COGME | Council on Graduate Medical Education

Meeting Minutes: Friday, September 8, 2023

The Council on Graduate Medical Education (COGME or the Council) held a meeting on September 8, 2023. The meeting was hosted by the Bureau of Health Workforce (BHW), Health Resources and Services Administration (HRSA), Department of Health and Human Services (HHS), and conducted via a videoconference platform. In accordance with the provisions of the Federal Advisory Committee Act (Public Law 92–463), the meeting was open to the public for its duration.

Council Members in Attendance

Appointed Members

Peter Hollmann, MD, Chair
Erin Fraher, PhD, MPP
Andrew Bazemore, MD, MPH
Ted Epperly, MD
R. Armour Forse, MD, PhD
Beulette Hooks, MD
Warren Jones, MD
John Norcini, PhD
Ashruta Patel, DO, MS
Linda Thomas-Hemak, MD
Thomas Tsai, MD, MPH
Surendra Varma, MD, DSc (Hon)
Kenneth Veit, DO, MBA

Federal Representatives

Joseph Brooks (Designee: Centers for Medicare and Medicaid Services)
John Byrne, DO (Designee: Department of Veterans Affairs)
CAPT Paul Jung, MD, MPH (Designee: Health Resources and Services Administration)
Leith States, MD, MPH (Designee: Assistant Secretary for Health)

Health Resources and Services Administration Staff Present:

CAPT Curi Kim, MD, MPH, Designated Federal Officer, COGME; Senior Advisor, Division of Medicine and Dentistry, BHW, HRSA
Raymond Bingham, MSN, Writer and Editor, Division of Medicine and Dentistry, HRSA
Zuleika Bouzeid, Advisory Council Operations, BHW, HRSA
Janet Robinson, Advisory Council Operations, BHW, HRSA

Welcome and Introductions

CAPT Curi Kim, the Designated Federal Officer for COGME, convened the Council's second meeting of fiscal year (FY) 2023 at 10:00 a.m. ET on Friday, September 8, 2023. CAPT Kim turned the meeting over to the COGME chair, Dr. Peter Hollmann. Dr. Hollmann conducted a roll call, indicating the attendance of 16 of the Council's 18 members. A seventeenth member joined after the lunch break. One member had an excused absence. Dr. Hollmann confirmed the presence of a quorum, allowing the meeting to proceed.

Update: White House COVID-19 Response Team

Thomas Tsai, MD, MPH
Member, COGME

Dr. Hollmann introduced Dr. Thomas Tsai, a former COGME member returning to active status after taking a year-long leave to work on the White House COVID-19 Response Team. Dr. Tsai noted that the COVID-19 response effort was centered within HHS, including the Surgeon General's office and the office of the Assistant Secretary for Planning and Evaluation (ASPE), but was spread across many federal agencies, as well as non-federal organizations including state and local health departments and private sector partners. He emphasized the importance of effective management and governance, with the Response Team coordinating and supporting these efforts through policy and regulation development, program implementation, oversight of operations and budgeting, coalition-building, and engagement through strategic communications.

While serving as the Response Team's testing and treatment coordinator, Dr. Tsai said that he worked to translate the administration's policy directives into effective programs and led the federal COVID.gov effort to provide free at-home COVID-19 tests. Through the work of the Response Team, the federal government delivered over 1.2 billion COVID-19 test kits to over two-thirds of all households in the United States, with another 50 million tests administered for free through local pharmacies and other community sites. He emphasized several collaborative interagency efforts devoted to assuring equitable access and distribution, including work with the Department of Housing and Urban Development for direct distribution to residents of low-income senior housing, the Department of Education to provide free testing in schools, the Department of Agriculture to distribute tests through community-based food banks and other organizations, and state and local health departments for help in accessing areas the federal government could not reach. Furthermore, almost 18 million courses of oral antiviral medications were provided through over 40,000 provider and pharmacy locations. He highlighted the role of HRSA in addressing the needs of underserved communities by quickly standing up testing and vaccination programs at federally qualified health centers (FQHCs), rural health clinics, and mobile clinics, as well as through telehealth visits. In 2022, private partnerships with Walgreens, Uber Health, and DoorDash assisted in the free delivery of the antivirals directly to individual homes, especially in the high social vulnerability index households.

Dr. Tsai discussed some of the challenges in launching changes to clinical care on such a massive scale in a short timeframe. He closed by stating his hope that the lessons learned through the pandemic response will help with future pandemic preparedness and response, as well as in providing for more resilient and equitable healthcare delivery going forward.

Q and A

Council members asked if the Response Team had considered using graduate medical education (GME) training sites to improve access to COVID-19 testing and treatment response and noted an example of COVID-19 testing and treatment provided by some local GME sites. Dr. Tsai replied that he had written a perspective about the possible use of GME sites within the Veterans Health Administration as a possible resource to assist local healthcare systems or communities. He also highlighted the role of GME in incorporating the rapidly changing knowledge about

COVID-19 into educational programs for medical students, residents, and other healthcare providers. Moving forward, he noted the need to develop and maintain relationships with local community leaders to help with initiating and implementing effective public health programs.

There was a question about how the Response Team addressed racial disparities regarding access to COVID-19 testing and treatment. Dr. Tsai cited the example of the team's work with the New York City health department and local emergency medical teams in providing at-home tests, mobile clinics, and telehealth services. He added that relying solely on the normal delivery systems during a public health emergency could exacerbate already-existing disparities in access.

Another member raised some primary care concerns, noting that many primary care providers had no way to access or track their patients' vaccination records and experienced difficulties in guiding patients through decisions on testing, treatment, and vaccination. Dr. Tsai agreed with the need to break down the historical barriers between public health and primary care. Part of the work of the Response Team involved engaging primary care clinicians to integrate their services in the public health response.

Discussion: Dissemination Strategies Toolkit

Moderator: Curi Kim, MD, MPH
Designated Federal Officer, COGME

CAPT Kim reminded Council members of the decision made at the previous March 2023 meeting to have a writing group create a toolkit of dissemination strategies for COGME's written products. She provided a brief overview of the draft toolkit document that was approved by the writing group. The opening sections state the objective of the toolkit and COGME's legislative authority to disseminate its recommendations. The main section of the toolkit describes specific dissemination plans, differentiated between systematic and individual activities. She added that each COGME report should have its own ad hoc dissemination writing group. For the COGME 24th Report, which was released in 2022, a writing group had developed one-page summaries that could be shared with stakeholder groups or at professional conferences, along with sample social media posts. The need for a dissemination writing group for other products outside of reports, such as letters or issue briefs, would be decided on a case-by-case basis. In addition, the toolkit mentions evaluating the impact of the dissemination efforts. Lastly, the toolkit includes some ethical guidelines for members to keep in mind as well as considerations for members to use in selecting appropriate dissemination outlets. She added that the toolkit is a living document, to be revised and updated as needed.

There was a question about any potential areas of controversies related to dissemination. CAPT Kim replied that the toolkit was based on guidance from HHS' Office of General Counsel and HRSA's Ethics Office, and guidelines on individual activities that were previously shared with Council members are referenced in the toolkit.

With no further comments, a motion was made and seconded to vote on accepting the toolkit. The motion passed by unanimous voice vote.

CAPT Kim then shared the results of some analytics conducted by the Wright Center, a federally supported community healthcare provider network, on its dissemination efforts for the COGME 24th Report. Dr. Thomas-Hemak, President and CEO of the Wright Center, noted that there had been over 2,000 "impressions" related to the report on the Wright Center's social media platforms and almost 150 clicks on the report hyperlink since May 2023, when the Wright Center started posting about the 24th Report.

Discussion: COGME Issue Brief on GME Data

Moderator: John Norcini, PhD
Member, COGME

CAPT Kim moved on to the next agenda item, recapping for Council members that this issue brief on GME data grew out of a document on underrepresented in medicine trainees that was presented to COGME during its September 2022 meeting, then discussed as a separate data document during its March 2023 meeting. She introduced Dr. John Norcini from the writing group that worked on the issue brief to lead the discussion. Dr. Norcini noted that longitudinal data regarding the inputs and outcomes of the GME system are limited, which hinders the ability of educators and policymakers to address concerns related to GME quality, efficacy, and efficiency. For example, it is difficult to judge the adequacy of the duration of GME training programs or the quality of educational interventions with current publicly available data. Enhancing access to the data to explore these issues could contribute to increasing the availability of high-quality, affordable healthcare. He added that these GME data concerns are not new. In 2018, the National Academies of Sciences, Engineering, and Medicine (NASEM) published *Graduate Medical Education Outcomes and Metrics: Proceedings of a Workshop*. Since that time, though, there has been little advancement. The writing group developed the issue brief to add COGME's voice to improve GME data.

Dr. Norcini remarked that current data on GME is being collected and stored by several different entities, and the data collection processes are not standardized or interoperable. To build on the NASEM report, the issue brief recommends that HHS bring together a group of stakeholders across relevant government agencies and private organizations involved in GME, with the goal to establish a standardized set of core metrics and data sharing strategies. Congress should then invest in longitudinal research derived from this data set to explore GME outcomes, physician workforce pathways and distribution, care patterns, and quality of care.

There was a suggestion to add the American Association of Colleges of Osteopathic Medicine to the list of invitee organizations. Dr. Norcini supported the suggestion, while noting that the list of potential invitee organizations in the issue brief is not exhaustive.

There was a comment on the meaning of the term "longitudinal research," with implications of individual-level physician tracking, and how this research can help elucidate the degree to which age, gender, cohort, and other life course factors may affect career pathway trajectories. There was some discussion about revising the wording of the recommendation to clarify the intent.

There was a comment on a growing sense within the GME community that the current situation on data collection and use had become untenable. In that case, the COGME issue brief could be timely in its call to spur change in this area. Dr. Norcini agreed and clarified that COGME is not recommending placing all GME-related data into one central repository because there are too many organizations involved and each one would need to retain control over its own data. The goal would be to help the various groups to collaborate and enable data sharing to address broad questions related to GME.

A member reminded the Council that one of the key reasons COGME began exploring the issue of GME data was to identify systemic obstacles and barriers in the GME process that impact medical students and residents from minority or under-represented populations. Thus, one goal would be to allow for the development of policies and mechanisms to overcome these barriers.

Another member stated that the nation's healthcare system faces enormous struggles with workforce maldistribution and disparities in care, which has been exacerbated by the pandemic. He expressed concern that the issue brief was rehashing old material and the recommendations needed to be more substantive and directive to bring about real changes.

There was further discussion that one purpose of the issue brief and its recommendations was to assure that the disbursement of federal GME dollars would be based on the healthcare needs of the country. Research using this data should address the accountability of public investment in GME. There was additional discussion on the wording and intent of the recommendations.

CAPT Kim mentioned that the issue brief was reviewed by HRSA staff and recalled that representatives from the Accreditation Council on Graduate Medical Education and HRSA's National Center for Health Workforce Analysis previously commented on GME data at COGME's last two public meetings, respectively. She observed that, from the current discussion, the general COMGE membership was expressing the need for more development and revision of the issue brief. Dr. Hollmann agreed. Thus, there was a decision hold off voting on the issue brief until the next COGME meeting to allow the writing group to incorporate the Council's feedback.

Discussion: Letter Supporting Community Health Workers

Moderator: Peter Hollmann, MD
Chair, COGME

Dr. Hollmann proposed that COGME offer comments on the Centers for Medicare and Medicaid's (CMS) 2024 Physician Fee Schedule proposed rule to allow reimbursement for specific services provided by community health workers (CHWs), including risk assessment, chronic disease management, and social determinants of health intervention. A motion to consider this proposal was made and seconded, and the motion passed by unanimous voice vote.

Dr. Hollmann then presented and reviewed a draft letter prepared with the approval of the team-based care writing group. He stated that the opening paragraphs briefly discuss the CMS rule and express COGME's support for team-based care and the role of the CHWs. The letter then

discusses some specific aspects of the rule and highlights some areas that may need clarification. It closes by presenting COGME's interest in improving the composition of the healthcare team to broaden healthcare access and improve community health outcomes.

A member noted that including CHWs on the healthcare team had been linked to job satisfaction and could serve as one strategy to reduce burnout among healthcare professionals. She suggested including some language about the role of CHWs in community health centers such as FQHCs and rural health clinics. Another member suggested including mention of a new HRSA-funded CHW training program. There was an observation that CHWs have played a role as trusted healthcare representatives in their communities, and they can reinforce the need for individuals and communities to be involved and proactive in their care. Refining some of the language in the letter was suggested.

At the conclusion of the discussion, a motion was made and seconded to approve the letter, pending minor edits to incorporate the feedback provided by the Council members. The motion passed by unanimous voice vote.

Presentations: Team-Based Care through Interprofessional Practice and Education and a Whole Health Approach

Christine Arenson, MD
Director, National Center for Interprofessional Practice and Education

Benjamin Kligler, MD, MPH
Executive Director, Office of Patient-Centered Care and Cultural Transformation
Veterans Health Administration, Department of Veterans Affairs

Team-Based Care through Interprofessional Practice and Education

Dr. Hollmann introduced Dr. Christine Arenson for the presentation. Concerning team-based care, Dr. Arenson said that the culture of the medical profession has tended to over-emphasize physician responsibility at the expense of working within an interprofessional team. She offered the view that interprofessional practice and education occurs when "two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes." However, physicians are rarely taught or prepared to work effectively with other health professionals or to use effective teamworking strategies. She referenced reports indicating ongoing problems with inequitable access to healthcare and risks to patient safety, while many proposed solutions fail to account for the human factors in health care.

Dr. Arenson called out what she referred to as a "founding myth" of the physician as solo practitioner and healer. In the current healthcare system, physicians work in multiple teams and every patient may have a different team involved in providing care. Still, many physicians feel responsible for leading the teams, while bearing the largest burden of blame and malpractice in the face of errors or other poor outcomes. As a result, physicians report high rates of burnout and depression, and the profession has a high rate of suicide.

Dr. Arenson acknowledged that each profession has its own unique culture, but they all share a mission to serve patients, families, and communities to improve health. She noted calls to change the underlying ideology and culture across health professions and develop a new mental model about how the professions should work together in our modern technological- and knowledge-based era. She closed by saying GME is well suited to lead this change. Medical training occurs within the nexus of the clinical learning environment and care delivery, where team members can share responsibility and engage in interprofessional collaborative practice. However, learning to work in teams requires guidance and coaching, and each team member needs to understand and respect the roles of different professions.

Whole Health and Team Care: What are We Learning?

Dr. Hollmann then introduced Dr. Benjamin Kligler for the next presentation. Dr. Kligler described the Veterans Health Administration (VHA) as a massive health system under the U.S Department of Veterans Affairs (VA), covering over 140 medical centers with almost 400,000 total staff. He said that the VHA is working to implement an approach known as Whole Health, with the aim to expand traditional medical care by emphasizing health promotion and prevention and empowering veterans served by the VHA to take charge of their own health and well-being. He said Whole Health promotes self-care, offers many complementary and alternative care approaches, and encourages individuals to focus on what is important to them. He mentioned health coaches as a rapidly expanding role, helping individuals make healthier lifestyle choices and navigate the complex health system.

Dr. Kligler said that team care in the Whole Health approach involves the veteran, the family, the community, the health coach, and all involved healthcare professionals, with three components:

1. ***Pathway***, to empower the individual to pursue what matters most at that time, determine practices or services that are helping, and evaluate what more may be needed.
2. ***Well-Being Programs***, to equip individuals to care for themselves, decrease their reliance on provider-delivered care, and offer health coaching and access to a variety of complementary and alternative approaches to health.
3. ***Whole Health Clinical Care***, to provide access to clinical services as needed.

Dr. Kligler discussed the expansion of the Whole Health approach within the VHA. In the previous year, over 1 million of the roughly 6 million veterans who use the VHA system engaged with Whole Health services. He noted the advantages of developing this type of approach within a federally funded, single-payer system. If successful, the VHA approach could serve as a proof on concept to help other systems implement similar reforms.

Dr. Kligler shared some of the results of a NASEM report on Whole Health, which found improved patient experiences; increased access; better outcomes for certain conditions, including pain management, mental health, maternal and infant care, and healthy aging; and reduced costs. The report concluded that Whole Health could benefit many patients, but it requires a systematic shift in mindset about health, along with multisector collaboration and investment. Dr. Kligler noted that there have been great advances in treating disease, but similar advances are needed in promoting health and well-being.

Dr. Kligler moved the discussion to talk about a similar approach, Employee Whole Health, aimed at improving staff health and resilience and promoting teamwork through an emphasis on mindfulness, self-care and self-compassion, gratitude, and improved engagement and joy in work. The VHA developed several educational videos and apps available to all staff. He presented findings of increased job satisfaction in VHA facilities that had implemented the Employee Whole Health program.

Q and A

In response to a member's question about the preferred composition of interprofessional teams, Dr. Arenson replied that some health professions schools and academic programs believe interprofessional education requires all professions to train together and to be involved in all scenarios, which creates an artificial environment that rarely reflects real-world situations. In practice, health professionals must work with the healthcare team in their local environment. For example, a rural primary care practitioner must work with the other available health professionals in the area to allow the full team to deliver the best care possible. She noted that the range of professionals available at an academic health center in downtown Philadelphia may be vastly different than at a senior center with an underserved population in south Philadelphia. Interprofessional education involves training providers to work effectively within different teams.

Another member asked if the team must be led by a physician. Dr. Kligler replied that physicians may not have the proper skills to lead the team in all situations. The physician may carry a responsibility for clinical decision-making, but that is not the same as always leading the team. Dr. Arenson agreed. She cited an example of a palliative care team, in which nursing, pastoral care, or social work may be the appropriate leaders to meet the needs of the patient and family. In other settings, such as a long-term care facility, the physician may not be regularly present and available, thus other staff need to take the lead.

Answering a member's question about the main points on team-based care and the Whole Health approach that COGME could highlight for a Congressional audience, Dr. Kligler emphasized the role of health coaches, noting that many veterans taking part in Whole Health point to their health coaches in promoting nutrition, exercise, stress management, social support, and mental and behavioral health. Dr. Arenson said that she would stress the need to change the healthcare culture away from the physician as having sole responsibility and toward a team approach with shared responsibility. She also pointed out that delivering patient-centered care means building the healthcare team around the needs and preferences of the individual, family, and community.

One member stated that he believed the younger generation of physicians and healthcare professionals is more accepting of interprofessional education and team-based care than the older generation. Dr. Arenson replied that she had not seen much of a generational shift as many younger students believe they know about teamwork from sports or from team projects in school, but these types of experiences do not always translate well in the professional work environment. Therefore, teamworking skills need to be provided in GME and in the training of other professionals. She added that workplace learning requires being intentional about bringing people together, with a vital component of guiding, framing the learning, and then reflecting and coaching about team-based care.

Dr. Kligler was asked about the role of his office in addressing the structural problems within the VA that may hinder the Whole Health approach and team-based care, such as productivity demands made on primary care physicians. Dr. Kligler responded that he felt the Whole Health initiative was in year two of at least a ten-year project and agreed that changing the culture will take time. He noted new conversations developing among the leaders in the VA on shifting the role of the VHA to focus more on health promotion and whole-person health.

Dr. Hollmann asked about specific recommendations that COGME could make to Congress to promote interprofessional practice and education and team-based care. Dr. Arenson replied that every graduate of an accredited GME program should demonstrate competency as an effective member and leader of an interprofessional team. She added that every GME program needs to have a patient or family advisory board which should be designed to meet the needs of the population it serves. Dr. Kligler emphasized that proper team care should include a health coach or similar professional to assure that the team is explicitly directed to understand the patient's needs and goals, and to avoid focusing only on a disease-specific agenda.

Presentation: Promoting Team-Based Care through the Quality Payment Program

Jeanette Ellis, DNP, RN
Senior Nurse, MIPS Quality Measure, MVP Development Lead, Division of Electronic and Clinician Quality, Quality Measurement and Value-Based Incentives Group, Center for Clinical Standards & Quality, CMS

Alexa Gallagher, DNP, APRN, FNP-BC
Health Insurance Specialist, Division of Electronic and Clinician Quality, Quality Measurement and Value-Based Incentives Group, Center for Clinical Standards & Quality, CMS

Dr. Hollmann introduced the next speakers, Dr. Jeanette Ellis and Dr. Alex Gallagher from CMS. Dr. Gallagher said that their presentation would focus on the quality payment programs (QPPs) under CMS, the Merit-Based Incentive Payment System (MIPS) and MIPS Value Pathways (MVP), and their role in promoting team-based care. She said the QPPs were established in 2015 as customized payment approaches to provide incentives to clinicians to provide high quality and high value care. Dr. Gallagher said clinicians in MIPS have different options related to quality measures and improvement activities, providing a lot of flexibility in the way they and their teams provide care to their patients. However, MIPS will soon be replaced by MVP, which offers more streamlined and cohesive sets of measures and activities, along with reduced reporting requirements and enhanced performance feedback.

Dr. Ellis noted that CMS has taken incremental steps to acknowledge variations in clinician practices, refine the program requirements, reduce reporting burden, encourage broader participation, and improve patient outcomes. She shared the CMS timeline in transitioning from MIPS to MVPs, with completion expected by 2026. Team-based care models supported under MVPs can lead to better outcomes for beneficiaries and better overall experience for the staff, while improving data and information sharing. The QPP system aims to move practices away from the fee-for-service payment models and towards the overall team-based care approach.

Dr. Ellis added that CMS encourages multispecialty groups to choose an MVP program that includes measures relevant to all clinician types within its group, to help drive quality improvement, promote team care, and lead to improved patient outcomes. She provided some examples of how different group configurations can work within the MVP system.

Lastly, Dr. Ellis explained the MVP development process, based on the needs and priorities of the MVP-candidate groups and the priorities being communicated by the administration, and shared some resources from CMS on the QPP and MVP process.

Q and A

Dr. Hollmann observed that the thrust of the QPP appears aimed at interspecialty teams within medicine, while COGME is also focused on interprofessional teams that may include nurse care managers, dieticians, health coaches, and other professionals. He asked how the MVP system would lead practices into becoming truly interprofessional. Dr. Ellis acknowledged that the MVP system remains focused on clinical practices with different medical specialties. However, CMS is in the early stages of discussions of involving interprofessional teams. Dr. Gallagher added that CMS needs input from the different providers who work in a range of team-based areas to develop program quality measures and expand the MVPs.

A member noted that the COGME 24th Report discusses the importance of team-based care within rural communities, so that the team can work to improve the health of the population. He noted that a more team-based payment model, such as a per member per month system, could help community health facilities develop the staff and infrastructure to improve community health. Dr. Ellis replied that there are ongoing conversations with the executive leadership team regarding those types of payment models. Dr. Gallagher added that the CMS Innovation Center is testing models to improve the evidence base for population-based payment designs.

Discussion: COGME 25th Report on Team-Based Care

Moderator: Peter Hollmann, MD
Chair, COGME

Dr. Hollmann moved to the last item on the agenda, a Council discussion on approaches to the COGME 25th report on team-based care. He reviewed some of the discussion from COGME's March 2023 meeting, noting that concepts of team-based care have around for many years. The report would not present a comprehensive review but would highlight the positives of team-based care and discuss some of the barriers and solutions.

Dr. Hollmann noted that the purpose of this report is to make strong, focused, relevant, and measurable recommendations that would serve to develop and improve team-based education and practice. He reviewed some of the recommendations from past COGME reports related to establishing and improving interprofessional practice and team-based care. He noted COGME's unique position among the other HRSA advisory committees in addressing the broad health workforce landscape. He outlined some of the most pressing challenges, including workforce shortages, a greater emphasis on value-based reimbursement models, and the impact of the COVID-19 pandemic on workforce stress and burnout.

Dr. Hollmann reviewed the basic premise for the report, that well-functioning teams provide better care, including improvements in access, quality, and efficiency. He added that value-based payment models often require team-based care and that federal GME funds can help to leverage or facilitate change. He noted that external forces such as greater awareness of the social determinants of health, the aging population, the rise in chronic health conditions, and the ongoing opioid crisis, are driving changes in the healthcare system.

One member emphasized that the healthcare delivery system will drive changes in both undergraduate medical education and GME. He added that private equity firms are taking over primary care delivery systems in some urban areas, and they rarely see teaching as a major obligation unless it has some sort of reimbursement. A second member concurred, and further noted the need to align payment models with workforce productivity and team-based care because "what gets paid for gets done." He also emphasized the role of teams in decreasing stress and burnout in the healthcare workforce.

A member advised that COGME should encourage interprofessional training along with interprofessional practice. Thus, COGME could recommend an incentive for the workforce training programs funded by HRSA, to be preferentially provided to grantees that have other workforce training programs. For example, a health center with a HRSA-funded Teaching Health Center Graduate Medical Education program could gain a funding priority by including a nurse training program, ensuring that doctors and nurses can train together.

Another suggestion was to add the Area Health Education Center program into the discussions on interprofessional training while also cautioning about the possible unintended consequences of incentivizing some specific types of programs, because those that already have funding may dominate the grant process. The member also proposed a closer look into joint partnerships between states and federal agencies in the use of Medicaid funding to support team-based practice and education in GME.

The importance of physicians training with physician assistants, nurse practitioners, and other advanced practice registered nurses was noted. All team members need to understand the knowledge, training, and roles of each other.

The need to tie funding for training back to community needs, especially in rural areas, was discussed. Concern was raised about the number of rural hospitals and critical access hospitals that are closing. It is not possible to build team-based care if the team has no place to function.

Public Comment

There were two comments from members of the public:

- Dr. Andrea Anderson, a member of the National Advisory Council on the National Health Service Corps, thanked the COGME members for their work in promoting primary care.
- Ms. Mandi Neff, a regulatory and policy strategist with American Academy of Family Physicians (AAFP), noted the AAFP's support for COGME's focus on physician-led, team-based care that optimizes patient care and outcomes.

Business Meeting

CAPT Kim provided a brief update on the state of the COGME membership. She stated that four members will roll off after the Council's first meeting of 2024, and four nominees, representing the membership categories of private teaching hospital, resident, medical student, and practicing primary care physician, are currently in the vetting process. She added that nominations for the next cohort will be open through January 2024, with the expectation that these new members would be onboarded in 2025. COGME will be looking for nominations for the 2025 cohort representing the categories of labor, schools of medicine, national physician organizations, and international medical graduates. She said that information for the nomination process is posted on the COGME web page.

CAPT Kim added that COGME will have some temporary intentional vacancies in the upcoming years, allowing it to return to a more orderly process of staggered member terms by 2027. She reminded members of the next COGME meeting [currently scheduled for March 4-5, 2024] is planned to be in-person at the HRSA headquarters in Rockville, Maryland.

Ms. Zuleika Bouzeid, from the HRSA Advisory Council Operations office, provided a brief overview of the HRSA travel procedures related to in-person meetings for Council members.

Wrap Up and Next Steps

Dr. Hollmann reviewed the events of the day and summarized the presentations the Council had received. He noted some next steps:

- For the GME data issue brief, the writing group and HRSA staff will revise the draft to reflect the Council's feedback and bring it back for review by the full Council at the next 2024 meeting.
- For the CHW support letter, the Council had voted to approve the letter pending minor edits. HRSA staff will work with the chair and writing group to finalize the text and submit the letter to the HHS Secretary and Congress.
- For the 25th Report, the writing group will prepare an outline and some draft recommendations for the full Council to review at the next 2024 meeting.

Adjourn

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

Acronym and Abbreviation List

AAFP	American Academy of Family Physicians
ASPE	Assistant Secretary for Planning and Evaluation
BHW	Bureau of Health Workforce
CHW	Community Health Worker
CMS	Centers for Medicare and Medicaid Services
COGME	Council on Graduate Medical Education
FQHC	Federally Qualified Health Center
FY	Fiscal Year
GME	Graduate Medical Education
HHS	U.S. Department of Health and Human Services
HRSA	Health Resources and Services Administration
MIPS	Merit-Based Incentive Payment System
MVP	MIPS Value Pathways
NASEM	National Academies of Sciences, Engineering, and Medicine
QPP	Quality Payment Program
VA	Department of Veterans Affairs
VHA	Veterans Health Administration