

**COUNCIL ON GRADUATE MEDICAL EDUCATION (COGME)
Webinar and Teleconference**

Rural Workforce and Training in the Face of the COVID-19 Pandemic

**July 17, 2020
10:30 a.m. – 5:00 p.m. ET**

Council Members in Attendance

Erin Fraher, PhD, MPP, Chair
Thomas C. Tsai, MD, MPH, Vice Chair
Andrew Bazemore, MD, MPH
Ted Epperly, MD
R. Armour Forse, MD, PhD, FRCS(C), FACS, FCCM, FASMBS
Beulette Y. Hooks, MD, FAAFP
John J. Norcini, PhD
Ashruta Patel, DO, MS
Karen Sanders, MD
Leith J. States, MD, MPH
Kenneth Veit, DO, MBA, FAOFP

Health Resources and Services Administration Staff Present:

Shane Rogers, Designated Federal Official, COGME
Kennita R. Carter, MD, Subject Matter Expert, COGME; Chief, Graduate Medical Education, Division of Medicine and Dentistry
Raymond Bingham, MSN, RN, Writer and Editor, Division of Medicine and Dentistry, HRSA
Janet Robinson, Advisory Council Operations, HRSA
Carl Yonder, Division of External Affairs, HRSA

Welcome and Roll Call

Shane Rogers, Designated Federal Official, COGME

Mr. Shane Rogers convened the meeting of the Council on Graduate Medical Education (COGME or the Council) at 10:30 a.m. on Friday, July 17, 2020. The COGME meeting was conducted via webinar and teleconference, sponsored by the Health Resources and Services Administration (HRSA), 5600 Fishers Lane, Rockville, MD 20857. He introduced himself as the new Designated Federal Official (DFO) for COGME, and explained that Kennita R. Carter, MD, the previous DFO, had transitioned to a new position as Chief of the Graduate Medical Education branch within the HRSA Bureau of Health Workforce (BHW), Division of Medicine and Dentistry (DMD). He added that Dr. Carter would continue to work with the Council and serve as a subject matter expert.

Mr. Rogers conducted a roll call, and noted a quorum was not initially present. However, other members of the Council soon joined the call, establishing the required quorum for the full meeting to proceed.

Overview of the CARES Act

Mr. Rogers provided a brief overview of the elements of the 2020 Coronavirus Aid, Relief, and Economic Security (CARES) Act, passed by Congress and signed into law by the President in March 2020, that related to COGME. He noted that the legislation:

- Added the HRSA Administrator or designee as a COGME member. The role will be fulfilled by CAPT Paul Jung, Director, Division of Medicine and Dentistry.
- Changed reporting requirements, with the next COGME report due no later than September 30, 2023, and every five years thereafter.
- Charged the Department of Health and Human Services (HHS) to develop a plan for its healthcare workforce development programs, in coordination with both COGME and the Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD).

Meeting Overview

Mr. Rogers turned the meeting over to Erin Fraher, PhD, MPP, the COGME Chair. Dr. Fraher started by recognizing the painful and difficult times facing the nation and the world, in the midst of the COVID-19 pandemic. She noted that at the current time, COVID-19 cases were rising in the United States, creating tremendous public health and economic challenges, and exacerbating existing health disparities within the nation's minority and vulnerable populations.

Dr. Fraher stated that the work of COGME typically culminates in the publication of a full report. However, over the last two years the Council had shifted the way it works to focus on the preparation of a series of shorter, more focused issue briefs in order to become more agile and flexible in responding to emerging issues. The public health crisis of the COVID-19 pandemic had underscored the need for such responsiveness and flexibility.

Dr. Fraher said that the topic of the first series of issue briefs was rural health. The first of these briefs, *Special Needs in Rural America – Implications to the Healthcare Workforce Education Training and Process*, contained a call for radically redesigning training investments to put patients, families, and communities at the center of all training investment discussions. This brief would soon be ready for public release.

Dr. Fraher stated that a second issue brief in development, *Rural Healthcare Infrastructure Necessary Investment*, would be discussed later in the meeting. The Council would also begin discussions on the third rural health issue brief.

Dr. Fraher noted that, with the rapid and unexpected rise of the COVID-19 pandemic, COGME had also drafted and submitted a letter to the HHS Secretary and Congress with recommendations to address the emerging health workforce needs arising from crisis, including:

- Bolster support for telehealth services and training,
- Stabilize rural practices and hospitals,
- Strengthen the public health workforce,
- Address issues of burnout and moral distress in our health workforce, and
- Provide for program flexibility for grant recipients, recognizing that some may need more time and creative solutions to accomplish their programmatic goals.

Presentation: Accreditation Council for Graduate Medical Education

Speaker: Kevin Weiss, MD, MPH, Chief of Sponsoring Institutions and Clinical Learning Officer, Accreditation Council for Graduate Medical Education

Dr. Fraher introduced the first speaker, Kevin Weiss, MD, MPH, for a discussion of the activities of Accreditation Council for Graduate Medical Education (ACGME) related to graduate medical education (GME) in rural areas. Dr. Weiss said that ACGME is driven by its mission, “to improve the healthcare and population health by assessing and advancing resident physician education through accreditation.” He described ACGME, with over 860 sponsoring organizations covering over 12,000 programs, as the world’s largest single accreditation system. He added that in July 2020, ACGME completed a years-long transition to a unified accrediting system covering both allopathic and osteopathic residency programs in the United States.

Dr. Weiss shared a map showing HRSA-designated medically underserved areas and populations (MUA/Ps), indicating that many regions across the country experience the need for a more robust physician and healthcare workforce. He noted that many osteopathic programs conduct training in rural areas, and bring an enriched understanding of rural health needs to ACGME.

Dr. Weiss discussed an ACGME workgroup on the Accreditation Framework for Medically Underserved Areas and Populations, charged with reviewing issues ranging from regulatory requirements to financing mechanisms that impact underserved areas. This workgroup travelled around the country to meet with representatives from federal and state government agencies, tribal groups, small and large health care systems and clinics, and rural organizations, as well as residency programs in rural and medically underserved urban community-based settings, to explore the nuances of rural care. As the workgroup noted, a physician in a rural area may be the only provider and point of contact for a large number of individuals over a wide geographic area, which few physicians encounter in their training. The workgroup heard about initiatives involving pipeline work to bring more medical students into contact with rural practices and help them understand the needs of rural communities. Dr. Weiss stated that the workgroup had sought to better align ACGME with the federal funding programs available to develop and enhance GME rural training tracks. With the impact of the COVID-19 pandemic, ACGME had introduced modifications to enhance telehealth and tele-supervision in rural areas.

Out of these meetings, the workgroup developed a framework for accreditation of programs focused on rural and other MUA/P areas to focus on:

- Enhanced ACGME support,
- Proposed modifications to the accreditation process,
- Potential variance in ACGME requirements to facilitate rural training, and
- Assistance to sponsoring institutions to succeed in educating physicians for MUA/Ps.

To promote its own institutional learning, Dr. Weiss said that ACGME is in the process of developing a National Learning Community, composed of three parts:

- A forum for hospital and institutional representatives,
- An idea exchange to provide information, and
- A vanguard program to promote innovation, which includes rural training.

Dr. Weiss introduced Dr. William McDade and Dr. Bonnie Mason, who joined the ACGME leadership in the past year to lead ACGME's targeted efforts in enhancing diversity, equity, and inclusion within the GME world.. Dr. Weiss closed by saying that the ACGME Clinical Learning Environment Review program would be conducting teleconferences and surveys to understand the impact of COVID-19 on the clinical learning environment and better understand the need to adapt systems to optimize both learning and clinical care.

Q and A

Dr. Fraher thanked Dr. Weiss for his overview of the role of ACGME in rural GME and opened the floor to questions from the Council. Given a lack of services in rural areas and difficulties in bringing services to underserved communities, Dr. Armour Forse asked if ACGME had engaged in discussions on how to define the term "underserved." Dr. Weiss responded that ACGME's definition was forthcoming, as clean definitions are important for data acquisition. Dr. Forse followed up with a question about the inclusion of general surgery as an area of primary care delivery. Dr. Weiss said that the growing complexity of healthcare has increased the need for many types of subspecialty services in rural areas, including surgery, cardiology, internal medicine, and orthopedics. Some services could be offered through telemedicine, but others, such as surgery, require appropriate facilities and a local workforce presence.

Dr. Fraher added that the Council's recent rural health issue brief focused on the importance and breadth of the workforce needed in rural communities to provide essential healthcare services, including family medicine, behavioral and psychiatric health, and geriatric and long-term care. She said that rural residency programs might experience difficulty meeting current accreditation standards, and asked about the role of ACGME in identifying and addressing potential barriers such as a required minimum program size. Dr. Weiss replied that ACGME had engaged in broad discussions in regions around the country, and initiated review committees to explore the issues. For example, given the aging of the population, particularly in rural areas, he noted the need for specialties including urology and dermatology. He said that the U.S. health care industry is evolving toward a network of large organizations that may cover broad geographic areas, and many of these "megasystems" are testing different ways to deliver services to rural communities.

Dr. Forse asked about the impact of the COVID-19 pandemic on public health systems and workforce training. He mentioned efforts towards making sure the healthcare system helps healthy individuals to maintain their health, rather than just treating active disease. Dr. Weiss replied that ACGME was invested in the public health approach and had modified its mission statement to add population health, a relatively new focus. He further noted a shift from the "medicalization" of health care directed at treating illness, toward a framework based on the nursing model of whole-person care and wellness.

Dr. Thomas Tsai, COGME Vice Chair, reviewed the recommendations developed by COGME for its rural health issue briefs, including expanding successful place-based training initiatives that provide access to rural communities, identifying and eliminating financial and regulatory barriers, creating a strategic plan around the health workforce investment for outcome measures to ensure value and return on investment, and testing alternative payment models to promote a focus on primary care. He asked Dr. Weiss for his thoughts on developing a set of metrics to measure and evaluate changes to the programs brought about by the response to COVID-19. Dr.

Weiss replied that ACGME had been exploring the development of a metrics framework, and invited further discussions between ACGME and COGME, adding that ACGME had been involved in a rapid learning cycle examining the impact of COVID-19 on the GME clinical learning environment. Dr. Fraher commented that she would welcome further engagement with ACGME on these issues especially in the context of the CARES Act and charge to HHS.

Dr. Ted Epperly asked about the outcomes ACGME aimed to achieve from its rural workforce education programs, in terms of both the short- and the long-term outcomes. Dr. Weiss stated that ACGME's Medically Underserved Areas/Populations and GME office was engaged in a deliberative process to address this issue. He speculated that some measures of success would include the number of programs in rural areas and the diversity of those programs in terms of location and specialty areas. Dr. Epperly further commented that rural communities often rely on team-based health care involving providers at several different levels, and asked how ACGME might promote or enhance team-based training. Dr. Weiss made the distinction between the concepts of *team-based care*, which might involve the same individuals working together on a daily bases, and *teaming*, in which different providers might come together to manage a patient's health care needs, while also bringing in other providers such as social work or behavioral health specialists. In rural areas, these concepts may be closely related, because of the limited number of providers in the community. As a result, the focus of education might need to include learning how to work within a more fluid type of team, depending on the needs of the community or the individual patient.

Lastly, Dr. Epperly asked if ACGME had considered adapting care models from countries such as Australia and New Zealand to rural regions of the United States. Dr. Weiss said that ACGME often looks to other parts of the world to better understand care delivery, adding that the COVID-19 pandemic had highlighted differences in care models between different countries. However, he noted that the rural programs in ACGME were still in their developing stages.

Presentation: Agency for Healthcare Research and Quality

Speaker: David Meyers, MD, Deputy Director, Agency for Healthcare Research and Quality

Dr. Erin Fraher introduced the next speaker, David Meyers, MD, from the Agency for Healthcare Research and Quality (AHRQ). Dr. Meyers described AHRQ as one of the smallest agencies within HHS, with the goal to improve the lives of the patients, and the mission "to produce evidence to make health care safer, higher quality, more accessible, equitable, and affordable." He noted that the main competencies of AHRQ are:

- Health systems research, helping systems think about themselves as systems;
- Practice improvement, with a focus on areas that are important to practitioners and to the patients, families, and communities they serve; and
- Data and analytics, helping the nation understand how the healthcare system works.

Dr. Meyers noted that the focus of AHRQ is on care delivery systems, looking at where services are located, how they are organized to assure patient safety and quality care, how practitioners provide and coordinate care, and how this care is paid for. He added that AHRQ focuses on health care accessibility and equity. He referenced studies by AHRQ on the rural primary care workforce, and discussed workforce models developed to explore rural healthcare delivery.

Dr. Meyers said that AHRQ had engaged in a series of steps to define what is meant by high quality, comprehensive primary care. From these efforts, AHRQ identified important capacities to include an engaged leadership, relationship-centered care and care continuity, and ongoing assessment and quality improvement. He listed a series of capacities or capabilities of primary care that allow these functions include:

- Evidence-based care,
- Empanelment – knowing the population of patients in the context of community,
- Complex care management – helping patients prioritize and focus on their goals,
- Behavioral health integration – including substance abuse treatment, mental health treatment, and behavioral change in areas such as nutrition,
- Medication management,
- Care coordination – connecting to the community and the larger health care system,
- Support for self-care and self-management,
- Recognition of the impact of the social determinants of health on health outcomes, and
- Population health management.

Dr. Meyers said that AHRQ had developed an interactive tool, accessible on its website, that can estimate total primary health care costs, as well as costs per patient, under different practice models. Of note, AHRQ approached this tool through the lens of the work to be accomplished by the health care team, rather than by focusing on the titles or the educational backgrounds of staff members. He noted that this tool can be adapted to use different system configurations, providers, staffing levels, and patient population characteristics, among other variables.

Dr. Meyers noted that the tool can be based on different models of care. He highlighted the Rural model, which assumed a small practice size of 5,000 patients, with around 20 staff to include physicians, physician assistants, nurse practitioners, nurses, pharmacists, social workers, community health workers, and administrative support. He noted that the model did not take into account the need for health professional workforce training, and suggested that further development of the model to account for the costs of training could be an area of collaboration between AHRQ and COGME.

Q and A

Dr. Epperly referenced the work from AHRQ on a global payment model for health care, and said that COGME has examined ways to transition away from the traditional fee-for-service payments to sustainable models that focus on population health. He noted that a global payment model could support community-level team-based care, especially in rural areas, and asked about the interest of AHRQ in developing pilot programs across the country employing global payment models as an initial proof of concept. Dr. Meyers replied the AHRQ has a strong interest in researching and testing alternative payment models developed in partnership with local communities. However, these models are often difficult to translate into real-world applications. He noted that the Center for Medicare and Medicaid Innovation (CMMI) worked to develop some community-level primary care models while making use of Medicare's purchasing power, but these often required compromises as a result of market conditions and real world pressures.

Dr. Meyers added that AHRQ built flexibility into its payment model to accommodate a range of scenarios, so that the model can be used as a starting point for COGME in exploring healthcare

costs while accounting for different baseline assumptions and limitations. For example, the model does not cover functions like the provision of clinical training. It is often assumed that clinical sites accept students for training on a volunteer basis, and that the time spent by clinicians working to train students has little impact on overall performance. In reality, though, taking on students tends to slow down clinical operations, which can drain the resources of a small clinic and increase costs. Dr. Tsai noted that a major academic medical center may be able to absorb the costs better than a small rural clinic with limited staff and multiple competing needs. He asked about ways to include measures of the time and resources spent on teaching and training. Dr. Meyers replied that one approach would be to add lines within the AHRQ model worksheet to estimate the time spent by various clinicians on training, and estimate the impact on the total cost of care. A simpler approach would be to assign a total across-the-board percentage of time and resources required, to figure into the cost estimates.

Dr. Forse asked if the AHRQ model accounted for obstetric care, as well as pharmacy services. Dr. Meyers replied that obstetric care was not included in the modeling assumptions, thus those potential costs are not reflected in its cost estimates. In terms of pharmacy services, he noted that AHRQ used an integrated care model where the pharmacist plays a significant role in medication management, and some models included the use of pharmacy assistants to handle some of the more basic work of medication preparation and distribution.

Dr. Andrew Bazemore noted that a future GME system would need a clear set of measures for use with a national health workforce strategic plan. He asked about the role that AHRQ could play in developing metrics for the rural health workforce and the promotion of high-quality, comprehensive primary care. Dr. Meyers replied that AHRQ has extensive expertise in measurement and modeling, and has developed strengths in research and evaluation that could serve as a resource in future workforce plans.

Panel: HRSA-Funded Graduate Medical Education Innovations

Presentation: Rural Residency Planning and Development Program

Speaker: Steve Crane, MD, Consultant, Rural Residency Planning and Development program

Dr. Fraher introduced the next speaker, Steve Crane, MD. Dr. Crane described himself as a family physician from rural North Carolina and a health economist, as well as a part-time consultant with the HRSA-supported Rural Residency Planning and Development (RRPD) program. He said that in 2019, HRSA funded 27 rural residency programs in three different primary care disciplines – internal medicine, psychiatry, and family medicine. HRSA also funded a Technical Assistance Center (the RRPD-TAC) to help support the development of new rural residency programs. A new HRSA notice of funding opportunity released in 2020 for the RRPD expanded the specialty mix to include rural residencies in general surgery, obstetrics and gynecology, and preventive medicine.

Dr. Crane argued that there is a rationale for expanding the total number of GME residency slots. According to the Association of American Medical Colleges, since 2002 medical student enrollment had increased by 52 percent, while GME slots only increased by 18 percent. This difference had created increased competition for slots at a time when projections indicate a significant shortage of physicians by 2030, particularly in rural areas. He noted the urgency to

add residency training in rural areas, as medical residents who live and work in a rural environment have a better understanding of the local needs and are more likely to remain in rural practice. He described a pipeline issue, noting that few students from rural areas are accepted into medical schools or have the financial resources to pursue medical education.

Dr. Crane shared a map of the RRPD programs and TACs, with widespread coverage across the country. He noted that each program needed to progress through a series of five stages:

- Stage 1: Exploration
 - Community assets, leadership, and sponsorship
- Stage 2: Design
 - Initial Educational and Programmatic design, financial planning
- Stage 3: Development
 - Program personnel, program planning and accreditation
- Stage 4: Start-up
 - Marketing and recruitment, infrastructure and resources, matriculation of new residents
- Stage 5: Maintenance
 - Ongoing efforts and reporting

Dr. Crane reviewed the characteristics of the initial 27 rural residency programs. Most were associated with a large health system that covered primary care clinics, federally qualified health centers, behavioral clinics, and rural health clinics. Most were sponsored by a non-profit healthcare organization or foundation, or a public institution of higher learning. Partnering organizations included schools of medicine, the Veterans Health Administration, and the Indian Health Service. While the programs were still new, one had accepted its first class of residents in July 2020, while several others had received accreditation to accept residents in 2021.

Dr. Crane discussed several barriers to developing rural residency programs. The current GME funding model does not cover the full cost of residency training, especially in low-resource rural hospitals. Residency positions are currently limited by a mandated cap, with a disproportionate impact on rural hospitals. Residents in rural training programs may leave the community to practice elsewhere after completing their residency, depleting local resources. Rural medical practices and hospitals are by their nature low volume environments, creating difficulties in meeting accreditation standards or maintaining appropriate supervision. In addition, many rural hospitals were in financial crisis, especially in states that did not expand Medicaid under the Affordable Care Act. He said that the loss of a rural hospital often led to loss of the primary care infrastructure in a community.

Dr. Crane stated that the HRSA-funded Teaching Health Center GME (THCGME) program had helped expand residency training and health care access in rural communities. However, its funding is always under threat.

Lastly, Dr. Crane offered some personal observations. He said that he takes care of a wide mix of patients in his rural practice, and in the midst of the COVID-19 pandemic many elderly patients were terrified about getting sick and had become increasingly isolated, with an adverse impact on both their mental and physical health. He had seen a spike in opioid-related deaths,

and his practice had experienced an increase in opioid and addiction treatment. Other individuals were delaying needed care due to financial stresses from a lack of health insurance. He believed the rural infrastructure was crumbling quickly, and that time to respond was short before exacerbating already prevalent health disparities in rural communities.

Q and A

Dr. Epperly asked Dr. Crane to select one issue to address that would “move the needle” to improve rural health. Dr. Crane replied that the simplest answer would be to correct GME funding for sole-access community hospitals, which would provide more opportunities to increase GME training in rural settings.

There was another question on funding for telehealth and telemedicine initiatives. Dr. Crane said that transitioning a rural practice to increase use of telehealth could be done relatively simply and inexpensively. However, in his practice, he noticed that many patients preferred coming into the clinic because they lacked internet access or a video link. He noted a significant gap in Medicare payment between video versus telephonic visits, which could threaten the financial viability of rural practices. He recommended a change in the Centers for Medicare and Medicaid Services (CMS) rules to provide full reimbursement for telephonic visits.

Dr. Forse commented on the importance of supporting faculty development for educators in rural training programs. Dr. Crane agreed that many faculty working in rural areas might provide excellent clinical care but might lack experience in teaching or in supervising residents within GME. He added that RRPD grant funds can offset some of the cost of faculty development.

Presentation: Designing the Quality Bonus System (QBS) for Children’s Hospital GME: Aligning Payment with Workforce Needs

Speaker: Edward Salsberg, MPA, FAAN, Senior Research Scientist, Fitzhugh Mullan Institute for Health Workforce Equity, The George Washington University

Dr. Tsai introduced the final speaker, Edward Salsberg, MPA, FAAN. As background, Mr. Salsberg stated that legislation in 2013 regarding the Children’s Hospital Graduate Medical Education (CHGME) program established a Quality Bonus System (QBS), with a set-aside of several million dollars intended for distribution as bonus payments to CHGME programs “that meet standards...which may include a focus on quality measurement and improvement, interpersonal and communications skills, delivering patient-centered care, and practicing in integrated health systems.”

Mr. Salsberg described the QBS as a creative approach to incentivize CHGME-funded programs to train more pediatricians and pediatric specialists to meet the workforce needs of the nation, and to improve the link between the payment and outcomes. The Mullan Institute had a one-year contract with HRSA to examine the QBS and to:

- Identify potential measures and metrics,
- Identify potential payment methodologies, and
- Make recommendations for the metrics and payment methodology.

Mr. Salsberg said that the Mullan Institute first identified several desirable characteristics for the

QBS: the criteria and the process for distributing bonus payments needed to be transparent; the system should have a low administrative burden for applicants, to avoid favoring large hospitals and allow smaller hospitals to compete; and the system should to allow the award criteria and metrics to be updated every four to five years, to assure that the payments and metrics remain tied to the priorities of the nation in terms of the skillset for pediatricians and the needs to promote children's health. He added that the Institute met with stakeholders in April 2020, and its final report with the recommendations would be due to HRSA in September 2020.

Mr. Salsberg said the Institute identified three domains for QBS metrics, with specific goals:

- Workforce Distribution and Diversity
 - Address access problems due to a shortage and maldistribution of pediatric generalists and specialists
 - Assure a diverse and inclusive pediatric workforce
- Workforce Education and Training
 - Assure competency of all new pediatric physicians to address health priorities such as mental health, substance abuse, obesity, and oral health
 - Prepare pediatricians to practice as part of a care team
- Community Health Workforce
 - Assure all pediatricians are competent to recognize and respond to social determinants of health with the potential to impact the health and well-being of their patients
 - Prepare all pediatricians to practice in community-based settings.

Next, the Institute developed a logic model to go from the general goals to specific recommendations to outcomes. In considering potential metrics for outcomes, the Institute considered such factors as the type of hospital, type of trainee, data collection and administrative burden, and alignment with the QBS program goals. As an example, Mr. Salsberg stated that objectives under the goal of improving access included:

- increase trainees working with underserved populations and in shortage areas,
- increase graduates working with underserved populations and in shortage areas, and
- increase graduates in needed specialties and subspecialties.

Mr. Salsberg acknowledged the challenge of identifying appropriate metrics to measure progress toward these goals. To assist data collection, programs are required to report annually on the residents and fellows training in their facilities and to include the national provider identifier (NPI), for the individual physician resident. Using the NPI, HRSA can track where the program graduates end up practicing, such as in a setting that serves the Medicare population. He said that there is no standardized system for identifying physician shortages in pediatric specialty areas. He suggested that COGME might play a role in determining national standards or guidelines for determining shortage areas related to both specialties and geographic areas.

For QBS payments, Mr. Salsberg noted the challenge in balancing the goals of incentivizing future improvement versus rewarding prior behavior. He noted that the Institute had recommended maintaining a three-tiered system already in place, based on annual payment amounts established by the CHGME formula, to allow hospitals to compete for bonus payments

with other hospitals of similar size and resources. Other principles include:

- Inform CHGME grantees of criteria ahead of time for awards to provide incentive for change, and update the criteria on a regular basis,
- Limit the number of awards to provide greater incentive for change,
- Prioritize the top goals and metrics, and
- Consider separate payments for each goal, to tie payments to specific activities and improvements.

Mr. Salsberg discussed several lessons learning in developing the QBS:

- The complexity of the training process creates challenges to linking bonus payments with desired outcomes,
- An effective and fair GME payment system must be based on accurate data and evidence, but much of the needed data and evidence does not yet exist,
- Financial incentives to participate must be balanced against administrative burden, and
- The QBS administrative infrastructure must assess, refine and update the metrics based on evolving needs and to assess the link between training process/structure and outcomes.

In determining the QBS awards, Mr. Salsberg said the Institute would likely recommend a combination of quantitative and qualitative criteria to allow for more flexibility, for example to allow an award that would provide recognition to hospitals going out of their way in terms of innovation in physician education and community service.

Q and A

Dr. Bazemore asked Mr. Salsberg for any guidance on developing a set of metrics to determine value and return on investment for rural health education and health care access. Mr. Salsberg acknowledged that building an evidence-based system is often hindered by incomplete data and measurement difficulties. He recommended an approach that allows for experts to come together over a multi-year effort to put some initial metrics in place and then conduct ongoing monitoring to evaluate if the measures are working as expected, or need to be revised.

Dr. Epperly noted that the United States has three separate tracks for pediatric training, including residency programs funded through CHGME, those funded through the THCGME program, and those that receive neither. He asked if the goals of the QBS system can be achieved across the three different tracks. Mr. Salsberg replied that HRSA's focus was on the CHGME program, but the QBS metrics were developed with input from stakeholders across the children's hospitals community, and could be adapted.

Dr. Tsai asked about taking some of the lessons from the CHGME QBS program and applying them to the rural residency development program, in terms of finding the key metrics to measure. Mr. Salsberg replied that one possible approach would be to think through the priorities for the rural training outcomes, and offer incentive funding toward those priorities. Dr. Crane added that it is difficult to know the proper metrics to deliver the greatest "bang for the buck," because of the difficulty in determining how many residents who complete rural training programs actually go on to practice in rural areas. Dr. Crane noted another challenge related to the rural health infrastructure, in that many rural hospitals are closing due to financial stresses. He

remarked on the importance of examining the entire pipeline to be thoughtful about who gets into medical school and where they can obtain a residency, while also supporting health care settings located in rural communities to maintain training sites.

Council Discussion on Issue Brief 2: *The Rural Healthcare Workforce: Necessary Investments*

Moderator: Dr. Ted Epperly, COGME member

Dr. Epperly moderated a discussion on COGME's Issue Brief 2, *The Rural Healthcare Workforce: Necessary Investments*, focused on investments in GME to enhance the rural health workforce. As a review, Dr. Epperly said that COGME has been examining the rural workforce concerns within the nation, and identified five major areas:

- Recenter and reframe the system around people, with the focus on patients, families, and communities,
- Identify the services that people in rural communities need,
- Determine the training and the health care teams that could best deliver those services,
- Determine how to best train these teams through either medical training, nurse training, pharmacy training, or social work training, and
- Develop a financial model that will sustain these teams.

Dr. Epperly said that the purpose of Issue Brief 2 is to take a deeper dive into the financial resources to develop these health care teams. The Council reviewed the previously approved recommendations, calling on HRSA and HHS to act immediately to:

- Expand and extend successful place-based training initiatives,
- Identify and eliminate financial and regulatory barriers,
- Authorize the creation of a strategic plan for investing in health professional workforce education,
- Develop a set of measures to ensure value and return on investment, and
- Support and test sustainable alternative payment models.

In reviewing the text of the issue brief, Dr. Beulette Hooks said that the brief captures the general sense of the value of telehealth, but the deeper problem is addressing the infrastructure to accomplish it on a national level. Since many rural communities may lack broadband internet coverage, telephone visits may be needed, but these are reimbursed at a much lower rate. She added that it is important to train both the medical staff and the patients on telehealth to achieve the best outcomes and greatest value.

Dr. Bazemore raised the potential of Medicare and Medicaid innovation under CMS, as discussed by Dr. Meyers. He said that conducting demonstration of pilots of alternative payment models, operating on a small scale in coordination with CMMI and HRSA, could develop and test methods to enhance team-based training for rural health. He added the measurement and evaluation expertise of AHRQ could help in determining the scalability of such projects.

Dr. Epperly referred to comments made by Dr. Crane about regulatory barriers within CMS, and

a recommendation to allow sole hospitals, which are often located in rural areas, to receive both direct medical education (DME) and indirect medical education (IME) funding for residency programs, as is common with larger hospitals and academic medical centers. He added that DME represents about one-third of the GME funding from Medicare, with the remaining two-thirds coming from the IME side. (Note: DME pays for direct costs such as the salaries and benefits of residents, whereas IME is intended to compensate teaching hospitals for the relatively higher costs that are attributable to the involvement of residents in patient care, such as increased need for diagnostic testing and follow-up.) This difference creates enough of a barrier that sole hospitals may decline to add or pursue rural residencies because the available funding does not reflect the true total costs. Dr. Epperly reminded the Council members that recommendations on GME funding are within the Council's purview.

There was further discussion on achieving the correct balance in supporting rural residency programs. If a successful residency program is able to build and fulfill the local workforce requirements, then it loses some impetus, and state and local funders may question the value of continued funding. The goal is to help programs become self-sustaining and enhance health care access in the local area, but no program can require all residents to remain and practice locally, or it will lose attractiveness to new residents. In rural areas, the balance between under- and over-supply can be very delicate.

The members discussed modifying some of the recommendations to focus on:

- Increasing GME funding to rural hospitals for training,
- Supporting the use of telehealth and developing the necessary training and infrastructure,
- Piloting new payment methods to determine sustainability, and
- Developing outcome measures to ensure that the recommended changes improve rural health care access and quality.

The members approved the changes to the recommendations by voice vote.

Council Discussion: Letter to the HHS Secretary

Dr. Tsai brought up the letter drafted by COGME in 2019 and revised in 2020 to urge ongoing support and increased funding for HRSA's Health Careers Opportunity Program (HCOP). HCOP is designed to provide individuals from economically and educationally disadvantaged backgrounds with the opportunity and resources to successfully compete for, enter, and graduate from schools of health professions. He noted that the Council had previously approved revisions to the language of the letter, and he shared the final version. He added that drafting letters is one mechanism for the Council to respond to emerging issues in a timely manner. Mr. Rogers said that the letter would soon be sent to the HHS Secretary and Congress. Dr. Hooks commented that she benefitted from the HCOP Program as an undergraduate, and was happy to see the Council take action to write and submit this letter in support.

Council Discussion on Issue Brief 3: *Training Needs to Prepare the Healthcare Workforce for Rural Practice*

Moderator: Dr. Thomas Tsai, COGME Vice Chair

Dr. Tom Tsai moderated a discussion on the planned third issue brief, intended to refine the Council's recommendations on rural health workforce training needs to address:

- Assessment of local community needs,
- Generalized training and provider plasticity,
- Team-based care, and
- Lifelong learning.

Referencing the ACGME presentation by Dr. Weiss, Dr. Bazemore noted the recent unification of the allopathic and osteopathic residency accreditation process, which will re-define residency training. With this consolidation, residency review committees at institutions across the country are revising their guidelines and continuing to build toward competency-based training and milestone measurement. Given the changing environment of GME, the Council would need to be very careful in considering its recommendations. Those that are not fully thought out could inadvertently reduce the flexibility of residency training in the future. There was further discussion on how to coordinate federal programs, particularly around the need for prototyping or innovation grants to test some of these recommendations of the Council.

There was discussion on how to involve different federal agencies, such as AHRQ, to offer expertise in measurement and analysis, or CMMI to develop innovative programs. Dr. Karen Sanders informed the Council that she represents the Veterans Administration (VA), and that HRSA is represented on the VA's National Academic Affiliations Council, so there is already opportunity for HRSA and the VA to interact in regards to both GME and the rural health workforce. Dr. States said that an initial step would be to identify relevant stakeholders for a discussion about alternative payment models.

There was discussion on the need for flexibility in addressing health care in rural communities and developing training programs, as different communities will have different priorities, resources, and needs. The Council further discussed the need to develop sustainable funding mechanisms, such as involving the states and local communities, and engaging stakeholders. There was also discussion on tying some of the recommendations to the many COVID-related training and workforce programs in development within HRSA and HHS.

Public Comment

There were multiple public comments offered:

Dr. Karen Mitchell, of the American Academy of Family Physicians, supported the Council's focus on rural health, and emphasized the need for flexibility and for faculty development.

Ms. Hope Wittenberg, with the Council on Academic Family Medicine, commented on the need to renew support to the HRSA-funded Teaching Health Center Graduate Medical Education program. She emphasized the need to identify and address regulatory and financial barriers to

GME training, particularly the need for residency cap exceptions for rural hospitals working to establish rural residency training tracks. She reinforced the need to be clear on defining terms when developing programs addressing different specialties or geographic areas.

Several individuals provided oral comments on behalf of Physicians for Patient Protection. Comments included the need to increase GME funding and expand residency caps to address the numbers of medical students unable to match into a residency program or to develop alternate career paths for unmatched graduates, concerns about support for non-physician healthcare providers within team-based care models, and lack of medical faculty in rural residency programs. COGME also received related comments from individuals identifying themselves as members of Physicians for Patient Protection in writing via email.

Business Meeting

Mr. Rogers reminded the Council members of the next COGME meeting, planned for December 8-9, 2020. He stated that, given the ongoing uncertainties around the pandemic environment, travel restrictions, and large gatherings, the meeting would most likely be held virtually, through teleconference and webinar. Mr. Rogers proposed date ranges for two COGME meetings in calendar year 2021: late April or early May, and late July or early August. He said he would follow up with the Council members to propose firm dates.

Mr. Rogers said that he had asked COGME Chair Dr. Erin Fraher and COGME Vice Chair Dr. Tom Tsai to remain in their leadership roles for one more year to maintain continuity within the Council. He added that the Council's charter is up for renewal, and will be modified to include legislative changes included in the 2020 CARES Act.

Meeting Adjourn

Dr. Fraher thanked the members of the public for their comments and their engagement in this meeting, underscoring the importance of the Council's work. She thanked the panelists for sharing the expertise, and the Council members for their work in the previous weeks to draft the initial recommendations, helping to make the meeting a success. She also thanked the HRSA staff for their support of the Council.

Mr. Rogers adjourned the meeting at 5:00 p.m.

Acronym and Abbreviation List

ACGME	Accreditation Council for Graduate Medical Education
ACTPCMD	Advisory Committee on Training in Primary Care Medicine and Dentistry
AHRQ	Agency for Healthcare Research and Quality
BHW	Bureau of Health Workforce
CARES Act	Coronavirus Aid, Relief, and Economic Security Act
CHGME	Children’s Hospital Graduate Medical Education
CMMI	Center for Medicare & Medicaid Innovation
CMS	Centers for Medicare & Medicaid Services
COGME	Council on Graduate Medical Education
DFO	Designated Federal Official
DMI	Direct Medical Education
GME	Graduate Medical Education
HCOP	Health Careers Opportunity Program
HHS	U.S. Department of Health and Human Services
HRSA	Health Resources and Services Administration
IME	Indirect Medical Education
MUA/P	Medically Underserved Area and Population
NPI	National Provider Identifier
QBS	Quality Bonus System
RRPD	Rural Residency Planning and Development
TAC	Technical Assistant Center
THCGME	Teaching Health Center Graduate Medical Education
VA	Veterans Administration