COGME | Council on Graduate Medical Education

Meeting Minutes: March 16–17, 2023

The Council on Graduate Medical Education (COGME or the Council) held a meeting on March 16–17, 2023. The meeting was hosted by the Bureau of Health Workforce (BHW), Health Resources and Services Administration (HRSA), Department of Health and Human Services (HHS), and conducted via a videoconference platform. In accordance with the provisions of the Federal Advisory Committee Act (Public Law 92–463), the meeting was open to the public for its duration.

Council Members in Attendance

Appointed Members
Peter Hollmann, MD, Chair
Erin Fraher, PhD, MPP
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: Centers for Medicare and Medicaid Services)
John Byrne, DO (Designee: Department of Veterans Affairs)
CAPT Paul Jung, MD, MPH (Designee: Health Resources and Services Administration)

Health Resources and Services Administration Staff Present:

CAPT Curi Kim, MD, MPH, Designated Federal Officer, COGME; Senior Advisor, Division of Medicine and Dentistry, BHW, HRSA
Kennita R. Carter, MD, Subject Matter Expert, COGME; Chief, Graduate Medical Education Branch, Division of Medicine and Dentistry, BHW, HRSA
Raymond Bingham, MSN, Writer and Editor, Division of Medicine and Dentistry, HRSA
Zuleika Bouzeid, Advisory Council Operations, BHW, HRSA
Janet Robinson, Advisory Council Operations, BHW, HRSA

Thursday, March 16, 2023

Welcome and Introductions

CAPT Curi Kim, the Designated Federal Officer for COGME, convened the Council's first

meeting of fiscal year (FY) 2023 at 10:00 a.m. ET on Thursday, March 16, 2023. CAPT Kim turned the meeting over to the COGME chair, Dr. Peter Hollmann. Dr. Hollmann conducted a roll call, indicating the attendance of 15 of the Council's 17 members. Dr. Hollmann confirmed the presence of a quorum, allowing the meeting to proceed.

Presentation and Discussion: Teaching Health Center Program Updates

Emily Hawes, PharmD, BCPS, CPP
Deputy Director, Teaching Health Center Planning & Development-Technical Assistance Center (THCPD-TAC)
University of North Carolina

Jennifer Trott, MPH
Senior Researcher
Teaching Health Center Graduate Medical Education (THCGME) Cost Evaluation Study, George Washington University, Milken Institute School of Public Health

Teaching Health Center Planning & Development-Technical Assistance Center

Dr. Hollmann introduced the first speaker, Dr. Emily Hawes, Deputy Director of the Teaching Health Center Planning & Development-Technical Assistance Center (THCPD-TAC), a partnership led by the University of North Carolina at Chapel Hill. Dr. Hawes stated that the THCPD program was developed to expand the successful Teaching Health Center Graduate Medical Education (THCGME) program. The THCPD-TAC was created to provide technical assistance for THCPD award recipients to support the establishment of new accredited community-based primary care residency programs in rural and underserved communities and is supported by a cooperative agreement through HRSA's BHW. HRSA made its first THCPD awards in FY 2022 to 47 grantees from 26 states. Most of the grantees proposed to start residency programs in family medicine; other specialties included psychiatry, pediatrics, internal medicine, and general or pediatric dentistry. The THCPD-TAC produced a roadmap to guide the THCPD grantees in their residency program development. Dr. Hawes reviewed the grantees' progress in meeting the roadmap goals, stating that 75% of the grantees pursuing medical residencies have confirmed health center support for program development and established their governance structure; she noted that grantees pursuing dental residencies face additional layers of accreditation, which makes launching dental residencies more time-intensive.

Dr. Hawes discussed several challenges for the THCPD grantees, including receiving start-up funding with no guarantee of ongoing funding to maintain their residency programs once they are established. Since its inception, the THCGME program has relied on periodic Congressional appropriations, rather than guaranteed funding as a federal entitlement program. As a result, the THCGME program has faced several funding cliffs. At the current time, federal funding is set to expire at the end of the current fiscal year (FY), September 2023, unless Congress acts to reauthorize the program. This financial uncertainty can jeopardize the sustainability of new—and existing—teaching health centers (THCs). Another challenge is that the THCPD grantees were awarded up to $500,000 for two years, but this timeframe is often insufficient to launch residency programs, with up to five years needed due to issues including recruiting staff and faculty, meeting accreditation standards, developing partnerships with medical or dental schools, and making needed infrastructure improvements for training space. The TAC is supporting grantees by matching them with advisors to monitor and facilitate their program development,

providing webinars and workshops, creating informational materials, and offering a toolkit containing a variety of resources available to both grantees and non-grantees.

To explain the benefit of growing and sustaining the THCGME program, Dr. Hawes provided a case study involving the Osteopathic Medical Education Consortium of Oklahoma (OMECO) Cherokee Nation Family Medicine Residency. American Indian/Alaska Native populations face disproportionate health disparities and a shortage of health professionals with the Indian Health Service (IHS) reporting job vacancy rates of up to 46% and few residency programs partnering with IHS facilities. In response, the Cherokee Nation, along with state and community partners, took a collaborative and innovative approach to align population health needs with workforce training. In this residency program, all the training takes place in rural IHS facilities, with a focus on treating the main conditions of concern within the IHS and incorporating tribal cultural perspectives. Dr. Hawes noted how the program has increased from 12 to 24 residents with THCGME funding, the THCGME-funded residents see over 12,000 patients per year, and 30% of the program graduates continue to practice within the Cherokee Nation health system.

THCGME Cost Evaluation Study

Dr. Hollmann introduced Jennifer Trott, lead research scientist in the Department of Health Policy and Management at George Washington University's Milken School of Public Health, and senior researcher on the HRSA-funded THCGME Cost Evaluation Study. Ms. Trott noted that the current study was the second to evaluate THCGME program costs. The first study, completed in 2016, estimated the per resident amount (PRA) of training costs for THCGME residents to be around $157,600 per year for FY 2017. Since the program had grown and the health care landscape had changed, HRSA called for a second evaluation. She reviewed some of the parameters of the follow-up study, which received input from 50 THCs. This study found the median PRA for FY 2022–2023 to be just over $209,600, reflecting increased training costs and health care inflation. However, she noted that THCs currently receive a PRA of $160,000, or only about 76% of the true training cost.

The current study recommends that the THCGME PRA should be pegged to a standard inflation factor (i.e., Consumer Price Index for Medical Care [CPI]) that is adjusted yearly. The Direct Medical Education (DME) formula for THCGME payments is expressed as: $THCGME_{current\ year} = [(PRA_{prior\ year} \times \text{full time equivalents}) \times (1 + \text{annual average CPI})]$. In addition, the current study recommended setting the Indirect Medical Education (IME) payment at $0 as the hospital-based IME concept does not fit in an outpatient-based THC context. This puts the onus of adequately funding THCs on an appropriate PRA that reflects true costs. However, recognizing the need for additional resources, the study also recommended that HRSA consider establishing an IME-equivalent funding to support best practices in the THCGME program.

Ms. Trott offered some recommendations for future data collection and evaluation to ensure that THCs are not underfunded by an outdated PRA:

- Develop a mechanism for periodic reporting to detect spending and cost trends, which can indicate the need to update the PRA based on training, practice, or accreditation-related changes.

- Conduct another cost evaluation of THCs in the future to determine the need for further modifications to the THCGME funding formula for payment variation based on program characteristics (e.g., rural location, residency program specialty).
- Use streamlined data collection tools and processes to minimize response burden.

Q and A

There was a question about comparing the resident training costs of the THCGME program with the traditional graduate medical education (GME) funding to teaching hospitals provided by the Centers for Medicare and Medicaid Services (CMS) through its DME and IME payments. Ms. Trott noted the difficulty of making a direct comparison given the very different approaches of the GME payment mechanisms between the THCGME program and CMS. She described the THCGME model as being more direct and accountable, and relatively efficient in terms of program administration expenses. Another Council member made a clarifying comment that the CMS DME and IME payments to hospitals were not created to directly pay for residency programs but represent an add-on hospital reimbursement for training expenses; the THCGME program is different because its goal is to create new residency programs and directly pay for residency training in community-based care settings.

There was a question about how the study evaluated the THCGME PRA against the real costs of training. Ms. Trott replied that the study determined that the current PRA payments alone covers about 50% of the training costs. However, the study factored in the clinical revenue from patient care visits conducted by the residents as an off-set to training costs, so with this contribution that the residents bring in, the current PRA was calculated to support 76% of THC program costs.

A Council member remarked that the THCGME program aligns with HRSA's mission to sustain a pipeline of physicians and other health care professionals into community-based primary care; thus, the THC cost evaluation study provides a clear examination of the federal investment needed to make a difference in rural, frontier, and other underserved areas. There was a follow-up comment for the Council to consider submitting a letter to Congress in support of permanent funding for the THCGME program.

Update and Discussion: National Center for Health Workforce Analysis

Michelle Washko, PhD
Director, National Center for Health Workforce Analysis, BHW, HRSA

Moving to the next item on the agenda, Dr. Hollmann introduced Dr. Michelle Washko, Director of HRSA's National Center for Health Workforce Analysis (NCHWA). Dr. Washko described the purpose of NCWHA as supporting informed decision-making on the range of issues that impact the United States healthcare system and the health workforce by expanding the evidence base. Through the HRSA Data Warehouse, NCHWA makes its health workforce data sets more transparent and available to health researchers, educators, policymakers, and the public. She noted that NCHWA recently completed data collection for the 2022 National Sample Survey of Registered Nurses (NSSRN), the largest health professions survey in the country. She said that comparing the 2022 NSSRN with the survey done in 2018 would provide pre- and post-pandemic snapshots of the nursing workforce.

Dr. Washko reviewed some updates to the Health Workforce Projections dashboards, which have replaced the five-year forecasting reports that NCHWA had published in the past. NCHWA will update the projections on a yearly basis, using 2020 as a baseline. She said that the data are starting to reflect the impact of the pandemic on the size of the workforce. She also demonstrated some of the available data analysis and visualization tools available from the Data Warehouse website. She pointed specifically to visualization tools in the Area Health Resource Files, which show the diversity of the health workforce by race, ethnicity, age, and sex, as broken down for various occupations, and in the Health Professions Training Programs, which show data for HRSA-awarded health workforce grants. These tools have generated interest from members of Congress to serve as evidence-based sources for driving health workforce legislation. She also noted that NCHWA had recently published its first brief focused on a sector of the health workforce, the State of the Maternal Health Workforce. NCHWA plans to release many more "State of" briefs, including ones on the long-term care services and supports workforce, primary care, and a comparison between U.S. and global health workforce metrics.

Lastly, Dr. Washko commented on COGME's draft document on underrepresented in medicine data. She advised members to dig deeper into existing data resources and consider recommendations for improvement or expansion.

Q and A

There was a comment about the opportunity to unify federal agencies and stakeholders around standardized, publicly available health workforce metrics that include diversity data. Another Council member remarked on the challenge of achieving a health workforce representative of the nation's population. Dr. Washko agreed and stated that NCHWA has funded Health Research Workforce Centers focused on health equity.

There was a question on data regarding the aging of the physician workforce, especially in rural areas. Dr. Washko replied that the Area Health Resource Files data tools allow analysis and visualization not only by race, ethnicity, and gender, but also age. Age information is available through the Health Workforce Projections dashboard, which can be used to estimate the future supply and demand of healthcare occupations under different scenarios, such as by changes in graduation rates or retirement ages, to help policy makers and planners in their decision-making process.

Public Comment

There were four public comments:

1. Dr. James Cutrell, representing the Infectious Disease Society of America (IDSA), spoke about the shortage of infectious disease (ID) physicians with only 56% of fellowship programs filling their slots in the 2022 match and nearly 80% of U.S. counties lacking a single ID physician, especially in rural areas. He stated that large medical school debt and low reimbursement rates for ID services contribute to the declining ID physician pipeline, which could hinder efforts to reduce the impact of communicable diseases and respond to future pandemic responses. Dr. Cutrell applauded Congress for creating the BIO Preparedness Workforce Pilot Program as part of the PREVENT Pandemics Act, which was enacted in December 2022; the pilot would establish a new student loan repayment program for health professionals providing ID care in underserved communities, but it needs to be funded. Dr. Cutrell also shared that IDSA has urged

CMS to increase reimbursement rates for the services that ID physicians provide, but this was not included by CMS in its 2023 Medicare Physician Fee Schedule. He noted that IDSA conducted a survey during the COVID-19 pandemic that revealed most of its members provided upwards of 20 hours per week on undertakings above and beyond clinical duties, such as developing treatment protocols, advising other physicians, and supporting infection control activities. This work was largely uncompensated, which can lead to burnout and further discourage physicians from pursuing ID fellowships. To address this, IDSA looking for support in Congress to propose the creation of a payment modifier that could be attached to existing billing codes to reimburse for ID-related indirect services and care provided by physicians during a public health emergency. Dr. Cutrell expressed appreciation for any support COGME could provide for the efforts he spoke about to boost the ID physician pipeline, and a member of COGME expressed an interest in engaging in further conversation.

2. Dr. Jason Reminick, representing Thalamus, an information technology organization supporting the medical residency interview process, spoke about its large GME data sets, including on diversity and matching patterns, and how market forces impact residency specialty fill rates. He expressed willingness to work with COGME and the appropriate federal agencies to improve GME data reporting. Several COGME members commented on the importance of a diverse workforce and maldistribution of GME programs.
3. Dr. Tiffany Ostovar-Kermani, currently employed as a post-doctoral research fellow and representing medical graduates who failed to obtain a residency match, requested support from COGME for the national development of the Assistant Physician or similar credential, which has been legislated in a number of states. Such a credential would provide unmatched graduates with an avenue to work as health care providers under supervision while gaining valuable experience. Dr. Sarthak Thanawala, another unmatched medical graduate, spoke to request COGME support of Congressional legislation which would increase the number of medical residency slots. He noted that there were roughly 6,000 unmatched medical graduates from the 2022 residency match process.
4. Mr. John Aguilar, manager of legislative affairs for the American Academy of Family Physicians (AAFP), and Dr. Karen Mitchell, AAFP Medical Education Vice President, spoke in favor of COGME preparing a letter to the HHS Secretary and Congress on permanent funding for the THCGME program and increasing the PRA to keep the program competitive and support access to primary care in underserved areas.

Council Discussion: Underrepresented in Medicine (UIM) Residents Letter

Moderator: Byron Joyner, MD, MPA
Member, COGME

Tammy Mayo-Blake, MEd
Chief, Health Careers Pipeline Branch
Division of Health Careers and Financial Support, BHW, HRSA

Council member Dr. Byron Joyner led a discussion on the draft letter addressing the disproportionate loss of underrepresented in medicine (UIM) medical students and residents during training. He stated that the current medical workforce does not reflect the diverse

populations it serves, often leading to poorer health outcomes in minority and underserved populations and a loss of trust in the healthcare system. He described the letter as presenting the need to provide a safe and fair learning environment for all within medical schools and residency programs as one path to promote diversity in the medical workforce.

To provide some background, Dr. Hollmann recapped previous COGME discussions about the disproportionately high rates of individuals from UIM backgrounds leaving medical schools and postgraduate residency programs, including feedback from Dr. William McDade, Chief Diversity and Inclusion Officer of the Accreditation Council for Graduate Medical Education (ACGME), during COGME's last public meeting in September 2022 about how the data ACGME collects could be misconstrued. As a result, the writing group prepared two products for today's meeting: 1) a discussion document focusing on long-term recommendations to improve data collection and sharing (to be discussed later) and 2) a draft letter with more immediately actionable recommendations to help recruit and retain UIM students and residents.

The draft letter reflects COGME's desire to note the waste of talent, reduction of diversity in the future physician workforce, and loss of investment, including federal tax dollars, when UIM individuals fail to complete their medical training due to discrimination. The goal of the letter is to highlight factors that lead to the UIM trainees "leaking" out of the pipeline, present successful programs that have helped to support UIM individuals while pursuing careers in medicine, and then make specific recommendations to the HHS Secretary and Congress to expand or enhance these models.

Dr. Hollmann summarized the proposed recommendations:

- Increase funding for HRSA's Health Careers Opportunity Program (HCOP) and related programs to provide more post-baccalaureate counseling programs that can help prepare and sustain students through medical school and residency.
- Advance a structured and supportive learning environment for all trainees by funding GME programs to adopt certain initiatives that could improve the experience of UIM trainees and help further their careers as medical practitioners, leaders, and faculty.
- Fund faculty development programs to increase the recruitment and retention of UIM faculty who can serve as role models, supervisors, and mentors to UIM residents.

The letter concludes by acknowledging the complex social issues involved, while reiterating the importance of developing a racially and ethnically diverse physician workforce that reflects the population of the United States. One member offered a clarification that the discussion of the "leakage" of UIM students and residents was not about individuals with knowledge deficits or who lack the academic achievement and rigor to succeed in a medical career, but rather those who made it successfully through medical school and into a residency, but then faced unfair pressures or biases that led them to quit or to be expelled.

Dr. Kennita Carter, the COGME subject matter expert, raised the issue of housing or food insecurity as another factor impacting some UIM medical trainees. A Council member reinforced this point, stating that issues of financial insecurity and related social determinants of health can present significant problems for many UIM students and residents, giving the example of initiating a food pantry to enable residents to eat and a clothes-sharing program to allow

residents to dress appropriately for an interview. The recommendations in the letter represent vital steps to lay a foundation for success for many individuals who have the ability but have not had the opportunity to attain their full potential.

In response to questions about HRSA programs, Tammy Mayo-Blake, Chief of HRSA's Health Careers Pipeline Branch in the Division of Health Careers and Financial Support, noted the faculty development component the HRSA Centers of Excellence (COE) Program, which trains junior faculty to become leaders and mentors. She added that HCOP and COE offer post-baccalaureate enrichment and advising opportunities, as well as some stipends. She pointed to another program, the Scholarships for Disadvantaged Students that offers financial support, with most recipients being UIM students.

At the conclusion of the discussion, there was a motion to accept the letter draft, pending minor revisions. The letter was approved by unanimous consensus.

Council Discussion: UIM Data Document

Moderator: Linda Thomas-Hemak, MD, FACP, FAAP
Member, COGME

CAPT Kim moved to the next agenda item, the discussion document addressing UIM data collection and sharing. To open the session, she stated that BHW aims to assess the representation of UIM individuals among grantees and establish a baseline of workforce diversity in its health workforce programs. She shared the BHW Program Specific Data Form, which will be used in future notices of funding opportunities to help standardize demographic data collection, to include race and ethnicity, from all applicants. There was a question about the inclusion of a non-binary gender category for respondents. Joel Fuentes, MA, Office of Minority Health Fellow, representing BHW's Office of Strategy, Programs, and Partnerships, replied that the form includes gender responses of male, female, and not reported, in accordance with current census data collection.

CAPT Kim handed the meeting over to Dr. Linda Thomas-Hemak who stated that the goal of the session is to solicit input from COGME members about the discussion document, which calls for a federal repository on physician workforce and GME data as well as a convening of federal agencies, accrediting bodies, and GME-sponsoring institutions and programs to generate a consensus around the terminology and shared metrics of success. She referenced Dr. William McDade's UIM presentation during COGME's last meeting, which was the genesis for this document as better measures of medical trainee and physician workforce composition over time can inform efforts to promote diversity in the health workforce.

There was a comment that state licensure bodies hold a wealth of health workforce data, some of which have been leveraged into national data sets. Another comment noted the importance of a longitudinal data set tracking individuals, which can help monitor trends such as attrition, but such data may also raise issues around data security and privacy. There was a third comment on the importance of data accessibility and having a reporting mechanism. Dr. Thomas-Hemak added that accountability is extremely important because of the taxpayer investments in GME. In terms of data security, she noted that the THCGME program requires the assignment of a

unique but deidentified number so that grantees can be tracked longitudinally over time in a confidential manner. Comments about challenges included: special interests owning their data sets and the difficulties of achieving cooperation among various stakeholders; the potential misuse of data; governance issues; the purpose of the data repository given the lack of national workforce planning even with existing data sets; where the data repository should be housed; concern about a federal repository previously expressed during the 2018 National Academies of Science, Engineering, and Medicine meeting about GME Outcomes and Metrics; and the need for agility in data collection as job market conditions can change rapidly, causing shifts in residency match rates for some specialties. There were several comments about aligning and having further conversations with NCHWA.

Members discussed whether this document should be in the form of a policy brief or letter, and the chair concluded that the writing group can work on a short policy brief with recommendations, which may not look that different than a letter, to bring back to the COGME general membership at the next meeting.

Presentation: Supporting General Surgery in Rural Areas

Gary Timmerman, MD, FAC
Regent, American College of Surgeons, Advisory Council for Rural Surgery

Dr. Hollmann introduced Dr. Gary Timmerman, Professor and Chair at the University of South Dakota Sanford School of Medicine, American College of Surgeons (ACS) Regent, and ACS Advisory Council for Rural Surgery founding member. Dr. Timmerman shared some statistics showing a decline in rural access to general surgical services, noting that the ratio of general surgeons to the population in rural areas was under half of the generally accepted optimal level, while over 60% of non-metropolitan counties have no general surgeons in active practice. In addition, about 60% of the general surgeons in rural areas are nearing retirement age.

Dr. Timmerman presented some of the challenges in training general surgeons, especially in preparation for rural practice. In the past, any resident completing a general surgery residency was expected to be knowledgeable in all fields of surgery, including trauma, orthopedics, vascular surgery, obstetrical surgery, and pediatrics. However, over the last 20 years, the profession of surgery has experienced a sharp rise in the number of surgical specialties and a rapid advancement in technology (e.g., endoscopy, laparoscopy, robotic surgery, etc.), requiring greater knowledge in each surgical field but with less applied time in training after the implementation of the 80-hour resident work week. Therefore, some surgical specialties, including orthopedics, urology, and obstetrics-gynecology, evolved away from broadly trained general surgeons and are not even required as part of a general surgery residency. With the increasing trend of most surgical residents pursuing sub-specialization, there are only about 200 to 300 graduating surgical residents a year planning on a general surgery career with even fewer who would consider practicing in a rural location. Given the shrinking scope of practice for general surgery and volume requirements for certain procedures, the ACS explored alternative curricula to train general surgeons for rural-based practice, including adding rural surgery electives, creating rural surgery residencies or tracks, and offering fellowships for surgeons to gain more experience in obstetrics-gynecology.

Dr. Timmerman discussed the main issues in recruiting and retaining rural surgeons, including:

- Concerns about student debt relief, given the lower income potential in rural regions,
- The low volume of certain types of surgeries to maintain competence,
- The training and expense involved with incorporating new technologies,
- Limited specialty support (e.g., interventional radiology, etc.),
- Retaining opportunities for life-long learning,
- Difficulty in spending time away from a rural practice due to lack of on-call coverage,
- Professional isolation, leading to concerns about depression and burnout, and
- Social isolation for spouse or partner and family.

He then shared some positive trends:

- The pandemic highlighted some benefits of telemedicine and surgical telementoring (e.g., virtual, intraoperative consultations).
- Healthcare networks can provide surgeons with call coverage and financial security.
- Evidence indicates that training in a rural area during residency increases the likelihood of remaining in rural practice.
- Community investment can help support medical practices.
- Doctors and surgeons are appreciated as community leaders.

Dr. Timmerman also outlined some ACS priorities, including: redefining "rural" and to apply this new definition to all aspects of surgical care; banning noncompete clauses; and considering the impact to rural surgery if Critical Access Hospitals convert to Rural Emergency Hospitals.

In response to a draft letter from COGME on steps to bolster the number of general surgeons in rural areas, Dr. Timmerman said that ACS concurred with COGME in endorsing two bills from the last Congress and stands ready to work with COGME to get the bills passed in the current Congress. He added that ACS supported COGME's recommendation on creating a new scholarship and loan repayment program for general surgeons within the National Health Service Corps (NHSC), as well as efforts to create and fund rural general surgery training programs.

Commenting on the concept of rural health care teams, Dr. Timmerman said that working alongside health care providers from different disciplines is a core competency for all surgeons. However, surgeons would not expect providers from other non-surgical disciplines to render surgical care or provide call coverage. The greatest benefit would be for rural hospitals to recruit two or more rural surgeons or find another suitable arrangement for reasonable surgical call coverage, while promoting the advantages of interprofessional surgical teams.

Q and A

There was a comment on the vital interconnections of the primary care workforce in rural areas with surgeons. When a surgeon leaves or retires from a rural community, some of the simple surgical work may fall to primary care providers, placing enormous stress on their skill development. In addition, the local healthcare and hospital system may face risk of collapse when surgeons leave.

There was a question about the potential development of a new hybrid specialty that would combine some of the skills of primary care and general surgery into a five-year residency. Dr.

Timmerman replied that his early experiences as a general surgeon in a rural area required him to take emergency room call as a general physician, along with frequent call as a surgeon. He suggested that a possible career path would be the completion of a five-year residency in general surgery, followed by a one- to two-year fellowship in primary care. There was a comment about the difficulty of trying to define a surgical health professional shortage area without better understanding the scope of practice and service areas that general surgeons are practicing in. Another Council member commented on ACS' support for mentoring programs to promote rural surgery. Dr. Timmerman replied that he had experience bringing surgical residents into rural practice for mentoring, but the program is limited to two months due to accrediting requirements. Still, it allowed residents a brief on-the-job experience of practicing in a rural hospital.

Responding to a comment about the challenges of attracting surgeons and their families to rural areas where there may be limited school options for their children, limited employment opportunities for their spouses, and social isolation, Dr. Timmerman acknowledged the potential problems for families, especially if they want access to a high-level school for their children or have a special needs child requiring particular services. He noted that rural communities are often looking to attract health care providers and may devote community resources to help.

Council Discussion: Supporting General Surgery in Rural Areas Letter

Moderator: Ted Epperly, MD, FAAFP
Member, COGME

Dr. Ted Epperly moderated a discussion on a draft letter about the critical shortage of general surgeons in rural areas and COGME's recommendations for four mechanisms, two legislative and two programmatic, to address this shortage. The letter expressed COGME's support for the two pieces of legislation introduced in the 117th Congress and mentioned in Dr. Timmerman's presentation as having the backing of ACS: the Ensuring Access to General Surgery Act (H.R.5149 and S. 1593) to study and designate surgical health professional shortage areas and the Specialty Physicians Advancing Rural Care (SPARC) Act (S. 4330) to encourage more specialty clinicians, including general surgeons, to serve in rural areas by establishing a loan repayment program. The two programmatic proposals involve creating a parallel program within the NHSC scholarship and loan repayment programs for general surgery and establishing a new rural residency GME program along the lines of the THCGME funding model, but for training general surgeons in rural areas. He stated that the letter has been well-vetted, with feedback provided by HRSA staff, including the Federal Office of Rural Health Policy, and Dr. Timmerman during the last session.

After discussion to clarify some of the wording, the Council voted and approved the letter by unanimous consensus, pending minor edits.

Discussion: Rural Health Teams

Moderator: Armour Forse, MD, PhD, FRCS(C), FACS, FCCM, FASMBS
Member, COGME

Council member Dr. Armour Forse led a discussion on developing interprofessional rural health teams into a sustainable workforce. He noted that most current health professions students had

trained in large teams and looked to work in a system that provides them with support, concepts that are critical in rural areas. Finding the most effective health care teams for rural settings requires more thought than just throwing individuals from different backgrounds and disciplines into a practice; it entails considering how to develop an efficient and effective group of health care providers who are able to work with each other and understand each other's roles, expectations, and responsibilities. He noted studies have shown that effective teamwork helps create workplace efficiencies, improve care outcomes, and decrease clinician burnout and turnover. He emphasized that teamwork requires clear communication, a strong sense of trust, and mutual physical and psychological support. Also vital to long-term success is establishing shared measurable goals.

Dr. Forse discussed his experiences as an instructor for TeamSTEPPS, an evidence-based team building program, which was implemented in the operating room at his hospital and involved physicians and anesthesiologists, students, nurses, operating room technicians, and other support staff. The program showed results in improved staff communication, as well as better clinical outcomes such as a reduced rate of complications and lower patient mortality. Dr. Forse mentioned that having people train together and work as part of that team has shown to be effective, citing the military as an example.

Lastly, Dr. Forse noted the need for buy-in and support from the community and facilities, such as critical access hospitals, for rural health teams to be sustainable and effective.

Q and A

There was a comment on the crucial need to address the long-term health of rural and frontier communities at a population level through forward planning and teamwork; an upstream approach is needed to keep communities healthy, which is a different skill set than reacting to diseases or injuries and involves employing and deploying social workers and community health workers as part of the team. There was another comment that the ACGME is including the concept of teams in its accreditation standards and that team-based training needs to involve faculty and leadership to successfully change the learning culture.

Dr. Timmerman said that the ACS had developed a Rural Hospital Surgical Verification and Quality Improvement Program, as a guideline for rural hospitals to follow in developing support teams for rural surgeons.

Wrap Up and Next Steps

Dr. Hollmann reviewed the events of the day and summarized the presentations the Council had received. He reminded the Council members that the topic of the next COGME report, focusing on team-based care, would receive further discussion during the second day of the meeting. He noted the consensus of the Council to finalize the two letters that were approved and for the writing group to continue its efforts on the data document.

Adjourn

CAPT Kim adjourned the first day of the meeting at 4:45 p.m. ET.

Friday, March 17, 2023

Welcome and Roll Call

CAPT Kim convened the second day of the COGME meeting at 10:00 a.m. ET on Friday, March 17, 2023. She conducted a roll call, and 14 of the Council's 17 members were present, meeting the requirement of a quorum. CAPT Kim turned the meeting over to the COGME chair, Dr. Peter Hollmann, who summarized the previous day's meeting and outlined the agenda for the day.

Update and Discussion: Dissemination Strategies

Curi Kim, MD, MPH
Designated Federal Officer, COGME

Laura Ridder
Ethics Advisor, HRSA

CAPT Kim led a discussion on the Council's dissemination efforts for its 24th Report, released in April 2022. She reminded the members that a writing group had created a one-page summary with the report recommendations, and thanked Dr. Thomas-Hemak and her team for formatting it, along with producing other related materials, including a postcard and social media posts. The Council had voted to approve the use of these materials during its last meeting. However, there were some questions about how Council members could use the materials.

Since the last meeting, CAPT Kim followed up with the HHS Office of General Council (OGC) and shared their responses to COGME's questions. OGC confirmed that COGME's authorizing statute supports its efforts to disseminate its recommendations by way of encouraging outside organizations and entities to voluntarily adopt or implement the Council's recommendations. OGC also reviewed and agreed with the ethics guidance document pertaining to dissemination efforts that was compiled from consultations with HRSA ethics adviser Laura Ridder. OGC offered some draft language that members could use when preparing commentaries for journals about COGME recommendations in their personal capacity; however, if COGME members wanted to write a letter or editorial in their committee capacity, OGC defers to the HRSA Office of Communications on the proper clearance and language. If COGME members write to journals in their committee capacity, OGC advised that COGME should have an objective rationale for selecting certain journals or publications to avoid ethics concerns, and may consider creating a process to ensure it has a clearly articulated basis for choosing appropriate dissemination outlets. OGC advised against sending COGME reports and related products to local chambers of commerce or to local or state government offices, as such an action could be viewed as an official action of COGME or HRSA and a form of lobbying. CAPT Kim reminded the Council members that they are considered special government employees when conducting official business, and the prohibited from lobbying or advocacy efforts.

CAPT Kim said that the BHW's Division of External Affairs facilitated mentions of the COGME 24th Report in several HRSA e-newsletters to both internal and external stakeholders. She asked COGME members about their individual dissemination efforts and several members mentioned how they shared the materials.

There was a comment on the potential value of tracking citations of the report in the literature, as well as tracking the report dissemination and outreach efforts, to help determine the audiences where it has the most impact. Several members expressed support for maintaining the dissemination writing group to continue discussing these issues and draft a process to ensure journals and other outlets COGME considers engaging with are chosen objectively. There was another comment of the availability of software and other tools to track mentions in social media.

CAPT Kim reminded the members that Ms. Ridder and other HRSA staff could serve as a resource if questions arose as to the permissibility of certain dissemination efforts. There was consensus to maintain the work group to address any issues that might arise and to further refine the dissemination products.

Panel Discussion: Federal Advisory Committees' Perspectives on Team-Based Care

Justin Bala-Hampton, DNP, MPH, MHA, RN, AGACNP-BC, OACNP
Interim Chair, National Advisory Council on Nurse Education and Practice

Sandra Snyder, DO
Chair, Advisory Committee on Training in Primary Care Medicine and Dentistry

Thomas Teasdale, DrPH
Chair, Advisory Committee on Interdisciplinary, Community-Based Linkages

Dr. Hollmann moved to the next agenda item, a panel discussion on interprofessional, team-based care. He introduced the chairs of three other federal advisory committees: Dr. Justin Bala-Hampton, interim chair of the National Advisory Council on Nurse Education and Practice (NACNEP), Dr. Sandra Snyder, chair of the Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD), and Dr. Thomas Teasdale, chair of the Advisory Committee on Interdisciplinary, Community-Based Linkages (ACICBL).

<u>NACNEP</u>

Dr. Bala-Hampton noted that the central theme of the NACNEP 19th Report, currently in development, is on improving and strengthening competency-based training in nursing education at both the undergraduate and post-graduate levels. One focus is on providing different types of clinical placements outside of the traditional acute-care hospital settings, such as at federally qualified health centers (FQHCs); another is looking at opportunities for nurse practitioners to have preceptors who are social workers, physical therapists, and occupational therapists. In addition, NACNEP is exploring ways to shift reimbursement away from the standard bed-charge for nursing services toward a system based on the care that nurses provide, as is common practice for other professions.

Dr. Bala-Hampton noted that the NACNEP 18th Report, released in January 2023, focused on preparing a public health nursing workforce to address current and future public health emergencies, with a strong emphasis on interprofessional training and practice.

There were several comments about the competition for clinical training sites. One Council

member mentioned the benefit of HRSA programs that promote interprofessional training and other initiatives like the nurse practitioner primary care fellowship that is being pioneered by health centers across the country. Dr. Bala-Hampton added that such nurse practitioner fellowship programs in which advance practice nurses and physicians train together can help them understand each other's mindsets.

ACTPCMD

Dr. Snyder noted that ACTPCMD has a unique role in combining components of primary care medicine and oral health. The Committee was authorized in 1998, under Title 7, Section 749 of the Public Health Service Act, to provide recommendations for primary care medical and dental training. The Committee maintains a strong perspective on integrating oral health and behavioral health within primary care, both in practice and in training, to improve health outcomes for the nation's most vulnerable populations.

Dr. Snyder highlighted ACTPCMD's 19th Report (2022), *Supporting Dental Therapy through Title VII Training Programs: A Meaningful Strategy for Implementing Equitable Oral Health Care*, which addressed oral health disparities resulting from the lack of access to care, and recommended including dental therapists as part of the health care team to help mitigate some of the disparities. She added that ACTPCMD is currently working on its 21st Report about the lack of staffing in primary care that was exposed by the COVID-19 pandemic, especially in rural areas. The Report will provide recommendations on the creation of an innovative program to support additional training of community health center staff, with the goal to keep well-trained workers within their communities to practice.

ACICBL

Dr. Teasdale shared his own experience with the interprofessional nature of public health, describing himself as a non-physician doctor of public health who teaches in a school of medicine. He noted that ACICBL, authorized in 1998, has maintained a focus on team-based, interdisciplinary practice. ACICBL is responsible for providing advice on programs under Title 7, Part D, of the Public Health Service Act, including:

- Area Health Education Centers,
- Geriatric Workforce Education,
- Mental and Behavioral Health Training for Professionals and Paraprofessionals,
- Graduate Psychology Education,
- Addiction Medicine,
- Integrated Substance Abuse Disorder, and
- Opioid-Impacted Family Support.

Dr. Teasdale noted that ACICBL welcomed COGME's focus on team-based care. Several of the past ACICBL reports addressed topics related to teams, and their recommendations have strongly endorsed interprofessional education and practice across a range of community health care settings. He specifically highlighted ACICBL's 12th Report (2013), *Redesigning Health Professions Education and Practice to Prepare the Interprofessional Team to Care for Populations*, its 17th Report (2019), *Preparing the Current and Future Health Care Workforce for Interprofessional Practice in Sustainable, Age-Friendly Health Systems*, and its 19th Report (2020), *High Value Healthcare and Health Equity: It Takes a Team*. The topic of ACICBL's

22nd Report, currently in development, is promoting well-being and healthy longevity by optimizing appropriate health care across the life course. While it does not have a specific focus on team-based care, it will discuss inter- and multi-professional involvement in providing health care because people transition to different health care needs at different points of their lives. Dr. Teasdale summarized the ACICBL perspective by saying HRSA and the United States healthcare system would benefit by the advancement of interdisciplinary and interprofessional teams at the training, accreditation, and practice levels. The clinical learning settings should provide ample opportunity for trainees to learn in team settings and similar educational opportunities should be made available for lifelong learning programs. He added the importance of including individuals who might have no clinical responsibilities, but who are trained in information technology, quality measurement, and quality improvement issues, as they bring insight that can lead to more effective healthcare.

Q and A

There was a comment about the need to attract more geriatricians and other health care providers to care for older adults in age-friendly health systems, and that COGME might need to take on the question of preparing the physician workforce to meet the needs of the aging population in the United States. Dr. Teasdale stated he and the ACICBL members appreciate the interdisciplinary expertise needed to care for older adults.

There was a comment on the difficulties of establishing a team-based care approach, as some patients may resist seeing clinicians such as a nurse practitioner rather than a physician and may have difficulty understanding that all members on the team are working together. There was another comment on the need for a formal process to train individuals to function as a team, citing the military as an example. Dr. Bala-Hampton emphasized the need for consistent messaging and the value of the team in providing different areas of expertise while maintaining continuity of care. Dr. Snyder added that training as a team is essential in developing a common language and defining the different roles and responsibilities. Dr. Teasdale reinforced the need for better communication to help the patient understand that the primary care clinician is responsible for organizing the team and clearly identifying the roles of the other team members.

Dr. Snyder noted more GME dollars are going to training in community health centers that support interprofessional teams; however, most GME funding still goes to large academic medical centers, where the different health professions are siloed. Dr. Teasdale stated that some medical schools conduct interdisciplinary activities early in their programs, but more is needed. Dr. Bala-Hampton emphasized the role of collaboration, citing the example of nurse-led mobile health clinics in rural and other underserved areas that develop close collaboration and referral networks with other providers and specialists.

There was a comment on the difficulties in sharing health information as a possible barrier to implementing team-based care. Dr. Teasdale noted that ACICBL had made a recommendation to include health informatics specialists as part of the health care team to facilitate the use of information technology in improving patient care; both Dr. Snyder and Dr. Bala-Hampton echoed the importance of interoperability between different electronic health record systems to provide seamless care, which often remains a struggle. A Council member commented on the direction of healthcare moving away from acute care hospitals and into the community. For the future, it will be necessary to develop teams that can work towards promoting health and

providing better care to individuals and families as close to home as possible, to include the hospital-at-home concept. Dr. Teasdale noted that family members should be incorporated as team members as well as community organizations like the YMCA. Dr. Bala-Hampton spoke about the need for states to allow nurses to practice to their full scope, noting that nurse practitioners having been doing more home visits than in the past. Dr. Snyder cited accelerated pathways as a model in which learners are placed in their future community where they will practice, and they start training with that team starting in medical school.

There was a final comment about the potential for a joint-Committee product about teaming, which could be around infrastructure funding for teams and focusing on AHECs, as much has been written about teams over the decades, but without enough results.

Council Discussion: COGME 25th Report

Moderator: Peter Hollmann, MD
Chair, COGME

Dr. Hollmann moderated a Council discussion on the development of COGME's 25th Report. He stated that the Council had decided on the theme of team-based care, under the hypothesis it is essential to improve both health care access and quality of care. However, current medical training (both didactic learning and clinical or experiential training) provides inadequate preparation for working in interprofessional teams.

Dr. Hollmann noted the need to define team-based care. The Council will need to decide if the focus should be inter-specialty physician teams, or interdisciplinary care with physicians working together with nurses and other health professionals, or both; members agreed that both should be addressed. Examples of possible interdisciplinary team members include physicians and residents (and other learners), advance practice registered nurses, physician assistants, registered nursing and care managers, pharmacists, physical therapists, social workers, and behavioral specialists, among others, as well as the patient. He shared some possible draft recommendations to bolster federal policies that support team-based training and care.

Dr. Hollmann listed some of the questions for the report to address:

- What is the evidence to support team-based care?
- Is the evidence to support team-based care limited to specific health settings/conditions?
- How prevalent is team-based training and education?
- What are the essential elements of a high functioning team and its optimal configuration?
- What are the barriers to implementing team-based training and care?
- What supports and barriers can the COGME report and recommendations best address?

Dr. Hollmann also discussed the process of the report development, noting that a report requires a significant amount of time to develop. He noted that process of the 24th Report involved the development of a series of issue briefs with recommendations, which were then merged into the final report. The Council could also elect to prepare letters to the HHS Secretary and Congress for matters of more immediate concern, which could then be referenced for the report. Finally, he shared a proposed draft outline for the report chapters.

Discussion

There were comments that discussions about interprofessional education and practice have been going on for at least 50 years, so the Council will need to frame its report around the current forces that are bringing this topic to the forefront now—why now and why COGME? The unique role of COGME was mentioned and how its recommendations may help Congress or HHS make policy changes or set funding priorities to accelerate the acceptance and adoption of team-based concepts. The 25th Report could address the impact of team-based care on enhancing health care access and capacity, improving learning environments, promoting trauma-informed education, and highlight successful models such as the Area Health Education Centers program. There was discussion to explore the evidence for workforce satisfaction and the impact of teams in helping individual clinicians feel more satisfied and be more resilient. The report could also address the use of information technology in organizing and facilitating teamwork; however, a member commented that health care technology should focus on supporting the delivery of care and improving patient outcomes, rather than providing administrative oversight. There was discussion on the effect of the COVID-19 pandemic on the health workforce and the possibility of transitioning to a more team-based approach in the post-pandemic phase.

One Council member referenced the recent report from the National Academy of Sciences, Engineering, and Medicine, *Achieving Whole Health: A New Approach for Veterans and the Nation*, which noted some of the struggles that large institutions have experienced with teams while also highlighting the Veterans Administration's whole health approach that is built around deconstructing silos and forming interprofessional teams. There was another comment that teams must work within current health care systems and a suggestion to consider how FQHCs or major organizations such as the Mayo Clinic or the Geisinger Medical Center see the value of health care teams in achieving their mission. Several members emphasized focusing on the outcomes of teams as well as looking to other industries for examples. There was a comment that the physician needs to be the leader of the team, but in further discussion it was raised that the leader could be from another profession depending on the setting and purpose of the team.

Dr. Hollmann raised the question of identifying barriers to implementing team-based care. He noted the difficulty of managing change in an already complex health care system. There was a concern expressed that many medical residents are not taught the knowledge, skills, or attributes to work in a team, and that residents will need to understand how to function in many kinds of teams. One member remarked on the benefits of using a case-based approach in teaching teamwork. There was a comment on the need to have interdisciplinary teams work together earlier in the educational process for all students, to facilitate the understanding of different roles and ease communication flow; however, it would need to be followed through with sequential training for physicians, starting in medical school and into residency through practice-based learning. The lack of clinical curricula needed for this was noted as a barrier, but another member suggested this could be addressed through simulation (standardized patients), which could be virtual. One member acknowledged that the lack of faculty who can provide training in teams, and the need to address the attitudes of faculty and older physicians in adapting to teams in both educational and practice settings, is a challenge. A member remarked that the major barrier remains financing (e.g., for GME, other professional training, and models of care).

Given the overlapping interests of COGME with the other federal advisory committees that

presented earlier in the meeting, there was a suggestion to explore a collaborative issue brief or letter to Congress. For COGME's 25th Report, one member advised that referencing COGME's past recommendations about teams, as well as incorporating the ACPCTMD and ACICBL's recommendations about teams, and providing updated recommendations would be an effective approach. The benefits of writing briefs first, as precursors to the report, was discussed. Another member suggested that the writing group frame the evidence for team-based care around the quintuple aim (do teams enhance patient experience, improve outcomes, lower cost, increase clinician well-being, and promote health equity?) and to bring in a speaker from the University of Minnesota's Center for Inter-Professional Practice and Education for the next COGME meeting as well as potentially synthesizing the work of HRSA's Health Workforce Research Centers around teams and reviewing the evidence from the THCGME and RRPD programs. A member mentioned bringing someone from ACGME to speak about defining or measuring the competency of teaming for the next COGME meeting.

Dr. Hollmann concluded the session with a summary of future actions: convene a writing group to gather more background information and draft potential recommendations, and then present the writing group's efforts at the next COGME meeting.

Business Meeting and Public Comment

Curi Kim, MD, MPH
Designated Federal Officer, COGME

For the business meeting, CAPT Kim reminded members of the next scheduled COGME meeting, on September 8, 2023. She added that COGME's first meeting in 2024, in the early springtime, will be planned to be an in-person event. CAPT Kim also noted that the terms of many members will be ending in 2024. HRSA is in the process of reviewing the nomination packets for new members; she also mentioned that HRSA is strategizing a process to return to staggered terms for more manageable turnover of members. Lastly, she reminded members of the need to complete their ethics recertification paperwork and submit it by May 15, 2023. There were no public comments.

Wrap-Up, Next Steps, and Closing Remarks

Peter Hollmann, MD
Chair, COGME

Before wrapping up, Dr. Hollmann noted that the Council had discussed submitting a letter to the 118th Congress in support of the THCGME program, as the program is currently up for re-authorization. There was a motion to update the Council's THCGME support letter previously sent to the 117th Congress in October 2022, and the motion was seconded. The motion was approved by unanimous consensus with Dr. Thomas-Hemak recusing herself and abstaining from the vote due to her role on the American Association of Teaching Health Centers Executive Committee. Dr. Hollmann then reviewed the events of the day and concluded with next steps for the 25th Report.

The meeting was adjourned at 4:20 p.m. ET.

Acronym and Abbreviation List

AAFP	American Academy of Family Physicians
ACGME	Accreditation Council for Graduate Medical Education
ACICBL	Advisory Committee on Interdisciplinary, Community-Based Linkages
ACTPCMD	Advisory Committee on Training in Primary Care Medicine and Dentistry
ACS	American College of Surgeons
BHW	Bureau of Health Workforce
CMS	Centers for Medicare and Medicaid Services
COE	Centers of Excellence
COGME	Council on Graduate Medical Education
DME	Direct Medical Education
FQHC	Federally Qualified Health Center
FY	Fiscal Year
GME	Graduate Medical Education
HCOP	Health Careers Opportunity Program
HHS	U.S. Department of Health and Human Services
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
IME	Indirect Medical Education
ID	Infectious Disease
IDSA	Infectious Disease Society of America
NACNEP	National Advisory Council on Nurse Education and Practice
NCHWA	National Center for Health Workforce Analysis
NHSC	National Health Service Corps
NSSRN	National Sample Survey of Registered Nurses
OGC	Office of General Council
PRA	Per Resident Amount
SPARC	Specialty Physicians Advancing Rural Care
THC	Teaching Health Centers
THCGME	Teaching Health Center Graduate Medical Education
THCPD-TAC	Teaching Health Center Planning and Development-Technical Assistance Center
UIM	Underrepresented in Medicine