U.S. Department of Veterans Affairs (VA)
National Academic Affiliations Council (NAAC)
Meeting Minutes for September 27-28, 2023

Ernest Childers VA Outpatient Clinic
8921 South Mingo Road
Tulsa, OK 74133-5841

The National Academic Affiliations Council met in-person and virtually on September 27 and 28 at the Ernest Childers VA Outpatient Clinic VA Eastern Oklahoma VA Health Care System (EOVAHCS). A quorum was present, affording the Council the opportunity to conduct normal business.

Attendance: See Appendix

Day 1: Wednesday, September 27, 2023

Welcome, Announcements, and Introduction of New Members

Ms. Mitchell called the meeting to order at 9:00 AM and provided administrative updates.

Dr. James Hildreth, NAAC Chair, welcomed NAAC members to the meeting and provided the opportunity for members to introduce themselves. Dr. Deborah German was announced as the new Vice Chair of the NAAC.

Dr. Bowman commented on the importance of the NAAC mission, highlighting how, through NAAC's work, the Office of Academic Affiliations (OAA) has developed technical improvements to support its affiliates in the field.

VA Eastern Oklahoma VA Facility and Academic Partnerships Overview

Moncarm Fouche, MD, MHA, Chief of Staff, EOVAHCS, stated the mission of EOVAHCS is to be a Veteran-centered, integrated health organization ensuring excellent health outcomes and a culture of safety through care coordination, research, and education, an organization where people choose to work; an engaged community partner; and responsive to national emergencies. He provided an overview of EOVAHCS, stating it has a main hospital, Jack C. Montgomery Medical Center, in Muskogee, OK, 6 Community-Based Outpatient Clinics (CBOCs), and is constructing a new Tulsa VA Hospital. With an annual medical care budget of more than $380 million, about $4 million of which is VERA funds, EOVAHCS serves nearly 50,000 Veterans, 2,921 of whom are American Indian/Alaska Native (AI/AN).

Jana Baker, D.O., Associate Chief of Staff for Education, EOVAHCS, played a short video on the 100-year history of the Jack C. Montgomery VA Medical Center, which is the first to be named in honor of a Native American, WWI U.S. Army Veteran,

Congressional Medal of Honor recipient. EOVAHCS has opened the nation’s first medical school on Tribal land, and its home-based primary care team is the first to use whole health care in their practice. Dr. Baker stated that EOVAHCS’ academic mission is to provide high-quality, scientifically grounded training opportunities for health professions trainees (HPTs) that emphasize collaboration and innovation in the care of our Veterans and to foster strong academic relationships that ensure future growth in clinical education. She briefed on the current and expanding programs and the academic affiliations at EOVAHCS; EOVAHCS will have over 300 learners in the 2023-24 academic year.

Dr. Hildreth asked how learners from different institutions interact with one another. Dr. Baker discussed how EOVAHCS' efforts at expanding interdisciplinary training and breaking down silos between the service lines have helped to develop collegial relationships. Dr. Hildreth asked how EOVAHCS is expanding their nursing program. Dr. Baker said they are affiliated with Connors State College and the University of Tulsa, as well as a pending affiliation with Oral Roberts University. EOVAHCS has taken full advantage of the national online onboarding system OAA implemented, which has made onboarding much faster.

Dr. German asked how EOVAHCS incorporates research into GME training of MD and DO students. Dr. Baker said their research in that arena is very new and challenging to facilitate due to issues with research reimbursement. She is working on future reimbursable research opportunities.

Dr. Byrne asked about the limitations of expanding the GME programs and if the new facility would alleviate those burdens. Dr. Fouche replied that EOVAHCS is taking those factors into account. Dr. Baker spoke about faculty development opportunities allowing hospitalists to accommodate more residencies.

Dr. Evans asked about home-based primary care and the whole health approach. Dr Baker discussed family medicine residents who rotate in home-based primary care. Dr. Fouche added that there are multi-disciplinary teams, primary-care psychologists who work with interns during home-based visits, and a current plan to implement virtual reality (VR) to support home-based care.

Dr. Thompson asked about developing subspecialty expertise for trainees and the need for faculty development, particularly regarding OAA's Rural Interprofessional Faculty Development Initiative (RIFDI). Dr. Baker said that two EOVAHCS members have participated in RIFDI in the past and that she remains committed to faculty development and knowledge management.

Dr. Bowman asked how students are housed when in residency at the VA. Dr. Baker said EOVAHCS does not offer housing but reimburses residents for travel. Dr. Fouche added that EOVACHS is looking into providing housing in the future.

Dr. Hildreth asked how EOVAHCS interacts with Tribal Nations and Indian Health Service (IHS). Dr. Baker said she works across the street from Cherokee Nation and interacts with OSU College of Osteopathic Medicine (COM). The goal is for medical students to train family medical practitioners at Northeastern Health System and to expand residency and training opportunities to increase access to quality health care.

Dr. Carter asked about space requirements for residency programs. Dr. Baker said that some spaces meet ACGME standards, but EOVAHCS currently needs a dedicated didactic area, one of her main requests to the space committee.

Mr. Robinson asked if EOVAHCS has a simulation center to hypothesize learning interactions in a clinical setting. Derek Ogle said the new hospital will contain a state-of-the-art simulation center that the education department can utilize. Dr. German asked if EOVAHCS has begun to use artificial intelligence and artificial reality in educational programs or patient care. Dr. Baker replied that doctors have used RIFDI funding to secure VR equipment with psychology specialists and interns. One of these interventions is called Bravemind, VR, which will be used in prolonged exposure therapy to treat PTSD. Other development programs include a rehab system for physical rehabilitation and the new nationwide X Series, which will create new environments based on Veteran feedback.

Communities Helping Invest through Property and Improvements Needed for Veterans Act (CHIP-IN) Overview & Updates

Derek Ogle, Chief of Engineering Service, EOVAHCS, presented on the new Tulsa VA Hospital, which is funded through the CHIP-IN Act of 2016 (Public Law 114-294). Mr. Ogle described that the new legislation authorizes the VA to receive up to five donations of property and facilities constructed by donors but requires the donors to fulfill all environmental and historical requirements and comply with any laws and regulations for the area. The CHIP-IN Act allows VA facilities to be constructed much quicker, prevents facilities from being outdated by the time they open, and increases community involvement in VA construction, especially regarding space allocations.

Tulsa was selected as the most appropriate site because of the high volume of Veterans in the Tulsa area not being seen at a VA facility, which costs the VA $34 million annually. The new hospital will provide services to resident Tulsa Veterans, reducing travel and out-of-system care costs; work with OSU to enhance the education of the next generation of providers; and work with OSU to diversify the healthcare services provided. The Ernest Childers VA Outpatient Clinic will continue serving EOVAHCS' s outpatient needs. The new hospital will have 58 inpatient beds, four operating suites, a full array of VA inpatient services, short-stay PACU recovery areas, sterile processing, pharmacy, sub-support areas, and a sky bridge connection to the OSU campus. The public contributed $20 million to the Tulsa VA Hospital project, and the VA will contribute the additional funding, bringing a significant construction budget to the project.

The Veterans Hospital in Tulsa (VHiT) is a non-profit LLC created to manage the development and construction of the new hospital. The role of OSU in the project is to construct a psychiatric hospital on the property and provide additional care and services to Veterans throughout their campus. VA's role is to contribute $151.2 million and assume future ownership and operation. The project started with the conversion of the Kerr Edmondson office building; a 273,000-square-foot 1976 office building donated by the state of Oklahoma. Mr. Ogle briefed on the project, including status, budget, challenges, and projected staffing and equipment needs. The finished building shell will be handed off (as a gift) to the VA in September 2025 and will anticipate receiving patients in January 2026. The savings from the CHIP-IN hospital treating patients within the VA network are expected to surpass building costs in 5 years.

Mr. Lily asked why a minor construction cap of $20 million threshold was applied to contributions to a significant construction project. Mr. Ogle said the threshold is an arbitrary line to demarcate the division between minor and major construction. The market currently finds that more than $20 million is needed to finance construction in the post-COVID environment so that cap must be reconsidered. Mr. Lily asked if the Muskogee VA will be downsized when the new Tulsa hospital is operational. Mr. Ogle briefed on the plan submitted to VISN leadership about how Muskogee will look at the end of the new project.

Dr. German asked if the hospital land grant counted as part of the $20 million contribution. Mr. Ogle explained that the government already owned the land and that, in addition to other real estate gifts, it did not accrue toward the statutory contribution cap. Dr. German asked if the design and demolition process for the Kerr Edmonson building was more expensive than starting from scratch. Mr. Ogle replied that it would have been cheaper to build from scratch. However, the location and historical significance leveraged much of the cost, and the CHIP-IN path will significantly reduce the project completion timeline. At the end of the process, the government will own the project. Dr. German asked if the VA secured state dollars for the project. Mr. Ogle replied that the city of Tulsa and the state of Oklahoma, in addition to OSU and VHiT, were involved in acquiring and donating buildings and land.

Dr. Whelan asked how much input the local VA had in determining how the $20 million would be spent. Mr. Ogle replied that the VA had limited involvement due to the nature of the CHIP-IN authorization, but that OSU created a board in an effort to bring VA executive leadership into the decision-making process. He also discussed the DDA agreement, which identified VA-specific items to be incorporated into the project.

Dr. Evans asked about the facility's long-term financing. Mr. Ogle replied that the likelihood of ever seeing 100% of the Veterans is very low. However, the VA always strives to make the VA system appealing to Veterans, and the cost of providing some of those services in-house is cheaper than in the community. As a new facility, the Tulsa hospital will get activation dollars to ramp up operations and receive VERA dollars as they continue to code Veterans' care.

Dr. Kowalski asked if eliminating congressional approval for funding and eliminating competitive bidding were being considered to reduce approval time. Mr. Ogle replied that CHIP-IN does not involve service-disabled veteran-owned set-aside contractors, and this project's original budget had to be congressionally approved as part of the major construction funding mechanism. Even so, the project received significant congressional support.

Responding to Dr. Hildreth’s question about educational space, Mr. Ogle said that the seventh floor of the bed tower would be dedicated to administrative and academic space, complete with a large classroom and a fully equipped simulation lab. The project scope does not include educational space within the clinical environment, but a resident program on-call space exists.

Dr. Carter asked if there would be a report to Congress on the project status and future needs. Mr. Ogle said yes, a report to Congress and VA will memorialize lessons learned, adding that CHIP-IN could be the only way large-scale construction is done in the future.

MISSION Act Section 403 Overview and Status

John Byrne, DO, FACP, Senior Advisor, OAA, provided background and status updates on the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018. MISSION Act Section 403 authorizes the VA to fund a pilot program that will place at least 100 residents in non-VA facilities to care for Veterans and non-Veterans and reimburse the cost of those services. This authorization has been extended to August 2031. Covered facilities will be selected from physician shortage areas, including local communities designated as underserved by the VA Secretary, identified shortage areas of health professions, or rural/remote areas. Priority will be given to facilities operated by his, Indian Tribes or Tribal organizations. Dr. Byrne provided details on the two pilot models, including covered costs and possible reimbursement processes for residents rotating through the VA under Section 403. Model A: VA reimburses the GME sponsor for the salary and benefits of residents rotating to covered facilities. Model B: VA reimburses covered facility GME sponsor for new GME program startup costs.

Dr. Byrne discussed the implementation of the pilot program and clarified that this is not a grant program and will not continue in perpetuity. It is a competitive Request for Proposal (RFP) process. He discussed the RFP process, selection criteria, and timeline for each model. Dr. Byrne also addressed the reporting requirements for Section 403 of the MISSION Act.

Dr. Evans asked if MISSION Act Section 403 would address rural healthcare needs. Dr. Byrne said it does not explicitly address rural health, and the priority in the legislation itself is the IHS and Tribal organizations. However, Federally Qualified Health Centers (FQHCs) and the Department of Defense (DoD) were also included. Dr. Evans asked if the legislation was limited to resident physicians, to which Dr. Byrne replied in the

affirmative. In prioritizing the order written in the legislation, the VA will not be able to meet the large rural needs.

Dr. German asked how the VA will ensure enough physicians are located in priority areas where the presence of medical faculty is already low. Dr. Byrne said that Model B covers some faculty and startup costs.

Dr. Jung asked about the prioritization of specialties. Dr. Byrne said the legislation does not specify specialties; however, the prioritized facilities would likely need primary care physician and psychiatrists.

Advisory Committee on Tribal and Indian Affairs & Office of Tribal and Government Relations (OTGR) Introductions & Discussion

Mary Culley, Seminole and Creek Air Force Veteran, VA Tribal Relations Specialist, OTGR, Alternate Designated Federal Officer (ADFO), Advisory Committee on Tribal and Indian Affairs (TAC), provided an overview of OTGR, which is a small office of six staff that works with all 574 federally recognized Tribal Nations across the U.S. It mediates relationships between the VA Secretary and any Nation that wants a collaborative working relationship with VA, whether local or national. The TAC was designed to emulate the 12 IHS regions and give a voice to the Nations at a cabinet level. Ms. Culley detailed the scope of past and ongoing collaboration between the VA and Tribal Nations. Collaborative efforts described include increased access to care for Veterans; behavioral health as it relates to suicide prevention; culturally appropriate treatment; counseling services for family members of Veterans; possible housing for VA staff working in small VA clinics; and assisting Veterans and their widow with Promise to Address Comprehensive Toxics (PACT) Act.

Ms. Culley discussed changes in the VA Veterans Justice Outreach Program and the collaborative Memorandum of Understanding (MOU) between Oklahoma City (OKC), VHA Veterans Justice Outreach Program, and the Bureau of Indian Affairs (BIA) to work together to ensure the continued availability of services to Veterans who have been arrested. She also briefed on the VA's reimbursement program with IHS, Tribal health, and two urban clinics in Oklahoma. Since 2012, Tribal and IHS facilities have received over $10 billion in reimbursement to reinvest in patient care.

Dr. Carter asked for clarification on the co-pay exemption. Ms. Culley replied that last year, legislation was passed stating that AI/AN Veterans no longer have to pay a co-pay for emergency VA health care, mainly because AI/AN Veterans tend to use Tribal health care rather than VA health care.

Susan Bray-Hall, MD, Chief of Staff, VA Oklahoma City Health Care System, asked how the AI/AN Veteran population feels about the rollout of telehealth services and training. Ms. Culley replied that it varies from location to location; many elders do not trust it, and many young members are comfortable with the electronic aspect. Each facility has a liaison available to help Veterans who need assistance. Dr. Christensen remarked that

AI/AN Veterans accept telehealth as a care modality. However, most encounters are telephonic due to the broadband limitation in Tribal and rural communities. Rear Admiral (Ret.) Kevin Meeks, MPH, Deputy Secretary, Chickasaw Nation Department of Health Member, TAC, remarked, based on experience with VISN 19 and the Chickasaw Nation, that once AI/ANs experience the telehealth modality, they're much more accepting of it. Peter Vicaire, Tribal Government Relations Specialist, OTGR, Designated Federal Officer (DFO), TAC, replied that VISN 19 has the most telehealth and tele-mental health services of all VISNs.

Dr. Fouche asked what unique feature is responsible for the successful collaboration at EOVAHCS between VA, IHS, and Tribal partners. Ms. Culley replied that she and the OTGR strive to facilitate communication between every stakeholder.

Advisory Committee Management Office Remarks

Jeffrey Moragne, Director, Advisory Committee Management Office (ACMO), briefed on the Federal Advisory Committee Act (FACA), reminding that although the Advisory Committee table was attended by both members and invited guests, only NAAC Advisory Committee members are empowered to act on NAAC business matters, including making recommendations to the VA Secretary. Mr. Moragne reported that the NAAC's spring meeting recommendations are with the VA Secretary, and he encouraged NAAC to continue making recommendations.

VA Health, Discovery, Education and Affiliate Networks (DEAN) Recorded Remarks

Carolyn M. Clancy, MD, MACP, Assistant Undersecretary for Health, Discovery, Education, and Affiliate Networks (DEAN), delivered a pre-recorded presentation acknowledging and thanking EOVAHCS personnel and NAAC members. She discussed the MISSION Act Section 403 and mentioned that the VA continues expanding affiliations to minority-serving institutions with health professions education programs. Dr. Clancy emphasized the constant pursuit of a diverse and culturally attuned workforce focused on advancing excellence for the diverse population of Veterans that the VA is privileged to serve. She added that NAAC meeting discussions and recommendations aid in this pursuit, and she looks forward to seeing the changes as they advance the future of health care in the VA and the country.

Overview of Healthcare in Tribal Communities

Loretta Christensen, MD, MBA, MSJ, FACS, Chief Medical Officer, IHS, briefed on IHS's history and mission, emphasizing that every effort is made to recognize the obligations and responsibilities to Indian residents on a non-discriminatory basis. IHS provides a comprehensive health service delivery system for approximately 2.56 million AI/ANs from 574 federally recognized tribes and 41 urban sites (considering that half of the U.S. AI/AN population lives off the reservation). Tribal partners run 279 IHS health centers.

Dr. Christensen said IHS is not currently funded for academic affiliations, even though all medical providers train at training hospitals, so starting new ACGME-approved residency programs positively impacts patient care, medical education, hospital operations, and the community. She provided research data on the benefits of GME residency programs and teaching hospitals, stating that GME programs are associated with higher quality of care. IHS's goals and objectives for GME include training physicians to be able to practice independently with competence and compassion in any setting; training academic and community leaders; creating cultural adaptation and knowledge; assuring a high-quality educational experience for residents and a safe experience for our patients; and enhancing recruitment, retention, and quality of care. Dr. Christensen discussed the GME programs in Indian Country and OSU College of Osteopathic Medicine at the Cherokee Nation, the first medical school on Tribal land. She stated that there needs to be an increase in partnerships with academic medical centers, onsite clinical care, specialty coverage either at larger facilities or regionally, participation in ECHO sessions and continuous learning, support for residency planning, advocacy for mandatory rural rotations in medical schools, incorporating social determinates of health (SDOH) into residency training, and advocacy with the Center for Medicare & Medicaid Services (CMS) for the reimbursement pathways for I/T/U residency rotations and programs.

Dr. Christensen discussed collaborations between IHS and VA, including coordinating MISSION Act implementation to develop medical residency programs at IHS Federal, Tribal, and urban facilities. She further briefed on a MOU signed in October 2021 to improve the health status of AI/AN and continue their work on the operational plan with upcoming Tribal consultation. Dr. Christensen also discussed that there are no co-pays in IHS and the impact of location and travel time on care.

Dr. Christensen discussed AI/AN military service census data, including war-time service statistics, highlighting that of the 11.3 million AI/AN in the country, comprising 3.4% of the U.S. population, 10.5% of eligible AI/AN have served compared with 9.6% of eligible non-AI/AN served. She briefed us on the federal services offered to the 394,439 AI/AN Veterans, including VA and IHS data illustrating the number of active Indian registrants receiving care. Dr. Christensen further discussed recent mental health trends among AI/AN Veterans. Suicide rates are inordinately high among all Veterans. However, age-adjusted suicide rates among AI/AN Veterans in the VHA cohorts have more than doubled (19.1 to 47.0/100,000 PY) over the 15-year observation period. In response to these concerning statistics, IHS has implemented partnerships to create early prevention. She said that AI/AN mental health strategies in the DOD are managed through individual commands, not a centralized function of DHA.

Dr. German asked if it would benefit all residents in VA to rotate through IHS. Dr. Christensen replied that all collaboration between the services is valuable and that the exchange between IHS, VA, and academic medicine should go each way. Dr. Kowalski asked about the current capacity of medical students to apply for a month's rotation to

IHS. Dr. Christensen replied that IHS is in the process of rebuilding its pre-COVID rotation information system.

Dr. Whelan asked about the use of virtual connectivity in the VA-IHS resident exchange initiative. Dr. Christensen remarked that they are about to establish a pilot program for tele-oncology because IHS does not have access to much cancer care. Ms. Culley stated that the NAAC should think more about disaggregating AI/AN women Veteran's health to address better the specific needs of that demographic and the current composition of tribes in the covered region. She also emphasized asking prospective patients about military service as opposed to Veteran status in onboarding documents because a majority of female AI/AN Veterans do not consider themselves Veterans. Dr. Christensen concurred. Mr. Meeks remarked on current developments in the Tribal sector.

Dr. Evans asked about the IHS's population health approach to service delivery. Dr. Christensen discussed the Hill Fellowship at UCSF, stating that they deliver care holistically and inclusively.

Office of Public and Intergovernmental Affairs (OPIA) Presentation and Discussion

Zaneta Inez Adams, Deputy Assistant Secretary, OPIA, presented an overview of OPIA, which is responsible for engaging with state, local, Tribal, and international leaders, as well as the White House's Office of Rural Engagement, the Center for Faith-Based and Neighborhood Partnerships, and a pacific advisor with the Freely Associated States and the Compact of Free Association (COFA), and to be a connector for a variety of components of Veteran health care. OPIA's objective is to make recommendations to the VA Secretary, the White House, and the committees and councils regarding the challenges Veterans and stakeholders are seeing. Outside of Tribal governments, OPIA engages most often with the states. Ms. Adams remarked that staying connected with state VA leaders is essential and that the government should not take actions that impact the tribes without consultation. Ms. Adams asked the NAAC to consider, as they move forward with their work, where they think there is a gap in care.

Panel Discussions

Jana Baker, DO, Associate Chief of Staff for Education, EOVAHCS, introduced the panel topic, asked the panelists about their experience training and teaching at EOVAHCS, and moderated questions. When asked about the strengths of the clinical training opportunities at EOVAHCS, panelists replied that the most significant strengths are the clinicians' and clinical educators' passion for serving Veterans and integrating different disciplines. Panelists shared some challenges they've encountered, including the fact that the VA system's size can make it challenging to connect other services to ensure a smooth transition, navigate the antiquated CPRS electronic health record, and send complex cases out of the VA into the community. Dr. Whelan asked what the most significant challenge in VA service is. A panelist who recently joined the VA said the

amount of onboarding paperwork required was burdensome. Another panelist added that when HPTs are deleted from the system when they are away from the VA for several months, getting them back into the system is a hassle.

Dr. German asked if the panelists see any obstacles for the spouses and families of Veterans who may not have the same access to care as the Veteran. Panelists discussed the significant support coming from social workers and case managers. Panelists remarked that they do see instances in which a spouse does not receive the same quality of care as the Veteran, and they shared some of the programs EOVAHCS is in the process of expanding that will help spouses and caregivers, including the CHAMPVA program that allows spouses to receive care in the VA system depending on income eligibility.

Dr. Evans asked if onboarding complications are attributable to regional versus national policies and procedures. Panelists agreed that the primary source of the hardship is regional, often related to staffing availability, and there are some national inconveniences like IT deactivating accounts. The panelist also discussed the health professionals' training registration and tracking system, which has been a 10-year effort; 50% of facilities are currently using it, and it will be mandated in the future.
The feedback reflects that it's greatly facilitating the onboarding process.

Dr. Kowalski asked what the VA does to foster and maintain respect and customer service shown by all staff members toward Veterans. A panelist relayed their experience with how the fiber of Veteran-centered culture becomes woven into the fabric of VA care. A panelist noted the culture of humility she witnessed throughout VA and EOVAHCS.

When asked about their recommendation to the NAAC, panelists emphasized involving physicians and clinicians in the design process for the new CHIP-IN hospital in Tulsa to ensure state-of-the-art equipment and facilities. Another panelist emphasized recruiting board-certified physicians willing and able to train fellows and residents and ensure adequate research space.

Strategic Academic Advisory Council (SAAC) Update

Anthony Stazzone, MD, MBA, FACP, Chief Medical Officer, MidSouth Healthcare Network (VISN 19) briefed on the SAAC. The SAAC renewed its charter, which now requires a minimum of two annual meetings; the third meeting for FY23 will be on October 27th. The SAAC recently increased allied health trainee stipends by 3%. There will be a minimum 1% increase for hard-to-recruit specialty clinical areas to be more competitive with non-VA trainee programs. OAA, in partnership with SAAC, has been making recommendations and will continue to follow through to get more standardization of training programs across the board.

Council Discussion and Recommendations

Dr. James Hildreth discussed two topics as recommendations for Secretary consideration:

- **The NAAC supports the adherence to the Department of Veterans Affairs' Program Guide for Space Planning Criteria, PG-18-9, Chapter 402: Educational Facilities, which incorporates designated and appropriately designed education space into all newly constructed or renovated healthcare facilities. This includes the Veterans Hospital in Tulsa (VHiT), which will be one of the first hospitals to be built under the Communities Helping Invest through Property and Improvements Needed for Veterans Act of 2016 (CHIP-IN Act). Appropriately designed education space should include health professions trainee workrooms, call rooms, conference meeting space, simulation training centers and allocated space at inpatient nursing stations.**

- **The NAAC recommends that physicians, nurses, and other healthcare professional stakeholder(s) be included in local facility space planning and designing activities to provide clinical expertise in the designing and layout of newly constructed or renovated clinical space. This is necessary to ensure full functionality and optimal usage of space for clinicians and health professions trainees (HPTs).**

Recommendations received voice support by council members present.

Public Comments

Dr. Fouche commented on the planned design of education space at the CHIP-IN hospital; due to the CHIP-IN Act restricting the funds available to the project and unforeseen COVID-related inflation, those plans had to be scaled back in the present phase. He also mentioned that the clinical staff has been very involved with planning the CHIP-IN hospital in partnership with VHiT.

Ms. Bray-Hall discussed systems thinking in public health that the VA offers and acknowledged the VA's Chief Resident for the Quality and Safety program, which she described as the most essential thing that can be done in this growing and changing time. She also commented on whether GME affiliates consider taking a job at the VA as second-tier training since they would be paid much higher at a university hospital, and the increasingly restrictive definitions of clinical time and education time are also a cause of concern.

Megan McArthur, PsyD., Neuropsychologist, GME Expansion Project Manager at EOVAHCS, discussed RIFDI-funded research that trains clinicians to become researchers and the PREP.

Final Comments and Adjournment

Dr. Hildreth thanked the Council and adjourned the meeting at 4:00 P.M.

Appendix: Attendance Records

Council Member Attendance

Marjorie A. Bowman, MD, MPA (Ex-Officio), Chief Academic Affiliations Officer, Office of Academic Affiliations; Loretta Christensen, MD, MBA, MSJ, FACS (Ex-Officio) Chief Medical Officer, Indian Health Services; Arthur Evans, Jr., PhD, Chief Executive Officer and Executive Vice President, American Psychological Association; Deborah German, MD, Vice President for Health Affairs, Founding Dean, UCF College of Medicine; James E. K. Hildreth, PhD, MD, (Chair), President and Chief Executive Officer, Department of Internal Medicine, Meharry Medical College; Paul Jung, MD, MPH, FACPM (Ex-Officio), Captain, United States Public Health Service (USPHS), Director, Division of Medicine and Dentistry, Health Resources and Services Administration (HRSA); Timothy Kowalski, DO, D.FRACN, Vice Provost for Professional and Public Relations, American Osteopathic Association; Ryan Lilly (Ex-Officio), Network Director, VISN 1; Christopher Robinson, MS, MBA, CPO, ATC, FAAOP (D), Clinical Resource Director, The National Commission on Orthotic & Prosthetic Education, Assistant Professor of Physical Medicine and Rehabilitation, Northwestern University's Prosthetics Orthotics Center; Anthony M. Stazzone, MD, MBA, FACP (Ex-Officio), Network Chief Medical Officer, VA MidSouth Healthcare Network, VISN 9; Alison J. Whelan, MD, Chief Medical Education Officer, Association of American Medical Colleges (AAMC).

Council members unable to attend:

Susan Bakewell-Sachs, PhD, RN, FAAN, Vice President, Nursing Affairs and Dean, School of Nursing, Oregon Health & Science University; Eric Elster, MD, FACS, FRCSEng (Hon.), CAPT, MC, USN (Ret.), Dean, School of Medicine, Professor of Surgery, Uniformed Services University (Ex-Officio); David Henderson, MD, Vice President for Equity, Diversity and Belonging, Medical Education, American Medical Association; Maga Jackson-Triche, MD, MSHS, Assistant Vice Chancellor and Health Executive Advisor for Diversity, Equity, and Inclusion (DEI), University of California San Francisco; Christopher Loyke, DO, FACOFP, Dean and Chief Academic Officer Lincoln Memorial University – DeBusk College of Osteopathic Medicine (LMU-DCOM); Thomas O'Toole, MD, Deputy Assistant Under Secretary for Health for Clinical Services, Quality and Field Operations, VA; Elena Rios, MD, MSPH, FACP, President & CEO, National Hispanic Medical Association; Kelly R. Ragucci, PharmD, FCCP, BCPS, Vice President, Professional Development, American Association of Colleges of Pharmacy (AACP); and Meredith Wallace Kazer, PhD, CNL, APRN, A/GNP-BC, FAAN, Dean and Professor, Fairfield University School of Nursing.

VHA Staff attending (all are OAA staff unless specified otherwise):

Zaneta Inez Adams, Deputy Assistant Secretary, Intergovernmental Affairs, OPIA; Jana Baker, DO, Associate Chief of Staff for Education, EOVAHCS; Stanley Brown, DO, Hospitalist, EOVAHCS; Susan Bray-Hall, MD, Chief of Staff, VA Oklahoma City Health Care System; Stanley Brown, Hospitalist, EOVAHCS; John Byrne, DO, FACP, Senior Advisor; Larissa A. Emory, PMP, CBP, MS, Management and Program Analyst (Alternate Designated Federal Officer for the NAAC); Moncarm Fouche, MD, MHA, Chief of Staff, EOVAHCS; Jeannie Howard, Management Analyst; Hannah Jayroe, MD,

Vascular Surgeon, EOVAHCS; Melissa Johnson, Health Behavior Coordinator, EOVAHCS; Megan McArthur, PsyD., Neuropsychologist, GME Expansion Project Manager, EOVAHCS; Nellie Mitchell, MS, RHIA, Program Analyst (Designated Federal Officer for the NAAC);Josiah Morris, TCF Healthcare Engineer, EOVAHCS; Derek Ogle, Chief, Engineering Service, EOVAHCS; Mark Randel, Chief of Surgery, EOVAHCS; Christy Stanfield, CRT Manager, Acting Deputy Chief of Staff, EOVAHCS; Jennifer C. Thompson, MD, MPH, Associate Chief of Staff for Education, Orlando VA Health Care System; Cheryl Whitney, Public Affairs Specialist; Matthew Wilkett, DO, Cardiologist, EOVAHCS; and Jennifer Wrensch, Program Support Specialist, EOVAHCS.

VA Staff Attendance
Mary Culley, Alternate Designated Federal Officer (ADFO), TAC, Tribal Government Relations Specialist, OTGR; Rear Admiral (Ret.) Kevin Meeks, MPH, Deputy Secretary, Chickasaw Nation Department of Health Member, TAC; Jeff Moragne, Director, Advisory Committee Management Office, VA; and Peter Vicaire, Designated Federal Officer (DFO), TAC, Tribal Government Relations Specialist, OTGR.

Members of the Public attending:
Dennis Blankenship, DO, Interim Dean, OSU Collage of Osteopathic Medicine; Kennita Carter, MD. Chief, Graduate Medical Education Branch, Division of Medicine and Dentistry, Bureau of Health Workforce, HRSA; Fungchow (Alex) Chiu, PhD, Senior Program Manager, Office of Research and Development; Sharum Maggie, U.S. Senator James Lankford; Mousumi Som, DO, Internal Medicine, OSU; Joanna Tyree, Constituent Services Representative, U.S. Representative Kevin Hern; Jacqueline R. Wall, PhD, Director, Office of Program Consultation and Accreditation and Associate Executive Director, Education Directorate, American Psychological Association; Gregory Woitte, Chief Medical Officer, IHS.