general surgery in underserved populations and explore potential methodologies for designating surgery shortage areas.

There was a consensus to continue work on the current draft letter and to consider a longer issue brief to allow a more comprehensive exploration, noting the urgency and complexity of this issue in supporting rural primary health care and critical access hospitals.

Update: 2023 BHW Federal Advisory Committee Plans

CAPT Curi Kim
Designated Federal Officer, COGME

CAPT Kim provided a brief overview of the charge, the recent activities, and future plans of the four other health workforce advisory committees within BHW:

- Advisory Committee on Training in Primary Care Medicine and Dentistry,
- Advisory Committee on Interdisciplinary, Community-based Linkages,
- National Advisory Council on the National Health Service Corps (NACNHSC), and
- National Advisory Council on Nurse Education and Practice (NACNEP).

CAPT Kim reiterated that the mission of BHW is to improve the health of underserved and vulnerable populations by strengthening the health workforce and connecting skilled professionals to communities in need. The BHW priorities focus on recruiting students from the local communities, providing training in rural and underserved communities, integrating behavioral and oral health into primary care, and developing interprofessional and collaborative teams. She noted that all five of the advisory committees provided consultation letters pertaining to the preparation of the 2021 HHS health workforce strategic plan.

There was a comment that COGME might consider consulting with the NACNHSC and NACNEP on the issues around general surgery training, as clinicians from a range of disciplines will be needed for rural health teams.

Public Comment and Business Meeting

There were two comments offered during the public comment session:

1. A request to have BHW program officers include the grant codes on their Notices of Funding Opportunities to help in tracking the award recipients and outcomes, as well as a comment on barriers to collecting data on diversity.
2. Support for the Council discussion on promoting general surgery residencies in rural areas, and issues related to GME funding of sole community hospitals.

During the business meeting, Ms. Zuleika Bouzeid of the HRSA Advisory Committee Operations office provided a brief review for the Council members on how to access and view their compensation through the MyPay website, noting that federal advisory committee members receive compensation for each day of participation during a public meeting, as well as any travel days. Then, CAPT Kim provided some COGME website and SharePoint updates.

Wrap Up and Next Steps

Dr. Hollmann reviewed the events of the day and summarized the presentations the Council had received. He noted the consensus of the Council to continue writing group efforts on the two products in development.

Adjourn

CAPT Kim adjourned the meeting at 5:00 p.m. ET.

Acronym and Abbreviation List

ACGME	Accreditation Council for Graduate Medical Education
ARP	American Rescue Plan
BHW	Bureau of Health Workforce
CHGME	Children's Hospitals Graduate Medical Education
COGME	Council on Graduate Medical Education
DEI	Diversity, Equity, and Inclusion
FQHC	Federally Qualified Health Center
FY	Fiscal Year
GME	Graduate Medical Education
HBCU	Historically Black Colleges and Universities
HDW	HRSA Data Warehouse
HHS	U.S. Department of Health and Human Services
HRSA	Health Resources and Services Administration
NACNEP	National Advisory Council on Nurse Education and Practice
NACNHSC	National Advisory Council for the National Health Service Corps
NHSC	National Health Service Corps
NPI	National Provider Identifier
THC	Teaching Health Centers
THCGME	Teaching Health Center Graduate Medical Education
THCPD	Teaching Health Center Planning and Development
UIM	Underrepresented in Medicine