US Department of Health and Human Services, Council On Graduate Medical Education and Rural Based Medical Education

D KEITH WATSON DO, FACOS, FAOADM
PRESIDENT, PACIFIC NORTHWEST UNIVERSITY OF HEALTH SCIENCES
Family Ties to Rural Arkansas

- Father’s Family
- Mother’s Family
Overview

- COGME
- Reasons to do a rural focused medical school—MISSION
- Challenges for Rural Mission medical schools
- Solutions for medical education evolving
- Rewards for communities associated with rural based medical education
COGME – Charges under Title VII PHS

Provide advice and make policy recommendations to the Secretary of Health and Human Services, the Committee on Health, Education, Labor and Pensions of the Senate, and the Committee on Energy and Commerce of the House of Representatives with respect to:

A. The supply, and distribution of physicians in the US;
B. Current and future shortage or excesses of physicians in medical and surgical specialties and subspecialties;
C. Issues relating to foreign medical graduates;
D. Appropriate Federal policies with respect to the matters referenced in A, B, and C including policies concerning changes in the financing of UME and GME;
E. Appropriate efforts to be carried out by hospitals, schools of medicine, schools of osteopathic medicine, and accrediting bodies with respect to the matters specified in subparagraphs (A), (B) and (C) including efforts for changes in UME and GME programs;
F. Deficiencies in, and needs for improvements in, existing data bases concerning the supply and distribution of, and postgraduate training programs for physicians..........
COGME – Charges under Title VII PHS

- Encourage entities providing GME to conduct activities to voluntarily achieve the recommendations of the Council under (E);
- Develop, publish, and implement performance measures for programs under Title VII of the PHS act, except for programs under part (C) or part (D) of Title VII;
- Develop and publish guidelines for longitudinal evaluations (as described in section 761(d)(2) for programs under PHS Act, Title VII, except for programs under Part C or D of that title; and
- Recommend appropriation levels for programs under PHS Act, Title VII, except for programs under Part C or D of that title.
Council On Graduate Medical Education

- Reports to and advises:
  - 1 Secretary of Health and Human Services
  - 2 Committee on Health, Education, Labor and Pensions of the Senate
  - 3 Committee on Energy and Commerce of the House of Representatives
- ADVISORY only—has no authority for action or decision making
- 22 Reports to Congress to date (with several letters and advisories)
- Discussion will Focus on
  - Report 21 and
  - Report 22
- Opinions expressed today are mine (KW) only and do not represent COGME beyond what is expressly written in those reports and advisories.
COGME 21 Recommendations

1. Fund GME at current level and increase funded slots by 3000 more per year
   Explore global or ‘all payer’ funding sources

2. Prioritize GME funding to critical need disciplines such as:
   - Family Medicine
   - Internal Medicine
   - Geriatrics
   - General Surgery
   - Pediatric subspecialties
   - Psychiatry

Prioritize funding for programs who embrace and add new competencies to meet the changing health care system
COGME 21 Recommendations

3. Improve efficiency in training
   Eliminate the transitional year programs and excess non-categorical slots
   Allow GME credit for some or all 4th year medical school activities

4. Criteria for recruiting medical students, as well as GME training requirements, should be revised to align with the physician work force that aligns with the needs of the populations served.
5. GME requirements should be revised to assure patient centered, safe and effective care.

IOM quality elements of safe, effective, timely, efficient, equitable and patient centered should be addressed in training standards.

Additional GME funding should be directed toward innovative faculty development programs to address this recommendation.

Decisions about completion of each phase of education should be based on competency (not calendar based).
6. The nation should invest in medical education research to increase quality and competency in the workforce

IOM should develop a national agenda for educational research

Authorize and finance a National Institute for Health Professions Education
COGME 22 Recommendations

1. GME training should be expanded in ambulatory and community sites to reflect current and evolving practice of medicine

2. A portion of the financial support for GME training in ambulatory and clinical settings should be transferred to the site where training is occurring

3. There should be greater transparency and accountability for IME in order to achieve national health care aims and objectives

Up to 10% of IME should be reserved and redirected to recognize innovation in medical education
COGME 22 Recommendations

4. GME funding for Teaching Health Centers and Children’s Hospitals should be stabilized with dedicated ongoing funding

5. New curriculum is needed to address health care delivery system change and patient and population centered GME

6. There should be further national effort to coordinate and engage underrepresented minority student in health care professions and medical careers. Public support for GME should be leveraged to encourage physician specialists to locate in otherwise underserved regions and communities
7. COGME should be strengthened by reconstituting the Council to provide strategic planning and oversight of GME innovation and funding with responsibility and authority to evaluate the accountability and outcomes of GME.

Funding and programmatic support for COGME should be enhanced and must be adequate to support the strengthened agenda for COGME.
Report 22: Differences between IOM and COGME perspectives

IOM

- No shortage of GME positions - continue to limit growth
- Recommended National GME Policy Committee to oversee GME policy and strategic management
- “Transformational Fund” from IME
- IME accountability is needed

COGME

- Shortage of GME positions AND maldistribution of both physicians and training programs
- COGME agreed and proposed that COGME be authorized and funded to assume that function
- COGME proposed 10% of IME money be reallocated for medical education research. Transformational Fund may hurt small programs
- COGME agrees that IME transparency and accountability is necessary
Suggested/requested the conversion of COGME to be the ‘National GME Policy Committee’ suggested by IOM report

- With proviso that adequate funding and staffing be provided to actually carry forward the administrative work necessary

Reasons:

- COGME has the expertise and knowledge to do this function
- COGME presently has NO funding, staffing of sufficient nature to even convene on a regular basis
- It is not clear that ANY group will be convened to carry forth this IOM recommendation

Answer: “Thank you, COGME is ADVISORY only.”

COGME is moving toward a strategic plan advisory as next major work.
Reasons to establish a rural based medical school

- Address maldistribution in a unique way
  - Recruitment
  - Education in anticipated practice environment
  - Return to practice at completion of GME training
- Access to Care issues are not otherwise addressed
  - County/State mortality and morbidity concerns (Delta region of Arkansas and Missouri Boot as examples)
- Aging population of region’s physician workforce (retirements and shifting workstyles)
- If production of physicians by state’s current medical school is insufficient to meet the needs or,
  - Choices of practice sites by graduates have left health disparities in delta counties or,
  - Retention of graduates is insufficient to meet needs (80.6% of AR graduates stay to practice)
Health Factors

Behaviors

Clinical Care

Social and Economic factors

Physical Environmental factors
Health Outcomes

How long people live

How healthy people feel while alive
Physicians over the age of 60  
(Data from 2012 AAMC Report)

- National Average = 26.5%

<table>
<thead>
<tr>
<th>State</th>
<th>Total Practicing</th>
<th>Over age 60</th>
<th>Percent</th>
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<td>5625</td>
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<tr>
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<td>15259</td>
<td>3996</td>
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<tr>
<td>Tennessee</td>
<td>15556</td>
<td>4119</td>
<td>26.5</td>
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</table>
Challenges for the communities

- Rural challenges
  - Geography/proximity/mindsets
  - Culture of the population—fear of travel etc..
  - Environment for practitioners, spouses, families
    - Amenities
    - Practice needs—call conditions, isolation, equipment, facilities
- Underserved challenges—diverse, economic
  - Culture (note minorities becoming majorities)
    - ‘norms’ - trust factors (NA)
    - Women do not leave home for education (Latino)
    - Family above all else (NA) – schedules and accreditation rules discounted and completion rates impacted
    - Isolation inside the education system (as currently constructed)
  - Exposure to ‘what is possible’
    - Belief that education is possible (knowledge of what is available)
    - Building of self-esteem against cultural biases and values
Challenges for Medical Schools
(especially those focused on rural and underserved populations)

- Faculty at Clinical Training Sites
  - Standard rotations availability
  - Competency based assessments
  - InterProfessional training challenges

- Clinical Sites for training
  - Rural Health Clinics-CHC, FQHC, etc.
  - Critical Access Hospitals
  - Appropriate tertiary care sites for non-primary care rotations

- Graduate Medical Education programs focused in or for rural areas not yet established

- Culture of matriculants and graduates
  - Year III training site versus GME site influences on practice sites

- Student Debt influence on specialty choice (MISSION RISK)
  - Reimbursement issues
  - Private versus public school costs
Challenges for Medical Schools
 especially those focused on rural and underserved populations

- UME Clinical Rotation Material
  - Inefficiency while learning to teach
  - Productivity fears/solutions
  - EHR issues
  - Competition for sites/faculty
  - Competency based curriculum
    - Teaching
    - Assessment
- GME availability
  - Rural hospital finances/volumes and current CMS rules for GME payments
  - Accreditation standards that favor academic health centers (volume and scope related)
Competency Based Education Models
- Colleges and Universities (MOOCS etc.)
- UME
- GME – ACGME

InterProfessional Education

Train UME with rural focus
- Recruit Educate Return model
- Develop curricular elements that highlight rural issues, promote IPE teams and utilize IT enhancements to care (robotics and distance defying technology)

Move/establish GME into areas where graduates will practice
- Dispel the idea this is ‘inferior or sub quality education’
- Migrate from entirely AHC locus to more rural, CHC, CAH and FQHC based rotations
- Develop curricular elements that highlight rural issues, promote IPE teams and utilize IT enhancements to care (robotics and distance defying technology)
College Credit

MOOC or individual study
With Exams
For credit (‘hours’)

Regular ‘credit hour’ degrees

Medical School

Online or hybrid courses with competency based testing

Competency Based Education verified by Entrustable Professional Activities and Milestones

GME/OGME

Lock stepped curriculum (time based) but retrofitted to ‘credit hour’ to get USDE Title IV eligibility

Time based but no ‘credit hour’ designation (attempts at competency completion)

NAS
Linking Medical Education to the Community

Recruit:
- ~50% from rural areas

Educate:
- 75% return to home state for rotations

Return:
- 80+% return to practice
PNWU Programs

- College of Osteopathic Medicine
- Dentistry?
- Podiatry?
- Optometry?
- Physical Therapy?
- Public Health?

Hosted Programs Non-PNWU

- Heritage MAMS
- Heritage PA
- WSU Pharmacy
- Heritage U Nursing
- WSU Nursing
- CWU EMS Degree Programs

Institute for Interprofessional Education

Mission/Vision
Health Care Teams for Rural and Underserved Pacific NW

Feasibility
Interprofessional Education: Core Competencies

Communication
Open, Continuous, Collegial, Direct

Values & Ethics
Respect and Understanding

Roles & Responsibilities
Understanding your role and respecting others

Teamwork
Consider the collective role
Challenge: Clinical Teaching Sites adopting ‘Collaborative Practice’

FIGURE 2: Framework for Action on Interprofessional Education & Collaborative Practice

HOW do we address the ‘shortages’ and/or maldistribution

- Why do we keep doing the same thing over and over and expect a different result (Einstein et al)—illustrates wrong assumptions
  - Produce more physicians (quantitative solutions to address shortages) AS OUR ONLY MANTRA?

- Refocus on the desired result (qualitative solutions to maldistribution)
  - Refocus HOW we educate physicians
  - Refocus WHERE we educate physicians

- DO BOTH for maximal effect !!!
“How” ideas

- More medical schools with a rural and underserved focus
- Faculty Development for preceptors in newer methods of medical education/productivity/and competency based outcomes—"Train the Trainers"
- Develop GME focused on final practice locations (not AHC centric)
- Support rural based hospital practices and hospitals (legislative and public awareness work)
- Develop telemedicine and virtual medical practice elements for enhanced effect in rural based practices
- Etc. Etc.
Opportunities - Good Things to Come for Medical Education

- Competency Based Education – both UME and GME
- Training moving from AHC to more Community Based Sites
- InterProfessional Education will expand and enable more collaborative practice models that will enhance community and rural care
- More individuals with ability to access health care
  - ACA effects
  - Expansion health care providers for rural and underserved areas
- Better and higher quality of care for underserved populations

MISSION
Top 10 reasons to start a rural focused medical school

6) Faculty engagement increases with every student ‘aha’ moment
7) Promotes integrated solutions for health care delivery (ACO and ACH concepts)
8) Lifts community expectations and esteem
9) It’s an economic engine for the home campus and for communities where students train
10) Promotes assimilation of new ideas and innovations into rural communities and facilities
Top 10 reasons to start a rural focused medical school

1) It’s the right and exciting thing to do……
2) Improves quality of care in hospitals and clinics (challenges status quo thinking)
3) It’s an innovative and directed effort to solve maldistribution issue
4) Provides more access to care for patients (allows new enrollees under ACA a place to find care)
5) Provides a pipeline for recruitment of health care providers
Thank You