COGME | Council on Graduate Medical Education

Meeting Minutes: March 4–5, 2024

The Council on Graduate Medical Education (COGME or the Council) held a meeting on March 4–5, 2024. 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 in a hybrid format, in-person and 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 [virtual]
R. Armour Forse, MD, PhD [virtual]
Beulette Hooks, MD
Warren Jones, MD
Ashruta Patel, DO, MS
Linda Thomas-Hemak, MD
Thomas Tsai, MD, MPH
Surendra Varma, MD, DSc (Hon) [virtual]
Kenneth Veit, DO, MBA [virtual]

Federal Representatives

Joseph Brooks (Designee: Centers for Medicare and Medicaid Services) [virtual]
John Byrne, DO (Designee: Department of Veterans Affairs) [Attended on March 4 only, virtual]
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

Day 1: March 4, 2024

Welcome and Introductions

CAPT Curi Kim convened the Council's first meeting of fiscal year 2024 at 9:00 a.m. ET. 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 and confirming quorum. Two members had an excused absence.

Review of the COGME Charge

Curi Kim, MD, MPH
Designated Federal Officer, COGME

For the benefit of the public, CAPT Kim provided some background on the purpose of COGME and reviewed the Council's charge and duties, including the various programs within its purview under Title VII of the Public Health Service Act. She stated that COGME is an independent advisory Council of HHS, supported within HRSA's BHW. Its purpose is to provide the HHS Secretary and Congress with an ongoing assessment of physician workforce trends, as well as training and financing issues related to graduate and undergraduate medical education.

Acknowledgement of Outgoing COGME Members and Membership Updates

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

CAPT Kim provided an update on the status of the COGME membership. She stated that COGME was currently fully constituted per its charter, with 18 members, including 14 members appointed by the HHS Secretary and 4 ex officio members. She acknowledged four current members for whom this meeting would be their last: Drs. Thomas Tsai, Armour Forse, Beulette Hooks, and Ashruta Patel. In addition, CAPT Kim acknowledged Dr. Ted Epperly, whose term ends in September 2024, since he will not be able to attend the September 2024 COGME meeting. CAPT Kim noted that the terms of four other COGME members will also end after the September 2024 meeting: Drs. Erin Fraher, Kenneth Veit, John Norcini, and Andrew Bazemore.

CAPT Kim stated that the terms of Drs. Peter Hollmann, Surendra Varma, and Warren Jones were scheduled to end in November 2024. However, all had graciously agreed to extend their terms for another six months. If the extension request is approved, these members would be able to participate in the spring 2025 COGME meeting, allowing for a smoother transition in the turnover of the membership. CAPT Kim stated that she is working to return COGME to a more orderly membership rotation process, per the original intent of Congress.

CAPT Kim added that the nomination packet of four new members is currently under review by the HHS Office of White House Liaison, with the expectation that these members would be appointed and onboarded in time for the September 2024 meeting. In addition, HRSA is in the process of reviewing nominations for the cohort of new members planned to onboard in 2025.

Fireside Chat: HRSA Updates

Luis Padilla, MD
Associate Administrator for Health Workforce, BHW, HRSA

Dr. Luis Padilla provided a general overview of the current federal budget situation in the wake of the recent passage of a continuing resolution. He highlighted the positive upshot of the 2024 Consolidated Appropriations Act, including the reauthorization of HRSA's community health center program, the National Health Service Corps, and the Teaching Health Centers Graduate Medical Education (THCGME) program. He stated that these and other HRSA health workforce programs focus on improving the distribution of the workforce across the country, promoting access to high quality health care, and decreasing health disparities.

There was a comment of appreciation for HRSA's focus on community health settings outside of hospitals and other tertiary care centers. Another commenter raised the issue of the stresses

faced by primary care providers and community health centers due to the long-standing disparity between the responsibilities they assume and the resources they receive. In particular, there was concern about increased pressures on primary care providers resulting from the COVD-19 pandemic. Dr. Padilla replied that the workforce across the country had been significantly traumatized. He noted that HRSA would soon release the findings from its most recent National Sample Survey of Registered Nurses (NSSRN). This most recent version of the NSSRN included items related to the impact of the pandemic on the respondents' careers. He also expressed concern about the rise of physical assaults on nurses and other healthcare providers. He discussed HRSA's health workforce resiliency funding, which the agency directed toward the development of new programs focused on promoting both individual well-being and organizational changes to improve the work environment.

Dr. Padilla emphasized a change in the culture of HRSA away from simply funding academic institutions to train more workers toward developing health workforce programs that meet the health care needs of individuals and communities, the real end-customers of HRSA funding. He noted that HRSA is in the process of developing a simplified notice of funding opportunity (NOFO) template that is shorter, easier to follow, and easier to read, encouraging more organizations to apply for funding. HRSA is also striving to get more grant reviewers from community organizations to evaluate the NOFO applications.

Referring a 2018 U.S. Government Accountability Office (GAO) report on the need to improve the accountability and transparency of federal funding for GME, a member noted a recent GAO review found that HHS has yet to adequately implement its recommendation. Dr. Padilla replied that HHS had developed a health workforce strategic plan, published in 2022. He added that HRSA has worked to gain access to medical claims data from the Centers for Medicare and Medicaid Services (CMS), to help the agency determine where its supported clinicians choose to practice after their training and to identify ongoing gaps. He noted that HRSA targets many programs in Health Professions Shortage Areas (HPSAs), and HRSA's National Center for Health Workforce Analysis (NCHWA) provides workforce projection reports. However, HRSA could use more granular data at the community level.

There were comments about the role of state funding in financing GME through Medicaid. Dr. Padilla agreed with efforts to partner with state GME programs. In addition, he briefly discussed the impact of a recent decision rendered by the Supreme Court that restricts certain race-based admissions procedures used by many colleges and universities to increase the diversity of their student populations. He said that HRSA is exploring alternative models of recruitment, education, and training that use factors outside of race and ethnicity to continue its efforts to diversify the healthcare workforce.

Presentation: VA MISSION Act Section 403

John Byrne, DO
Depart of Veterans Affairs (VA) ex officio member, COGME

Dr. John Byrne provided an overview of the MISSION Act Section 403, which expands the VA's support for GME. Dr. Byrne noted that the VA health professions education program is the second largest federal funder of GME, spending around $850 million annually and training

120,000 health professionals each year in over 60 different disciplines.

Dr. Byrne noted that VA medical facilities do not hold the accreditation for GME programs, but rather establish affiliation agreements with the sponsoring academic institutions that support the residents. When these residents rotate through VA facilities, the VA provides faculty supervision and learning environments and reimburses the sponsoring institutions.

Dr. Byrne stated that the MISSION Act Section 403 authorizes a pilot program, involving no more than 100 residents, to modify the affiliation agreements by ending the requirement that the supported residents practice only in VA facilities and provide care only for veterans. In an effort to serve more veterans who do not live within easy access of any VA facilities, the VA would provide funding support for residents in the pilot program as long as their rotations occur in select covered facilities, which include those operated by the Indian Health Service (IHS), tribal organizations, the Department of Defense (DoD) and federally qualified health centers (FQHCs). Dr. Byrne noted that Section 403, authorized through the end of 2031, created two new authorities for the VA to provide: 1) reimbursement for resident time (salary and benefits) for the delivery of non-veteran care in non-VA facilities, and 2) reimbursement for start-up costs for new residency programs at non-VA facilities.

Dr. Byrne reviewed the selection criteria, reporting requirements, and timetable for the request for proposals under Section 403, with a planned start date in academic year 2025–2026

Q and A

There was a question about whether an FQHC receiving THCGME funding could also be funded by the VA. Dr. Paul Jung provided precautions about such a strategy.

Another member asked if the VA reimbursements would cover administrative costs of the sponsoring institution. Dr. Byrne replied that the VA can only reimburse resident salary and benefits through its disbursement process.

There was another question about efforts to increase the number of minority residents and physicians who receive training through the VA. Dr. Byrne stated that the VA had been involved in many efforts to increase the diversity of its health professional education programs and has achieved some success by reaching out to minority-serving institutions (MSIs). He added that the VA Office of Academic Affiliations had hosted a day-long summit to discuss the issues around increasing its affiliations with MSIs.

Discussion: COGME Issue Brief on GME Data

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

Council members reviewed and discussed a draft issue brief (in development for over a year) on initial steps needed to improve access to and interoperability of the many data sets related to GME and the physician workforce that are siloed across several federal and non-federal organizations. The brief highlighted the need to develop, coordinate, and implement a concrete action plan to better link medical education and training metrics to physician practice patterns

and population health. It included recommendations to:

1. Convene an inclusive group of GME stakeholders to develop guidelines on standardizing and systematizing the collection and sharing of GME data.
2. Provide federal funding for longitudinal research on GME training outcomes to assess the efficacy of current GME investments.

After a brief discussion to address some wording changes, the Council voted to approve the issue brief for release, pending further non-substantial edits.

Discussion: 25th COGME Report Recommendations

Moderator: Peter Hollmann, MD
Chair, COGME

Dr. Hollmann provided a brief overview of the past Council discussions on the development of its 25th Report. He stated that the Council had decided to focus the report on team-based care and interprofessional education (IPE), with an emphasis on teams within community-based settings. He noted the Council's previous discussions on the literature that supported IPE, as well as the history of barriers to achieving true interprofessional team-based care across all healthcare settings. The purpose of the report is not to rehash old arguments, but call for a renewed push to pursue team-based care in response to changes in the healthcare system, particularly the disruptions imposed by the COVID-19 pandemic. COGME's report should make recommendations on areas and programs under its sphere of influence, as well as amplify recommendations made by its fellow HRSA advisory committees in promoting team-based care.

COGME members then broke out into three separate groups to discuss and revise draft recommendations, with the report-out from these sessions to occur on Day 2.

Adjourn

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

Day 2: March 5, 2024

Welcome and Overview

CAPT Kim convened the second day at 9 a.m. ET. After roll call and a brief review of Day 1, each small group reported out.

Group Report-Out

Moderator: Peter Hollmann, MD
Chair, COGME

Group 1: EDUCATION and TRAINING STANDARDS
Drs. Armour Forse (facilitator), Ashruta Patel, Kenneth Veit, Surendra Varma, Beulette Hooks

Reporting for Group 1, Dr. Forse stated that their group agreed that concepts of IPE and team-

based care had been around for many years, and studies have shown good clinical outcomes. However, a common experience was that many medical schools had developed an IPE curriculum to fulfill accreditation requirements, but students rarely recalled receiving any true IPE experiences. There was a group consensus that IPE and team-based care models need to be instilled from the beginning of medical training and continue through residency and into practice.

Dr. Forse noted a program developed through the DoD and the Agency for Healthcare Research and Quality called TeamSTEPPS, an evidence-based framework to optimize healthcare team performance. Despite demonstrated effectiveness in teaching individuals from different health professions to function within teams, it has not been broadly used outside of the military.

Dr. Veit added that the greatest traction where team-based learning occurs is often in the clinic, rather than in didactic classroom instruction. Within his own academic health system, interprofessional teams of students are formed in non-acute, ambulatory care clinics, and work together to share their different perspectives in addressing the complex care needs of the patients. However, in broader health systems, the real-world issues of how to fund such a system may impact sustainability.

Recommendations included:

- Accreditors to better define IPE and mandate meaningful IPE during clerkships.
- Funding to establish regional training sites to provide coaching for IPE; individuals could then bring back best practices for team-base care to their clinics.

There was a comment on the need to move the health system toward a population-based payment system, which could break down some barriers and drive practices to embrace more team-based care models. There was another comment on the need to involve students from a wide range of professions, including nursing, pharmacy, social work, physical therapy, dental, and others.

Group 2: FEDERAL FUNDING FOR GME
Drs. Linda Thomas-Hemak, Erin Fraher (co-facilitators), Ted Epperly, Andrew Bazemore, Paul Jung

Reporting for Group 2, CAPT Jung noted the need to identify some core concepts:

- The definition of IPE training should include training of physicians with students from at least two additional professions (i.e., nursing, pharmacy, social work, etc.).
- IPE training should be focused wherever possible on the community, meaning that improving community-based population outcomes should the primary goal.
- There should be a meaningful IPE curriculum. Simply placing trainees together on a team is not enough. There has to be a goal and a purpose for putting the team together.
- There should be specific population health metrics related to the team-based training.

CAPT Jung said the group noted an overarching need for Congress to enact changes to the current system of GME payments to create a more rational and responsive GME system. Until then, COGME and other stakeholders may only be able to recommend patchwork solutions.

Recommendations included:

- Funding to advance the successful IPE model from the HRSA-funded Area Health Education Centers (AHECs).
- Tripling the funding for HRSA's Preventive Medicine Residency program to train residents and other team members in population health and in measuring population health outcomes.
- Charging that all GME funding mechanism (e.g., CMS payment system, HRSA grant funding, etc.) be directed toward consortia comprised of several health professions schools and multiple training sites.
- Asking CMS to require IPE and population health outcomes for states utilizing the Medicaid 1115 waiver program to fund GME.
- Funding HRSA or some other agency in HHS to provide grants to organizations, such as state primary care associations, to coordinate funding from the Department of Labor and other sources in promoting IPE to meet the health workforce needs of the state.

There was a comment that the original conception of the AHEC program encompassed many of the ideas COGME was discussing in promoting interprofessional teams, improving health care access, and addressing the health needs of the local community. CAPT Kim noted that COGME can recommend appropriation levels for certain programs under the PHS Act Title VII, but not those programs under Part C or D, and the AHEC program is authorized in Part D, which falls under the purview of the Advisory Committee on Interprofessional, Community-Based Linkages (ACICBL). As such, COGME should be careful with the wording of this recommendation. She noted that COGME is authorized in Part E and Preventive Medicine is the only medical specialty authorized in Part E.

Group 3: MEDICARE AND MEDICAID FUNDING
Drs. Peter Hollmann (facilitator), Thomas Tsai, Warren Jones, Leith States, and Joseph Brooks

Reporting for Group 3, Dr. Hollmann stated that health care teams have existed in many forms over the years. The group members discussed examples from their own experience, such as interdisciplinary teams providing pre- and post-operative care to bariatric surgery patients; medical center home teams consisting of physicians, nurse care managers, social workers, pharmacists, and behavioral health providers; and IPE activities in undergraduate education. The group talked about the significant variability of teams—even within one institution, high-functioning teams may form on some units but not others. The group discussed how to create and develop clinical sites that further IPE and promote collegial interactions.

Noting that reimbursement is a critical issue, Dr. Hollmann mentioned the current fee-for-service model may inhibit some areas of team function, leading to calls for a population-based or value-based payment system. Another overarching issue concerned current healthcare workforce shortages, especially in nursing and pharmacy. Thus, any discussion of team-based care must take consider building the workforce across many professions and having both students and practitioners work together. Dr. Hollmann echoed Group 2 on funding consortia of educational institutions.

The group recognized the need for more advanced practice registered nurses (APRNs), and the possibility of reviving and funding a pilot Graduate Nurse Education (GNE) program along the

GME model. However, there was recognition of the need to make sure that schools across many disciplines are adequately funded and provide opportunities for students to train together to break down the current silos that separate students. There was discussion that Medicare has made some changes to bolster team-based care under the Physician Fee Schedule. The group discussed different ways to create classifications and rules to incentivize the development of team-based clinics to serve as training sites. There was also discussion to increase the amount of reimbursement for APRNs and physician assistants, as well as changes to the billing codes to capture services from a wider range of professionals.

Dr. Hollmann commented that all efforts to support team-based care should be centered on serving the patient. He mentioned the need to include measures of patient satisfaction with the care team. There was further discussion about the possible role of Patient Advisory Councils to provide feedback and help more practice settings transition to team-based care. The group also discussed successful Accountable Care Organizations (ACOs), many already established at academic medical centers, that are engaged in team-based care. COGME could recommend the creation of a dedicated center or learning collaborative to support the implementation of team-based care based on the ACO model.

In response to a comment on payment reform to support team-based care models, Dr. Hollmann raised the possibility of developing a recommendation for learning collaboratives for state Medicaid agencies to help them best understand how to leverage Medicaid funding and other state appropriations to sustain interprofessional training program and sites.

There was a further comment about the need to support continuing medical education as a component of lifelong learning to help current providers, both physician and other professionals, learn team-based care components.

General Discussion

There was a comment on the need for the report to cover the impact of team-based care in reducing isolation and burnout, especially for rural care providers. Another COGME member noted that there are few rural models of IPE in the literature. COGME could underscore the importance of studying and understanding successful rural and urban models and their impact on patient outcomes, particularly in opioid use disorder, behavioral health, and maternal mortality.

There was another comment on the need to recognize the barriers within the current healthcare system and look for creative solutions. In addition, team-based care may generate the real impetus to move toward value-based payment models that benefit the public. Another member brought up the efforts of the VA to improve health outcomes in the veteran population, including support for community health workers and health coaches. These individuals are often from the local community and provide patients with valuable resources, and they need to be included in the team training experience.

Council Discussion: Review of 25th Report Draft

Moderator: Peter Hollmann, MD
Chair, COGME

Dr. Hollmann offered an overview of some initial draft sections planned for the COGME 25th Report. He stated that the introduction would focus on why COGME is focusing its recommendations on team-based care in the post-COVID pandemic phase. The report would not present a comprehensive review of team-based care, given its long history in the healthcare system. However, it could cite past reports from COGME and other HHS advisory councils, the current HHS health workforce strategic plan, other stakeholder foundations and organizations, and the National Academies of Sciences, Engineering, and Medicine (NASEM). The body of the report would provide the reasoning for recommendations regarding changes needed in the healthcare environment to support and promote team-based care as well as describe the anticipated improvements in efficiency and quality. The report would also need to outline some metrics of success.

Dr. Hollmann added that the report would need to define team-based care, as well as provide some of the key underlying principles. It would also need to address past barriers and failures in attempts to implement team-based care and the options to overcome them. One section would need to offer some examples of successful programs and models and discuss how these might be scaled up and implemented on a national level.

There was a comment that the goal for the report should not be to say COGME made a particular recommendation resulting in the funding of some new program, but rather that COGME helped set the agenda for propelling innovation in team-based care to drive action downstream. COGME would also need to focus on the correct measurement tools to characterize the real value of its recommendations. There was another comment on the need for two levels of metrics and outcomes: one for measuring team behaviors across the industry and the other for determining the impact of the report.

There was a comment that many leaders in the healthcare system may have become cynical about IPE and team-based care initiatives, given its long history without many successes and the fragmentation of the healthcare system. The COGME report could highlight some successful models to provide an impetus for change.

Dr. Hollmann reviewed the proposed guiding principles:

- The creation and sustenance of teams must be intentional and must include education and training in the general principles of teams.
- Effective teams utilize the right leader for the right task at the right time. Every member must be capable of stepping into a leadership role to best serve the patient.
- The team structure and composition must be specific to the task as required for optimal patient care or for improving the health of the community.
- Teams are a fundamental tool in addressing the lack of diversity in the healthcare system.
- Teams should include members of the community and population served.
- Appropriate training and education depend on clinical care delivery sites that can model team-based care. Clinical delivery sites must be structured and financially supported in team-based care, which may require some fundamental changes in payment models.

There was a comment about a NASEM report that tried to connect optimal team structure and performance to patient success and to the well-being of the team members. Another comment

noted the need to integrate team-based care into workforce projection models, assessments of adequacy, and concepts of workforce plasticity. Workforce availability, composition, and skills will vary across different communities, yet it can be difficult to define the contributions of different team members from different professions and levels of training. Failure to understand and accommodate such differences can derail the development and functioning of teams.

Another member suggested adding to the principles the concept that teams are dynamic over time and that team members bring a variety of lifelong experiences, learning, and attitudes. Another comment noted that teams might grow with the addition of community health workers and other specialists, and specific tasks and roles may be redistributed. However, while the individual responsibilities may shift, the accountability of the team needs to remain constant.

Business Meeting and Public Comment

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

A COGME member raised the issue that a growing number of state legislatures are undertaking efforts to provide alternative career pathways for international medical graduates living in the U.S. who have not completed a U.S.-based residency program. There were further discussions on related programs for U.S. medical graduates who fail to obtain a residency match, thus preventing them from completing their medical training and progressing toward independent practice. COGME members briefly discussed a variety of these proposals and bills and how they reflect states' attempts to bolster the supply of licensed physicians in their jurisdiction, especially those who intend to go into primary care or to practice in rural or other medically underserved areas. However, there was caution expressed about the lack of standardization, as well as the possibility of unintended consequences if the pathways to licensure are not properly designed. There was a comment that COGME may wish to study this activity further at a future meeting.

Public Comment

There were two comments from members of the public:

- Karen Mitchell, M.D., Vice President of Medical Education at the American Academy of Family Physicians (AAFP), offered comments about the value of team-based care. She added that AAFP policies support the principles of relationship-building and teams to provide effective and equitable patient- and population-centered care.
- Mandi Neff, Regulatory and Policy Strategist with AAFP, spoke in support of team-based care, commenting about the need for federal investment in primary care.

Adjourn

CAPT Kim adjourned the meeting at 2:00 p.m. ET.

Acronym and Abbreviation List

AAFP	American Academy of Family Physicians
ACICBL	Advisory Committee on Interprofessional, Community-based Linkages
ACO	Accountable Care Organization
AHEC	Area Health Education Center
APRN	Advanced Practice Registered Nurse
BHW	Bureau of Health Workforce
CMS	Centers for Medicare and Medicaid Services
COGME	Council on Graduate Medical Education
DoD	Department of Defense
FQHC	Federally Qualified Health Center
GAO	Government Accountability Office
GME	Graduate Medical Education
GNE	Graduate Nurse Education
HHS	U.S. Department of Health and Human Services
HPSA	Health Professions Shortage Areas
HRSA	Health Resources and Services Administration
IHS	Indian Health Service
IPE	Interprofessional Education
MSI	Minority-Serving Institutions
NASEM	National Academies of Sciences, Engineering, and Medicine
NCHWA	National Center for Health Workforce Analysis
PHS	Public Health Service
VA	Department of Veterans Affairs