

COUNCIL ON GRADUATE MEDICAL EDUCATION (COGME) MEETING MINUTES

COGME History and Strategic Directions

June 20-21, 2018

Day 1: Jun 20, 2018

Council Members in Attendance:

Kristen Goodell, MD, FAAFP, Chair	Assistant Dean for Admissions Boston University School of Medicine, Boston, MA
Lois Margaret Nora, MD, JD, MBA, Vice Chair	Immediate Past President American Board of Medical Specialties Chicago, IL
Peter B. Angood, MD, FRCS(C), FACS, MCCM	Chief Executive Officer and President American Association for Physician Leadership Tampa, FL
Andrew Bazemore, MD, MPH	Director Robert Graham Center Washington, DC
Ted Epperly, MD	President and Chief Executive Officer Family Medicine Residency of Idaho, Inc. Boise, ID
Erin Fraher, PhD, MPP	Director Carolina Health Workforce Research Center University of North Carolina at Chapel Hill Chapel Hill, NC
Monica L. Lybson, MD, MHPE	Director, Medical and Dental Education, Office of Academic Affiliations Veterans Health Administration, Department of Veterans Affairs Washington, DC
John J. Norcini, PhD	President and Chief Executive Officer Foundation for Advancement of International Medical Education and Research Philadelphia, PA
Beth Roemer, MPH	Assistant Dean for Admissions, Outreach, Diversity and Inclusion Kaiser Permanente School of Medicine Oakland, CA
Eric Scher, MD	Chair Department of Medicine Henry Ford Hospital Detroit, MI
Thomas C. Tsai, MD	Surgery Resident Brigham and Women's Hospital, Harvard University Boston, MA
Kenneth Veit, DO, MBA, FOCFP	Dean and Senior Vice President of Academic Affairs Philadelphia College of Osteopathic Medicine Philadelphia, PA

HRSA Support Staff:

Kennita R. Carter, MD, Designated Federal Official, Council on Graduate Medical Education (COGME), Health Resources and Services Administration (HRSA), and Senior Advisor, Division of Medicine and Dentistry (DMD), Bureau of Health Workforce (BHW), HRSA
Nicole Hollis-Walker, Public Affairs Specialist, BHW
Raymond Bingham, MSN, RN, Division of Medicine and Dentistry, HRSA
Kimberly Huffman, Director, Advisory Council Operations, HRSA
Kandi Barnes, Advisory Council Operations, HRSA

HRSA Staff:

George Sigounas, MS, PhD, Administrator, HRSA; Luis Padilla, MD; Associate Administrator, BHW; Candice Chen, MD, MPH, Director, DMD; Joan Weiss, PhD, RN, CRNP, FAAN, Senior Advisor, DMD; Marshala Lee, MD, MPH, Branch Chief; GME, Michelle Goodman, MPA, Policy Analyst, BHW; Lisa Flach-Fulcher, Budget Analyst, DMD

Introduction

The Council on Graduate Medical Education (COGME, or the Council) held an in-person meeting at the headquarters of the Health Resources and Services Administration (HRSA), 5600 Fishers Lane, Room 5W07, Rockville, MD 20857.

Dr. Kennita Carter, Designated Federal Official (DFO), called the meeting to order at 8:30 a.m. ET, and conducted a roll call. From the initial roll call, Dr. Carter informed the Council that all current members were present except for two, so that a quorum was achieved and the meeting could proceed.

Dr. Carter turned the meeting over to Dr. Kristen Goodell, the COGME chair. After a brief round of introductions, Dr. Goodell introduced Dr. George Sigounas, the HRSA Administrator. Dr. Sigounas welcomed the COGME members. He noted that COGME has a long history of providing advice to the Secretary of Health and Human Services and to Congress on matters involving the physician workforce and both undergraduate medical education (UME) and graduate medical education (GME). He said that HRSA takes the advice of COGME very seriously. HRSA oversees over 90 programs with the goal of developing the healthcare workforce and providing health care to people who are geographically isolated or economically or medically challenged. HRSA programs also cover organ donations, poison control, and HIV/AIDS care, maternal/child care, and other areas. In particular, the HRSA Bureau of Health Workforce (BHW) has over 45 programs devoted to the healthcare workforce, including the National Health Service Corps (NHSC) and NURSE Corps programs. HRSA grants and cooperative agreements go out to colleges and universities, hospitals and health care systems, community health centers, and state, local, and tribal governments.

Dr. Sigounas highlighted two programs focused on GME, the Teaching Health Center Graduate Medical Education (THCGME) and Children's Hospitals Graduate Medical Education (CHGME) programs. THCGME is working to expand the number of primary care providers, and over 50 percent of medical and dental students who receive THCGME funding go on to

serve in rural and other underserved areas. CHGME works to increase the number of physician pediatric specialists in several areas of severe shortage.

Dr. Sigounas stated that he urged all HRSA bureaus and offices to be innovative in developing programs to address workforce shortages, with the focus on helping the patient, family, community, and nation. He encouraged collaborations with other federal agencies, including the Centers for Medicare & Medicaid Services (CMS), and the Department of Veterans Affairs (VA), as well as with academic, professional, and other stakeholder organizations.

Presentation: Council on Graduate Medical Education Overview

Dr. Kristen Goodell stated that the COGME membership represents a wide range of expertise in the areas of healthcare education, practice, workforce, and policy, and reminded the members of their charge to address the country's health workforce needs. She encouraged the members to work together and be willing to ask questions and engage in discussions. She informed the members that, as chair, she would oversee the first day of the meeting, and announced that Dr. Lois Margaret Nora, vice chair would run the second day of the meeting and assume the position of chair. She turned the floor over to Dr. Carter for a brief overview of COGME's history, along with the roles and responsibilities of the members.

Dr. Carter introduced herself as an internist and fellowship-trained geriatrician. In addition to being the DFO for COGME, she serves as a senior advisor in the Division of Medicine and Dentistry of BHW.

Dr. Carter stated that COGME was first authorized in 1986 to provide an ongoing assessment of the physician workforce. The charge of COGME covers issues of the supply and distribution of the physician workforce, physician training, and specialty mix. In terms of the supply pipeline, COGME has placed significant focus on both UME and GME, as well as GME financing. Through its reports, research briefs, letters, and related publications, COGME provides advice to the HHS Secretary and Congress, and its authorizing statute also calls for it to recommend "appropriate private sector efforts to address identified needs."

Dr. Carter said that, when fully constituted, COGME consists of 17 members – 14 non-federal members. The remaining three members are federal representatives, including designees of the Assistant Secretary for Health, CMS, and the VA. She said that all federal advisory committees are governed by the Federal Advisory Committee Act (FACA), which has established rules for the conduct of committees that ensure openness and transparency. All meetings of the full Council must be announced in the Federal Register and be open to the public, and all must provide an opportunity for public comment. The minutes of all meetings are publicly available and posted to the Council's web page. The charter for the Council is renewed every two years, with the next renewal due in August 2018.

As the DFO, Dr. Carter said that her role was to support the Council, ensure efficient operations, and ensure compliance with all FACA rules. Other HRSA staff also provide support in the conduct of meetings and the preparation of Council documents and reports.

Dr. Carter noted that all COGME members are experts in their fields, and may be asked to speak or testify on subjects within their expertise as private citizens. She noted that Dr. Goodell had provided testimony on primary care at a recent Congressional hearing. However, FACA rules prevent individual members from speaking as a Council representative.

In terms of roles and responsibilities, Dr. Carter said that the chair leads the Council, works with the DFO and the vice chair to develop meeting agendas, presides over the meetings, calls for votes among the members when needed, oversees the public comment period, and certifies the accuracy of the meeting minutes. The other members are expected to bring their expertise and experience to the Council discussions. Members are asked to attend all meetings, review required materials before the meetings, actively engage in Council presentations and discussions, and participate in the development of Council recommendations and reports. Members also have the responsibility to complete required paperwork and training related to conflicts of interest and ethics, as well as to submit all required documentation for travel and lodging related to meeting attendance or related matters.

In regard to the upcoming charter renewal for the Council, one member asked about making changes to the charter. Dr. Carter replied that there is a limited opportunity for the Council members to suggest changes. HRSA is working to standardize the charters of each of its advisory committees for consistency, while making sure that each charter meets the unique needs of each committee and stays within the authorizing legislation.

Referring to a section in the charter that stated the Council should “recommend appropriate federal and private sector efforts” to meet identified needs, a second member asked what types of organizations are meant under “private sector.” Dr. Carter replied that U.S. Department of Health and Human Services (HHS) and HRSA do not have the authority to require or enforce Council recommendations within private sector organizations. However, the Council can make recommendations addressed to hospitals, schools of medicine, educational accrediting bodies, or other such entities. Private sector organizations may incorporate these recommendations as they see fit.

Discussion: The Charge of COGME

Dr. Carter introduced Dr. Candice Chen, Director of the HRSA Division of Medicine and Dentistry (DMD). Dr. Chen stated that the charge of the Council is to examine issues related to:

- 1) the supply and distribution of physicians in the United States,
- 2) current and future shortages or excesses of physicians in medical specialties and subspecialties, and
- 3) international medical school graduates

International medical graduates make roughly 25 percent of the physician workforce. She added that the physician workforce cannot be examined outside of the healthcare workforce as a whole, so an important area of focus is team-based care and interprofessional practice and education.

Dr. Chen noted that the issues of workforce are very broad, covering the medical school pipeline, UME and GME, physician training, and medical practice. Most of the recent COGME reports

have focused on GME, which is the largest workforce development investment of the federal government. However, over its 30-year history, COGME has written reports on changes in the healthcare system, healthcare financing, and workforce diversity, among other topics.

Dr. Chen discussed two COGME reports in particular. The 18th Report, *New Paradigms for Physician Training for Improving Access to Health*, published in 2007, took a broad look at the physician pipeline. In particular, it examined the idea of mandatory service for physicians – which the Council ultimately rejected. A second report from 2010, *Advancing Primary Care*, provided an overview of the healthcare system as a whole. In this report, the Council made recommendations on increasing the primary care workforce, changing payment and practice transformation to promote primary care, and improving the geographic and socioeconomic distribution of physicians. However, other recommendations addressed areas outside the purview of the federal government, including the premedical and medical school educational environment, and ways to better allocate resources and improve admissions practices.

Dr. Chen said that the country's healthcare system is undergoing rapid changes. She invited the Council members to think about what recommendations on federal policy or to the private sector they could make to ensure that the workforce can achieve the desired healthcare transformation. She said that COGME could be very valuable in the push towards value-based care and improving healthcare access, quality, and cost-efficiency, while addressing physician burnout.

One of the members asked Dr. Chen to name some top priority areas for the Council to consider. Dr. Chen replied that healthcare access in rural and underserved areas remains a major focus for HRSA. This topic would also include the integration of care and the interprofessional organization of the workforce, and preparing the workforce for new healthcare delivery models and technical advances such as telehealth.

Another member asked Dr. Chen if she could identify the top changes that have resulted from COGME recommendations. Dr. Chen responded that it is often difficult to link an advisory committee recommendation with a specific change, especially as changes can take 10 years or more to implement. However, she provided two examples. Many of the recommendations made in the 2010 report on primary care have been implemented by CMS. In addition, many medical schools have implemented an holistic admissions approach to improve student diversity, which was discussed in the 2016 COGME resource paper, *Supporting Diversity in the Health Professions*.

Dr. Goodell asked Dr. Sigounas for his thoughts on how COGME could best interface with other federal agencies working on health workforce issues. Dr. Sigounas replied that the President's Budget for FY 2019 contained a proposal that CMS and HRSA co-manage GME programs. CMS provides most of the GME funding, while HRSA has more experience in addressing workforce issues. HRSA would look to COGME for its input, particularly on addressing areas of workforce shortages. He added that recommendations from COGME had been instrumental in establishing the THCGME program in 2010. He also pointed out that HRSA first established an office devoted to telehealth over 27 years ago, when the concept was just beginning to form.

Another member brought up the most recent COGME report, which called for the development of a national strategic plan for GME. Dr. Goodell stated that COGME had initially considered the idea for a strategic plan several years ago, when the Council found that while the GME system produced skilled and excellent physicians, it was failing to meet the needs of the nation in terms of workforce distribution and specialty mix. As a result, the Council had written a letter to the HHS Secretary that offered the Council's services in developing a strategic plan. This offer was rejected. The Council then devoted its 23rd report, published in April 2017, to presenting the case for a strategic plan and recommending ways such a plan could be developed and funded. Dr. Goodell suggested that the report and its recommendations may have gotten lost in all of the changes of the new administration, which came into place in January 2017. She asked for ideas on how the Council could improve the impact of its reports, and make sure that they are seen and understood by policymakers.

Dr. Chen reminded the Council members that the COGME reports go directly to the HHS Secretary, and any recommendations relevant to HRSA come back for implementation. She pointed to the proposal in the President's Budget for CMS to work with HRSA, as well as efforts of HRSA to work more closely with the VA, as ways in which the underlying principles of the strategic plan are being put into place.

Dr. Lois Nora said that one of the key issues of both the strategic plan letter and the 23rd report is that the healthcare system is exceedingly complex, and no single group can address all of the issues. Efforts to improve the GME system will have to involve multiple stakeholders. She added that COGME has traditionally worked to "push" for change through its reports and recommendations, but there has also been a recent transformation to offer the expertise of COGME as a resource for other agencies and organizations to consult.

While recognizing the importance of the COGME reports, Dr. Bazemore asked for more information on other formats the Council can consider. Dr. Goodell replied that the Council can write letters to the HHS Secretary and Congress, as well as shorter resource papers and briefings. Letters are generally written in response to a particular issue that is coming up in legislation or a particular program that needs support or funding. She cited the example of the letter written by the Council in support of funding for the THCGME program.

The Council can also consider preparing a research brief, often in response to a specific request from another agency or advisory committee. HRSA staff will typically provide much of the background research and information for the Council members to review. Such a brief might take roughly 6 months to develop. Members may also take part in a conference call with legislative staff to address a particular question or issue.

Dr. Chen mentioned another resource available to COGME, the Health Workforce Research Centers, funded by the National Center for Health Workforce Analysis (NCHWA) at HRSA. These Centers can prepare a rapid response document consisting of a literature review and a quick analysis, on a variety of topics related to the healthcare workforce.

Dr. Carter recalled that the Council had sought input, on national GME strategic planning, from a wide range of stakeholder organizations in the development of its 23rd Report. The members

developed a brief questionnaire and sent it to representatives from several prominent national organizations. She stated that this mechanism is one way of engaging key stakeholders who may not attend the COGME meetings. Dr. Chen added that COGME can also engage with stakeholder organizations by asking them to have a representative present at a COGME meeting.

Council Discussion

Dr. Goodell initiated a discussion among the Council members by asking if the information presented in the meeting to that point met their expectations.

One member commented on the struggle to understand how COGME can best make an impact. While part of COGME's role is to add its voice on broad issues such as promoting primary care or supporting diversity in the workforce, the Council may also need to look further ahead to anticipate and tackle more long-range issues or propose more innovative approaches.

Dr. Ted Epperly also voiced concern about the impact of COGME's past recommendations, and suggested tracking the recommendations to assess percent of uptake. Related to the proposed partnership between CMS and HRSA in managing GME, he stated that both agencies tend to operate in silos and will need to build connections so that funding of GME aligns better with current needs, which he described as "ground zero for impact." Another member raised the issue of the VA Mission Act, signed into law in June 2018. The bill was designed to provide the VA with more funding and to increase health care access for Veterans. The Act includes some language covering VA financing for GME, which may provide an opening for COGME to respond. Dr. Goodell replied that one strength of the Act is that it directs more GME funding towards needed specialties and other areas such as outpatient care and community-based training. Addressing Dr. Epperly's point, she concurred that GME funding is not directed to the areas of greatest need, such as training in rural areas. She said that there are successful models within HRSA and the VA, and that COGME could amplify successful efforts.

Another member raised the issue of the Teaching Health Center (THC) program, which is widely regarded as a success. However, THCs have to constantly fight for funding, which limits their stability and growth. He asked if COGME could recommend more flexibility in the types of institutions that sponsor a THC, or alternative funding methods. Another member stated that there have been several efforts aimed at getting more physicians to practice in communities in need, but less attention paid to keeping them there. One issue is the financial insecurity of community health care settings such as THCs and federally qualified health centers (FQHCs).

Another member commented that COGME has a broad mandate, allowing room for it to grow and expand the areas it touches on. The COGME reports have become increasingly long and rich, but there was a suggestion to explore alternate methods of presenting information and recommendations in more condensed and digestible formats.

Dr. Goodell said that she saw the discussions falling into two broad themes. One theme addressed how COGME should conduct its work. Should COGME continue its focus on broad, big-picture issues addressed through its reports, or shift toward addressing shorter, more timely and responsive interventions, of some combination of both approaches? The other theme concerns what issues COGME should focus on. The COGME charter allows the Council to

address not only GME, but broader issues of the physician workforce, including residency programs and funding, workforce flexibility, and emerging technologies such as telehealth. Dr. Lois Nora added that the charter also covers other health professions. For example, COGME could explore new roles for community health workers or peer support specialists to increase access to behavioral health services.

One member commented on the need to shift the GME training model away from being centered within medical schools and academic centers to promote more training in rural and community settings and to attract a more diverse workforce. However, making this shift would require greater control over funding. Another member agreed that discussions on reforming health care often come down to financial alignments. While the health care system remains physician-centric, there are an increasing number of clinical disciplines working in care delivery. The system is moving towards interprofessional team-based care, supported by efforts of several professional organizations, including the National Academy of Medicine (NAM), the Macy Foundation, and the National Coalition for Improving Clinical Learning Environments.

A member noted that the GME system can produce a good doctor who can pass the board exams, achieve established training milestones, and satisfy all accreditation requirements, but it is hard to track the long-term outcome of how the individual performs years down the road. Dr. Chen concurred on the need to track long-term outcomes of the training programs that HRSA supports, and stated that NCHWA is working on ways to improve this tracking. She added that the Acting Director of NCHWA would be speaking to the Council later in the day.

Presentation: Bureau of Health Workforce Updates

Dr. Goodell introduced the next speaker, Dr. Luis Padilla, Associate Administrator of BHW. Dr. Padilla welcomed the members, and said that he had listened in on some of the previous discussion involving reforms to GME and health care financing. He said that grants from HRSA can serve as a catalyst for innovative models of care, but sustaining these changes will require significant reforms to payment.

Dr. Padilla said that HRSA provides support to rural and underserved communities across the country. HRSA's programs touch tens of millions of lives nationally each year. The Health Center Program alone touches one in six Americans, while the National Health Service Corps (NHSC), which serves over 10 million patients each year, plays a critical role in the health care safety net. The 40-plus health workforce programs under BHW work to improve training, increase access to high-quality care, and reduce health professional shortage areas. BHW views its programs as a continuum of education to training to service. The three areas of focus for BHW are preparing a skilled, culturally competent workforce; improving workforce distribution; and advancing modern healthcare.

Dr. Padilla stated that BHW programs emphasize community-based training. A major example is the Teaching Health Center Graduate Medical Education program, which has trained over 600 new primary care physicians and dentists since 2011. These positions are above the Center for Medicare and Medicaid Services GME cap. Having students train in community settings promises to encourage more of them to stay in those areas after they graduate. BHW is also preparing students to work in the area of telehealth to extend the reach of health care services.

Dr. Padilla noted that one priority of the HHS Secretary is value-based care, and BHW programs are working to align workforce training to promote value and build training capacity within community-based settings.

Dr. Padilla said that in academic year 2016-17, BHW helped to train 575,000 students at 8,400 clinical training sites located in underserved and rural communities under Title VII and Title VIII programs. Over one-third of these students came from rural backgrounds. However, some stakeholders report that there are gaps in training and that clinicians are not always prepared to provide the most effective care to address varied populations.

In FY 2018, BHW changed its guidelines to expand the use of telehealth within the NHSC, noting that many NHSC mental and behavioral health clinicians are already utilizing telehealth. BHW now allows NHSC trainees to offer up to 100 percent telehealth services, depending on the needs of the health system where they train.

The NHSC received additional funding in FY 2018 to address the opioid crisis across the country. Together, the NHSC and the Nurse Corps have over 12,000 clinicians, with over a third working in the areas of behavioral health and mental health, and about one-third currently practicing in rural areas. While the Nurse Corps is smaller than NHSC, it supports almost 2,000 nurses working in critical shortage facilities to address the maldistribution of the nursing workforce. Dr. Padilla clarified that Nurse Corps provides training to registered nurses (RNs), nurse practitioners (NPs) and nursing faculty. Dr. Padilla added that programs funded under the Nursing Education, Practice, Quality, and Retention line support community-based training primarily for RNs at the baccalaureate level. The funding for HRSA nursing workforce development programs increased by almost \$11 million from FY 2017 to FY 2018.

Dr. Padilla referenced other health professions training programs. The Children's Hospital Graduate Medical Education (CHGME) program supports freestanding children's hospitals. CHGME produces approximately 48 percent of all general pediatricians, and over half of pediatric specialty providers, across the country. The Primary Care Training and Enhancement (PCTE) program supports the training for physicians, physician assistants (PAs), and residents in underserved areas, with thirty percent of training in rural communities.

Dr. Padilla mentioned that HRSA has collected an enormous amount of data that can serve to identify trends over time. HRSA has undertaken a pilot program making use of National Provider Identifier (NPI) numbers to track its trainees. HRSA is analyzing a cohort of over 15,000 graduates of its programs from 2012 to 2017 to see where they completed their service obligation and where they currently practice.

Dr. Padilla discussed other HRSA resources. The Health Workforce Connector (HWC) web portal helps to connect skilled professionals to communities in need. Clinicians can create a profile in the HWC, allowing recruiters to reach out to them. The HRSA virtual job fairs offer another way for clinicians to view nursing, behavioral health, mental health, and other positions available in health care systems nationwide. HRSA's Alzheimer's curriculum offers the opportunity for entities to take advantage of the core modules and supplemental modules for educators and caregivers in the area of Alzheimer's care.

One member posed a question about funding for telehealth services. Dr. Padilla replied that he was not aware of any current program in HRSA to provide that direct financial support. Dr. Sigounas has a very strong interest in telehealth and wants HRSA to develop a more coordinated approach. BHW has a focus on training to develop skills to deliver telehealth, while the Bureau of Primary Health Care would be providing some funding to help build the capacity for telehealth. In addition, the Federal Office of Rural Health Policy has been working to develop a payment structure for telehealth. This office has also been active in providing telehealth to those populations and geographical areas that have adequate high-speed internet access. However, such access remains unavailable in many areas across the country.

There was a comment that telehealth tends to work best when rooted in the relationship established between the patient and the primary care physician, who can make a referral to a remote-based specialist. Telehealth has also proven valuable for home monitoring and visitation with home health workers and visiting nurses. There was another comment on the barrier posed by state licensure restrictions to providing telehealth services across state lines.

A member asked Dr. Padilla what COGME could do to help the work of BHW and HRSA. Dr. Padilla replied that there is a need for a greater emphasis on data and on tracking the long-term impact of HRSA's training programs. A second area is the need for more community-based training. A third area is the need to promote telehealth and other technological innovations that can broaden access to care and improve care quality.

National Center for Health Workforce Analysis (NCHWA) Overview

Dr. Goodell introduced the next speaker, Dr. Michelle Washko, acting director of NCHWA. Dr. Washko said that NCHWA was established under the Affordable Care Act, and focuses on the use of data and research in the analysis of the health workforce. Dr. Washko described NCHWA as having both internal and external functions. Internally, the Center evaluates HRSA's workforce programs for performance and accountability. Externally, it produces and publishes workforce projections for different health professions and occupations. The Center funds some of its external research through its Health Workforce Research Center program.

In analyzing the physician workforce over the last five years, Dr. Washko said that an interesting story had emerged. Some projections have shown a shortage in physician supply. However, other projections are showing an oversupply of MDs and PAs in primary care and some other specialties. As a result, NCHWA has started to examine alternative scenarios that seek to take into account unmet needs and other factors. For example, one scenario showed an adequate supply of geriatricians. However, another scenario examining potential unmet needs showed a shortage of geriatricians by almost 28,000 by the year 2030, while a projected oversupply of PAs and NPs could help alleviate that shortage.

Another significant issue in the geographic maldistribution of providers, with ongoing shortages projected for rural and other underserved areas. NCHWA produces its projections at a national, and sometimes at a state, level. These projections are used to help form policy. For example, many of the programs that HRSA funds attempt to address this maldistribution and attract more

clinicians to areas of need. A question for the Council to consider is are these efforts enough, or are there better options to try.

Dr. Washko said that the Health Workforce Research Center program funds five-year research centers at institutions across the country that focus on various sectors of the health workforce, including allied health, oral health, long-term care services and support, behavioral health, and emerging topics. NCHWA is also looking to fund a center on health equity. Dr. Washko stated that NCHWA would soon release projections for nine occupations in behavioral health, including opioid treatment and behavioral health providers. She said that research on the workforce in this area is critical due to the ongoing opioid addiction crisis. Dr. Washko identified Council member Dr. Erin Fraher as the principal investigator at one of these centers, the Cecil B. Sheps Center at the University of North Carolina, Chapel Hill.

Dr. Fraher said that the NCHWA funding has allowed the Sheps Center to develop its evidence base, particularly related to rural disparities. In addressing a priority of the HHS Secretary on value-based care, the center is working to develop better outcome measures to evaluate GME. The center is also developing evidence around the use of social workers. She described social work as a fast-growing profession, but one not typically included in health profession analyses.

Dr. Washko added that the 2018 Standard Occupational Classification, which provides the mandated federal taxonomy for use by statistical agencies, has added several new codes for physician specialties. The revision should improve the accuracy of federal data for the next ten years, until the classifications are revised again.

One Council member asked for clarification on the projections of oversupply of NPs and PAs, particularly in terms of geographic distribution. Dr. Washko responded that the projections were made at the national and state level, and did not take into account any alternative scenarios.

Another member commented that most experts agree about health workforce maldistribution. However, many are skeptical about the projections of undersupply, especially as other organizations such as the Association of American Colleges of Medicine (AAMC) are making different projections. He asked how NCHWA is altering its statistical modeling, particularly as other nontraditional businesses are entering the health care market. Dr. Washko replied that NCHWA has had many discussions on how to account for new and developing delivery care models. She noted that projections are based on assumptions and are always hypothetical. In addition, projections are open to revision as more information and data are collected.

Another Council member asked if NCHWA is able to account for the redistribution of care in certain instances to use community health workers and other providers, without the higher educational and salary costs of physicians. Dr. Washko replied that current data on occupations such as community health workers is insufficient to include in NCHWA's statistical models.

Dr. Chen said that COGME has the potential to offer recommendations to NCHWA on how to interpret the workforce projections or address some of the leading challenges in health care that might impact the projections. As an example, she pointed to an industry trend in the 1990s, with the movement toward managed care and an anticipated shift toward primary care. COGME

wrote a thoughtful report on the implications for the physician workforce if the trend continued. While the system as a whole moved away from the original managed-care model and the workforce projections changed, it was important that the Council at that time review and assess the implications of the current system trends.

Another Council member expressed his concern around the issue of physician burnout, with some surveys showing up to fifty percent of primary care physicians experiencing burnout symptoms. Burnout can drive some important workforce trends, as affected physicians tend to see fewer patients, their patients have poorer outcomes, and both patients and physicians show a decline in satisfaction. Dr. Washko stated that NCHWA has not yet been able to add components of burnout to its data collection, but their supply-side models can look at issues such as attrition, retirements, and related factors.

The Council member also asked about the best ways for COGME to tap into the resources that NCHWA has to offer. Dr. Washko replied that advisory committees are composed of thought leaders in the field, and may see firsthand how the workforce is evolving. NCHWA can help provide the evidence base to examine policies or provide background information. Dr. Chen added that the Council can go to NCHWA and its research centers with specific requests for research or background information to help develop its reports and recommendations.

Council Discussion: COGME Strategic Directions: Identifying Key Issues in Physician Workforce Development

To open the discussion, Dr. Goodell recognized Dr. Andrew Bazemore. Dr. Bazemore wanted to clarify earlier comments on the COGME publications. He said that the length and depth of a full report has benefit in capturing the richness of evidence and information on a chosen topic. In addition, a report can include appendices, infographics, and an executive summary to make the information more accessible. However, there are times when packaging information in a shorter and more focused letter or issue brief might be a better approach. There was further discussion that shorter documents can be more responsive and timely on a particular issue. Dr. Fraher added that the greatest impact often comes from being aware when bills are proposed on GME or when there are public debates regarding physician shortages issues, and weighing in at that time.

Dr. Goodell stated that the Council seemed to have a consensus to focus its efforts on shorter formats, to have information readily available when needed. There was another comment suggesting that the Council be more proactive, rather than reactive, in addressing important issues in health care, GME, or the physician workforce.

Dr. Goodell asked for ideas on how COGME could best stay aware of proposed legislation or new policies on health care or the health workforce. There was a comment that each of the members has connections to different national organizations that work to maintain awareness on a range of issues. Another comment was that COGME could have a listserv or hold more frequent conference calls as a way to share information. Dr. Carter stated that HRSA could help support conference calls, but HRSA staff have limited resources to prepare notes or minutes from the calls to share with all of the Council members. According to FACA regulations, the flow of communication for the Council must go through the DFO to make sure that any information being shared is relevant and appropriate.

Small Group Discussion and Public Comment

Dr. Goodell turned the meeting over to Dr. Nora for the next session. Dr. Nora provided instructions on the process of small group discussions. The members would break up into groups of 4-5, and spend an hour discussing what they felt were the most pressing issues and highest priorities in GME, physician workforce development, health care policies and regulations, and related areas for the Council to address in the coming year. Dr. Nora opened the floor to other comments from the public on areas in need of attention.

Dr. Eric Sid, a fellow with the National Institutes of Health, National Center for Advancing Health Translational Sciences, identified himself as a recent medical school graduate and was speaking as a private citizen. He raised the issue of burnout, citing in particular new medical residents who often become overburdened with responsibilities and with the sheer volume of data and information they need to assimilate. Mr. John Voorhees identified himself as policy consultant, and raised the issue of workforce in underserved areas. He said he would save his full comments for the public comment period of the meeting. Dr. Marshala Lee, branch chief for GME within DMD, raised the issue of the long-term career paths for physicians.

The members broke into three small groups for one hour of discussion.

Small Group Report-Out

Dr. Nora reconvened the full Council for a report-out from the small group session.

Main Points of Discussion:

Group 1: Dr. Ted Epperly, Dr. John Norcini, Ms. Beth Roemer, Dr. Kenneth Veit

In reporting for Group 1, Dr. Epperly stated that the group discussed the importance of improving GME, in the absence of a national strategic plan. The group felt that GME remained too stuck in the Flexnarian model, with an over-emphasis on science. The members discussed concerns about the UME to GME pipeline, and the need to ensure that the students coming out of the UME system are prepared to enter GME. Major themes include a lack of diversity, rigidity in financing, a focus on competitiveness instead of collaboration, and the value of team-based care. He listed the top-five priorities as:

1. Get GME right.
2. Improve diversity to reflect society.
3. Decrease rigidity of financing of GME, which remains hospital-centric, and align of financing of GME with the desired outcomes.
4. Train the workforce in team-based care and to use technology as a tool, to improve care and decrease burnout.
5. Make the pipeline more seamless so that students coming out of UME are well-trained learners and better prepared to maximize GME.

Group 2: Dr. Kristen Goodell, Dr. Monica Lybson, Dr. Eric Scher, Dr. Thomas Tsai

Dr. Monica Lybson said that their group discussed workforce distribution as a priority, including the need to extend the pipeline to students in K-12 to help communities develop their own practitioners. The group also discussed increasing the capacity and quality of community training sites. The members also raised the issue of competency-based versus time-based education to improve educational outcomes. Lastly, they noted the need to improve GME outcome metrics and develop more reliable data. The top priorities the group identified were:

1. Maldistribution
 - Perspective of trainees regarding shortage and distribution
 - Early education pipeline [K-12]
2. Quality and capacity of community training sites.
3. Competency Based Education
4. GME metrics/Outcomes
 - Reliable data across Federal platforms
 - Tracking outcomes, encourage use of the NPI

Group 3: Dr. Lois Margaret Nora, Dr. Peter Angood, Dr. Andrew Bazemore, Dr. Erin Fraher
Dr. Bazemore said that the group raised concern about burnout and a morale-depleted workforce. They discussed the need for changes in the training and work environments to achieve truly patient-centered care, improve population health, and address the social determinants of health. They noted the trend for providers to define themselves ever more narrowly by specialty, versus the need for more generalist clinicians in team-based care. They also talked about the need to improve data collection, quality, and analysis to demonstrate the value of GME and evaluate the effectiveness of training programs. He summarized their discussion by stating the need for COGME to speak as a group towards how the workforce can deliver value to population health. The main priorities they identified included:

1. Workforce planning to improve population health.
2. Better data on all healthcare professions to demonstrate value and return on investment.
3. Interprofessional education and practice.
4. Maintain HRSA's emphasis on vulnerable populations.
5. Increase training in areas of greatest need, in both rural and urban medically underserved communities.

Update on the Division of Medicine and Dentistry

Dr. Goodell welcomed back Dr. Chen for an update on DMD. Dr. Chen stated that DMD manages at least three GME programs: THCGME, CHGME and the Preventive Medicine Residency Program. Another related program in DMD is PCTE, which is authorized under Title VII, Section 747.

Dr. Chen reminded the Council members that the federal fiscal year runs from October 1, 2017 to September 31, 2018 and that the government is currently in FY 2018. The president released

his budget for FY 2019 in February 2018. The president's budget is a request and signifies the administration's priorities, but Congress determines the actual appropriations. In FY 2018, Congress did not pass the appropriations until March 2018.

She reminded the members that BHW has three advisory committees that provide advice and oversight on other workforce programs under Title VII and Title VIII. These include the Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD), and Advisory Committee on Interdisciplinary, Community-Based Linkages (ACICBL), and the National Advisory Council on Nurse Education and Practice (NACNEP). In the past, COGME has not delved into those programs too deeply, but it will sometimes make general recommendations about Title VII investments.

The FY 2018 and FY 2019, the President's Budget did not request funding for the majority of the health professional training programs. Instead, it focused on programs that are seen as directly related to service, including THCGME, CHGME, NHSC, and Nurse Corps. She noted that Congress increased funding for THCGME for FYs 2018 and 2019, but that much of this increase would go to restoring funding back to a sustainable level. However, Congress took an unusual step to require the THCs to report on the number of patients seen. Dr. Chen noted that Congress increased funding for PCTE by around \$10 million in FY 2018, largely to provide more funds around mental and behavioral health training programs to combat the nation's opioid crisis.

Congress also increased the appropriation for CHGME in FY 2018, while authorizing the creation of a quality bonus payment system. Last year, DMD published a Federal Register Notice asking for public input on the quality bonus system. The results, which will soon be published, found that the comments were very supportive, along with a laundry list of different initiatives for DMD to consider for implementation. To qualify for a bonus in FY 2019, DMD is asking that children's hospitals report on their efforts in experiential training, telehealth and health information technology, population health, the social determinants of health, and initiatives to improve access and quality of care to rural and underserved communities. DMD is still considering the bonus requirements for FY 2020 and beyond. Dr. Chen stated that while there are no projections of shortages in the general pediatric workforce, there remain significant issues of access and workforce distribution, along with shortages in several pediatric specialty areas.

She added that last year the federal government convened a meeting involving several health profession associations to talk about the challenges of tracking longitudinal outcomes of training programs, and the use of NPI numbers. For the physician workforce, the NPI number provides useful way to the career progress of an individual provider. However, many providers in other professions do not get NPI numbers. She said that the Physician Assistant Education Association (PAEA) is working to have PAs obtain NPI numbers, which would then allow the schools to track their graduates moving out. Some nursing programs are piloting programs to have each provider obtain an NPI as well.

There were other comments related to changes proposed in the FY 2019 President's Budget that would consolidate several different GME programs into a single grant program co-administered between HRSA and CMS. From this proposal, it would appear that the administration is

interested in doing something different with GME. For the programs to change, though, Congress would have to intervene. Dr. Chen said that the proposal remains unclear, but does reflect an interest within the administration of addressing the costs of GME. There was discussion that the HHS Secretary has substantial decision-making authority, and COGME is one of the groups that is supposed to provide advice and recommendations. In the coming year, COGME may need to be thinking about what questions are most likely to be raised, and how to get the best information to respond. Another member commented that the HHS Secretary wants to continue to focus on value based care. The areas of mental and behavioral health are seeing large increases in investments, and this might be another area for COGME to provide information and recommendations.

A member asked Dr. Chen for more information about the preventive medicine residency program. Dr. Chen said the program was established by statute and is run as a grant program under public health training. The amount of HRSA funding was not high, and some programs brought in partners, such as the VA. She added that there were several challenges in terms of timing of the awards and other issues. However, the grants were made for two years, so that programs could be assured of funding to cover the full length of the residency.

Discussion: Letter on CMS Rule Change for Student Documentation

Dr. Goodell moved to the next item on the agenda, a discussion of a rule revision published by CMS in March 2018 regarding medical student documentation in the electronic medical record (EMR). Previously, clinical preceptors would have to re-document in the EMR any care provided by a medical student, a time-consuming process, in order to bill for services. The CMS rule revision allows preceptors to use medical student documentation, with proper review and supervision, for Medicare billing. Many clinicians support this change, as it lightens the administrative burden of preceptors while helping students develop important charting skills. However, the rule does not cover either PAs or NPs as students, or PA and NP faculty working with medical students in interprofessional programs. The rule also unclear if a medical resident, as part of the clinical care and teaching team, can review, edit, and sign the student's note. ACICBL is also looking into the issues that this rule change has raised. Dr. Goodell asked if there was support within the Council to write a letter supporting this change and requesting that CMS consider further revisions.

Dr. Lybson stated that the VA has been very involved in this conversation. She said the VA had submitted a question for the CMS administrator about including other health professional students and preceptors, and CMS responded that the rule change was narrowly focused around medical students as a way of keeping the regulations within the current statute. Further changes might require a legislative change to the statute.

Dr. Carter added that, as the DFO for ACTPCMD, she would share information about the CMS rule change with the members of that committee as well. Dr. Goodell recommended that the members consider the issue overnight, and there could be further discussion on the second meeting day, if the Council believed that writing a letter of support would be appropriate.

Public Comment

Dr. Goodell opened the floor for public comment.

Mr. John Vorhees, Senior Vice President, Applied Policy, said he was representing a group of stakeholders, including hospitals in seven different states, two organizations that are specifically set up to work on workforce issues in states, and several medical society associations, who are deeply concerned about the distribution of medical resident positions nationwide. The stakeholder group supports greater flexibility in the cap on medical resident positions that limits residency programs in many areas, to permit more residents to train in rural and other medically underserved locations. Such a change would help improve workforce distribution, as studies have shown that most physicians - tend to practice near where they complete their postgraduate residency training. This group would ask the Council to recommend to the HHS Secretary to use current statutory authority to make the current GME funding system more flexible to better address the physician workforce needs around the country, and to consider testing the viability and effectiveness of such a change through the CMS Center for Medicare & Medicaid Innovation.

Roberto Haddad, said that he was providing public comment on behalf of Armour Forse, MD, Chief Academic Officer at Doctors Hospital at Renaissance, Texas (Doctor's Hospital). Doctor's Hospital is "in the rural ground "of deep south Texas, one of the poorest areas in the country. He reported uninsured rate of about 34 percent, high rates of obesity and diabetes and the region is facing severe physician shortages. He reports that the last physician workforce report, published approximately two years ago estimates that between 400-500 additional physicians are needed to meet the region's needs over the next 10 years. They working hard to address the need as a new naïve teaching hospital. They have five programs in general surgery, family medicine, internal medicine, preventive medicine, and OBGYN. Currently, they have 100 residents and are going into their 4th year this July. Their dream is to get upwards near 300 residents, but it doesn't seem like they will be able to get there in the five year window after which CMS caps, or limits, the number of residents slots. They think that cap flexibility is an important tool that CMS should implement. In addition, the region has a new medical school. They're currently in their third year, so they have their first cohort of medical students rotating through their hospital in their third year. They are having major issues with securing resources, building up programs, and especially recruiting faculty. Recruiting faculty to deep rural south Texas, in addition to the other stated challenges, has been one of the biggest obstacles. Cap flexibility would allow for additional time to address these challenges and build their residency programs and meet the future physician workforce needs of their region.

David Pizzimenti, DO, Chair of Graduate Medical Education and Internal Medicine Program Director at Magnolia Regional Health Center, Florence, Mississippi, stated he had a similar situation. He started a residency program in 2008. In the initial five-year time period to establish the maximum number of physician resident positions, they had 18 physician residents positions which is their cap. He added that Mississippi is number 50 in most healthcare demographics. Mississippi has the shortest life expectancy of any state, and one of the ways they trying to combat that is to bring more physicians to the region. He reinforced that under currently under the CMS rules, they are capped at 18 residents. One approach that they currently are using is Section 5506 (*Preservation of resident cap positions from closed hospitals*) of the Affordable Care Act to pick up additional slots. However, it takes more than five years for these rural sites to have the infrastructure to build programs. He closed by asking the Council to, "in

any way possible”, help programs and areas that really need cap flexibility, to help citizens of these regions have more doctors and access to care.

Kathy Sanders, MD, spoke on behalf of the National Association of State Mental Health Program Directors. She stated that she is a psychiatrist and is the state medical director for the Department of Mental Health in Massachusetts. She emphasized that the ability to use a medical residency cap flexibility model to increase the workforce needs at this time is extremely crucial. She talked about addressing the distribution of behavioral health and medical, surgical healthcare throughout the different states, and their varied needs for workforce help. What is really needed is the ability to build out in rural and underserved urban areas, a real primary care workforce which includes family, OBGYN, pediatrics, including very basic surgical and some subspecialties. In addition she emphasized that “there’s no good health without good mental health...” underscoring the workforce shortage in psychiatry.

Another comment came from Hope Wittenberg, of the Council of Academic Family Medicine. She addressed a question to the HRSA staff about the Council responding to inquiries from Congress on specific issues that are not made public. Dr. Carter said that there are occasions when her office might receive a request from Congress to coordinate a call with members of COGME for information. For these calls, the members are speaking as individuals who are subject matter experts, and are not speaking for the Council.

Dr. Eric Sid, a recent medical school graduate, stated that he was speaking as a private citizen and supported the point made by Dr. Padilla about the need for better behavioral health data. He believed that metrics on wellness or resilience metrics would be useful to include. Dr. Sid referenced a recent publication from National Academy of Medicine on the growing absence of black men in medicine and science and ways to increase diversity. In addition, he mentioned another publication on discrimination and sexual harassment as factors that may influence where providers end up practicing.

There were no further public comments.

Conclusion

Dr. Goodell adjourned the meeting at 5:00 p.m.

Members of the public in attendance (in-person and virtual): Casey Brenna, Applied Policy; Matt Coffron, American College of Surgeons (ACOS); Marcia Collins, Texas Medical Association; Adam Easterday, Optum; Armour Forse (Roberto Haddad), Doctors Hospital at Renaissance (Texas); John Iglehart, New England Journal of Medicine; Gabriel Miller, American Osteopathic Association; Blake Murphy, American Medical Association (AMA); Pamela Murphy, American Association of Colleges of Osteopathic Medicine; Cassandra Pineda, The Greater New York Hospital Association; David Pizzimenti, Magnolia Regional Health Center (Mississippi); Carrie Radabaugh, AMA; Kathy Sanders, National Association of State Mental Health Directors; Jim Scott, Applied Policy; Shamaal Sheppard, American Association of Medical Colleges; Lauren Foe, ACOS; Catherine Welcher, AMA; John Vorhees, Applied Policy.

Day 2: Jun 21, 2018

Dr. Kennita Carter called the meeting to order at 8:30 a.m. All members were present except Ms. Kriger and Dr. Goodell. Dr. Carter turned the meeting over to Dr. Nora.

Dr. Nora referenced a draft document provided to the members with a list of potential areas of emphasis for the members to consider, collected from the Day 1 discussions, and stated that the goal of the day was to determine one or two strategic priorities for the Council to focus on in the coming year.

As a resource on the Health Workforce Research Centers, Dr. Fraher distributed a brief document summarizing the work of the Sheps Center on GME, including information on data collection, methodologies, and state efforts at GME reform. She added that the Center had developed some data visualization tools to show the job placements of residents. Dr. Nora thanks her for the materials and said that members should feel free to share information that could be relevant to the Council's work.

Dr. Kenneth Veit expressed concern about the proposed change of turning federal GME funding into a grant-based system, and other members agreed. Dr. Peter Angood said he was trying to understand the balance for COGME between developing recommendations that focus on incremental versus disruptive change. In response, one member referred to a NAM report on government financing of GME that made some controversial recommendations for change that ultimately were not implemented, adding that recommending disruptive changes runs the risk of COGME becoming marginalized. One member brought up the discussions that arose in a recent meeting of NAM on the need for a coordinated system to measure GME outcomes, focusing on data and metrics. Another member commented that a central issue that keeps cropping up is the misalignment of GME financing with the desired outcomes.

There was further discussion related to the proposed National Health Workforce Commission, which had been authorized under the Affordable Care Act (ACA) but never funded. This Commission was intended to work with NCHWA as a strategic oversight body for the health workforce, and some of the language around its strategic mission might still apply.

Presentation: The History of COGME

Dr. Nora introduced the next speaker, Dr. Robert Phillips, a former member of COGME and currently the Vice President of Research and Policy for the American Board of Family Medicine.

Dr. Phillips stated that he served on COGME from 2006-2010, a period spanning two administrations and covering the beginning of the Affordable Care Act (ACA). He was involved in producing three reports (Reports 18, 19, and 20), as well as the first letter from COGME to the HHS Secretary. He noted that COGME had received a letter from the Health, Education, Labor, and Pensions Committee of the Senate asking for expedited release of the 18th and 19th Reports in time for a major committee meeting. At that time, COGME had commissioned several white papers written by experts in the field that were incorporated into the 18th Report. In addition, COGME had held several panel presentations as it developed its 20th Report, and was able to bring in a fellow to help support the research and writing.

However, Dr. Phillips also recalled a time early in his tenure on the Council when there was a question on the need of the continued existence of COGME.

Dr. Phillips noted that many issues around GME from his time on the Council remain relevant. One is the funding of GME through Medicaid, with many states experimenting with different ways of allocating these funds. He added that COGME had collaborated with another advisory body, MedPAC, to work on trying to align GME and the workforce needs. He believed some of the issues were no longer a matter of data or funding, but rather a willingness to make change.

Dr. Phillips referenced a recent report from the Government Accountability Office (GAO) on GME financing, which re-opened the question about the purpose of federal GME financing and how best to measure the outcomes. Lastly, he noted work by some of the Council members from his time in meeting with members of Congress to promote the role of COGME in providing information and advice.

Dr. Fraher asked Dr. Phillips how the Council had addressed the trade-off between longer, more comprehensive reports and shorter forms such as a letter. Dr. Phillips replied that the Council had been unclear on its latitude outside of the traditional report format, and so had put expensive work into the executive summaries of the reports, to make the information more accessible. He encourage the members to look into all formats, keeping in mind the need to keep the information credible, while summarizing the main points for the benefit of stakeholders and highlighting how its recommendations might align with current policy work. He also encouraged members to look into writing brief summaries or commentaries for publication in peer-reviewed journals.

Dr. Ted Epperly recalled that the COGME 23rd Report called for the development of a national strategic plan for GME, and asked Dr. Phillips for his thoughts on how to drive this initiative. Dr. Phillips said that COGME might consider forming partnerships with organizations such as NAM or the Macy Foundation to increase exposure of the current problems within GME and the benefits of a strategic plan. Dr. Angood suggested developing a summation of all of the COGME reports to set the context for the need of a strategic plan. Dr. Carter said the Council members could work on such a summation, with HRSA providing limited writing support.

Dr. Carter asked about how the Council had engaged stakeholders. Dr. Phillips responded that the members held out-of-meeting conference calls, as well as planning calls for white papers or panel presentations. He added that the development of the COGME reports required the participation of all members and involved a high degree of outside work, and the writing was a “labor of love” from the Council as a whole. He added that passage of the ACA had afforded a window of opportunity for COGME to influence policy around GME.

There was further discussion on the suggestion to review and summarize the past COGME reports and recommendations. Dr. Chen commented that some recommendations can be framed as direct actions for HRSA or HHS, while others might address areas in need of greater investment. She suggested Council could make a specific recommendation to NCHWA or to the Health Workforce Research Centers to address an identified a gap in the current workforce data

and analysis. Dr. Phillips agreed, pointing to an example from the Macy Foundation that tested the idea of measuring the actual outcome of GME funding. He noted that COGME has little resource allocation of its own, but it had the ability to recommend to the federal government or other stakeholder groups where other big resource allocations might have the greatest benefit.

Presentation: Update on the Veterans Health Administration

Dr. Nora introduced the next speaker, Dr. Lypson. Dr. Lypson stated that she is the director of medical and dental education in the Office of Academic Affiliations, Veterans Health Administration (VHA), and serves as the VA representative to COGME. She identified herself as a primary care general internist who had benefitted from Title VII funding in pipeline programs from high school through in her medical training, and that she worked as an internist in a clinic that received Title V funding. So, she had a strong belief in the value of those programs.

Dr. Lypson shared the VA motto from President Abraham Lincoln, “To care for him who shall have borne the battle and for his widow, and his orphan.” The quote reflects the VA’s focus on veterans and their families. Dr. Lypson said that the veteran population in the United States is highest in Florida, Texas, and California. There are around 21 million veterans, with nine million enrolled in care through the VA. Both the active duty and the veteran populations are very diverse, with a higher proportion of minorities than the general population. Women make up about 11-13 percent of active duty forces and a growing percentage of veterans.

The VHA is the largest integrated health system in the nation, with around 170 VA medical centers and over 1,000 community-based outpatient clinics. It has four statutory missions: 1) provide healthcare for veterans, 2) provide education for clinicians, 3) provide research on issues related to veterans, and 4) serve as an emergency back-up for the public health system.

Dr. Lypson said that the VA provides about 9 percent of the annual federal expenditures on GME, or roughly \$1.8 billion per year. The VA was at the forefront of developing specialties such as geriatrics and palliative care. VA facilities provide a clinical learning environment to over 127,000 trainees each year, including medical students and residents, nursing students, and students in allied health. The VA currently has affiliations with all 34 of the doctor of osteopathy programs, and 144 of 149 doctor of medicine programs, in the country.

In reaction to complaints over lack of available services, Congress passed the Veterans Access, Choice, and Accountability Act in 2014. This legislation provided funding for up to an additional 1,500 physicians over 5 years in an attempt to improve access to care. Dr. Lypson stated that in 2014, 22 of the VA facilities had no GME programs, and that number has now declined to three as a result of planning and infrastructure grants.

Dr. Lypson brought up the Mission Act. She said the significant sections related to GME are:

- Section 301: Expanded the VA scholarship program to a ten-year horizon.
- Section 303: Increased the amounts of the VA loan repayment program.
- Section 304: Established scholarships for veterans entering the health professions.
- Section 403: Expanded pilot residency programs.

The VA is also working to establish connections with the Indian Health Service (IHS).

Council Discussion

To open the Council discussion session, Dr. Nora said that one goal of the meeting was to develop a clear sense of the direction for the Council in the next six months. Her understanding from the previous discussions was that the members wanted to:

- Work toward shorter, more rapid responses to current issues, such as letters to the Secretary, statements of support, and issue briefs or white papers;
- Emphasize data to inform the Council's stories and recommendations, and explore different sources of data; and
- Develop stronger relationships with other GME stakeholder organizations.

In terms of potential topics, there had been much concern and discussion related to proposed new GME funding models. There was a comment on maintaining the Council's focus on patient-centered population health-oriented approaches, and training methods to improve geographic distribution. Another member emphasized the need to look to innovative models for interprofessional care and community-based training. There was a comment that innovation and real curricular reform is easier to achieve in new, start-up programs, especially ones located in rural or community-based hospitals, rather than in trying to reshape existing programs.

Noting the example of the THCGME program, Dr. Epperly said that GME reform needs to align with funding, otherwise it is not sustainable. He added that enhancing the funding for scholarship and loan repayment programs such as through the NHSC, especially targeted to students working in the IHS, the VA, and in rural and underserved areas, could be a powerful tool to help improve geographic distribution.

Dr. Fraher said that there had been talk of leveraging lessons learned from innovative state-level programs. However, the Sheps Center had found little innovation among the state programs they had studied. She said there is a need to educate legislators on the health workforce needs. Increasing funding within the current GME will not address the main issues; rather, funds need to be targeted toward improving geographic distribution, specialty mix, and training in community-based settings. However, any proposed changes tend to meet significant resistance from existing academic health centers.

Dr. Angood emphasized the need to pay attention to the behavioral decision-making of students going into medical school and residency programs, as well as the choices of international medical school graduates.

Dr. Nora reviewed two items she understood the members wanted to work on:

- Monitor new legislation, and determine ways to stay up-to-date on new proposals.
- Write a letter to the Secretary in support of the new rules on use of student documentation, and request further steps.

She then listed three potential areas of focus for the next six months:

- Aligning GME funding with outcomes.
- Developing new education or practice models.
- Promoting research to develop new sources of data.

Ms. Beth Roemer said that she would also like to learn more about the efforts and initiatives of potential collaborating organizations, such as MedPAC. There was further discussion in support of this idea as a way to keep COGME as a relevant resource to others and further the concept of a strategic plan. There was a comment that members could serve as informal liaisons to the other stakeholder groups to which they belong or have connections, with the need to have talking points and an understanding of what type of collaborative relationship might be of interest to COGME. Another comment addressed the consideration for the Council to prepare a brief response from COGME on the proposed changes to GME funding outlined in the President's budget, with a suggestion that the Council could bring on a fellow or a medical student to provide writing and research support.

Dr. Nora requested that the members send her recommendations for organizations that COGME could develop collaborative relationships. She said that the members could communicate regularly by email, and set up times for conference calls to keep each other informed.

Dr. Nora adjourned the meeting for lunch.

Presentation: Ethics Training

During the lunch period, Ms. Laura Ridder, HRSA ethics advisor for COGME, presented a brief update on the ethics requirements for the members as special government employees.

One part of the presentation covered a ban on partisan political activity while on government duty. Dr. Nora stated that the members had engaged in extensive discussions related to an element of the President's budget that would impact funding of GME. Ms. Ridder replied that the discussion was within ethics rules as long as it did not "target the success or failure of candidates for office in the coming election."

Council Discussion: COGME Strategic Priorities

Dr. Nora reiterated what she understood to be the main themes for the Council to work on in the coming six months: the alignment of funding activities and outcomes; the development of new training models; and the consideration of a letter to the Secretary addressing structural issues related to proposals on GME funding contained in the President's budget request. In addition, the Council had decided to prepare a letter on the CMS rule change regarding student documentation, with some consideration on whether COGME should write a letter on its own, or join with other advisory councils on a joint letter.

She added that the members could identify potential collaborators, including information on particular contacts or relationships with the proposed organization. She said that she, Dr. Goodell, and Dr. Carter would review the organizations, pare out these organizations to particular members, and work on developing a message.

Public Comment

Dr. Nora opened the floor for public comment.

Ms. Hope Wittenberg stated she had three areas to discuss.

First, she thanked the Council for deciding to work on a letter related to the student documentation rule.

Second, she urged the Council to review the THCGME program, and consider developing a statement or report in support on the program and urging more stable and sustainable funding.

Third, she wanted to bring to the Council's attention a bill introduced by Senator Corey Gardner, *Rural Physician Work-force Production Act of 2018 (S. 3014)*. This bill addresses some of the issues related to geographic distribution of the physician workforce and training in rural areas.

There were no further public comments.

Business meeting

For the business meeting, Dr. Nora stated there were two items the Council needed to address:

- Selecting a new vice chair
- Determining a date for the next meeting.

Dr. Nora requested that any members wishing to be considered for vice chair send her a brief statement of interest, and the Council would vote at an upcoming meeting.

After some discussion, there was a consensus that the next meeting be in-person, to help with building relationships between the members. Dr. Carter requested that the members examine their calendars for potential dates for a two-day meeting in November or December of 2018, or January of 2019. She stated she would then follow up with the members by email, after checking room availability.

Dr. Nora also requested volunteers to work on the two proposed letters:

- Student letter: Volunteers –Dr. Lypson and Dr. Bazemore.
- Response to the President's budget proposal: Volunteers – Dr. Bazemore, Dr. Epperly, Dr. Scher, and Dr. Veit.

Dr. Carter thanked the members for their participation, and adjourned the meeting at 1 p.m.

Acronym and Abbreviation List

AAMC	Association of American Medical Colleges
ACA	Affordable Care Act
ACGME	Accreditation Council on Graduate Medical Education
ACICBL	Advisory Committee on Interdisciplinary, Community-Based Linkages
ACTPCMD	Advisory Committee on Training in Primary Care Medicine and Dentistry
BHW	Bureau of Health Workforce
CHGME	Children’s Hospitals Graduate Medical Education
CMS	Centers for Medicare & Medicaid Services
COGME	Council on Graduate Medical Education
DFO	Designated Federal Officer
DMD	Division of Medicine and Dentistry
FACA	Federal Advisory Committee Act
FQHC	Federally Qualified Health Center
GAO	United States Government Accountability Office
GME	Graduate Medical Education
HHS	United States Department of Health and Human Services
HRSA	Health Resources and Services Administration
NACNEP	National Advisory Council on Nurse Education and Practice
NAM	National Academy of Medicine
NCHWA	National Center for Health Workforce Analysis
NHSC	National Health Service Corps
THC	Teaching Health Center
THCGME	Teaching Health Center Graduate Medical Education
UME	Undergraduate Medical Education
VA	United States Department of Veterans Affairs
VHA	Veterans Health Administration