

GME ENHANCEMENT: EDUCATIONAL INNOVATION

1. PURPOSE

a. Request for Proposals for Educational Innovation

This is a Request for Proposals (RFP) for graduate medical education (GME) Enhancement: Educational Innovation. The RFP provides information, policies, and application procedures to Department of Veterans Affairs (VA) facilities and Veterans Integrated Service Networks (VISNs) that wish to submit applications to the Office of Academic Affiliations (OAA) for additional physician resident positions **for Academic Year 2010-2011, which begins July 1, 2010.**

The Educational Innovation RFP is a part of VHA's implementation of the recommendations of the Federally Chartered Advisory Committee on Resident Education. This RFP allows facilities to request new physician resident base positions to enhance their ability to care for veteran patients by redesigning medical education and patient care. **Only facilities and programs willing to transform established systems of education and patient care should apply.** Applicants are expected to demonstrate creative approaches to redesigning educational processes for one or more specific GME programs. Program-specific requests are limited to ACGME-accredited programs. ***Only training years and programs that are accredited by the ACGME and required by the American Board of Medical Specialties qualify for funding under this initiative. Specifically, NON-ACCREDITED programs and extra, non-accredited training years in accredited programs are NOT eligible for funding.***

This year sites may also apply for the following:

- (1) **Associated health¹ trainee positions** in accredited programs when these are fully integrated into an interprofessional model of collaborative care for both the physician residents and the associated health trainees.
- (2) **A Chief Resident in Quality and Patient Safety position** (non-accredited) when there is a strong curriculum outlined for the position, when there are a minimum of 8 other accredited positions in the same specialty training program, and when the availability of a dedicated chief resident position would enhance the educational innovation at the facility and promote faculty development. [See below for further details regarding this possible application.]

b. Eligibility to Apply.

- (1) **Applicant facilities and programs** must be willing to transform established educational and patient care systems in order to:
 - (a) Enhance education and the quality of care;
 - (b) Promote professionalism, patient-centeredness and continuity of care;
 - (c) Incorporate residents into interdisciplinary and interprofessional models of care;

¹ Note: 'Associated Health' includes all health professional disciplines apart from physician and dentist training programs - i.e., nursing, pharmacy, podiatry, psychology, audiology, social work, etc.

- (d) Actively engage residents in systems-based patient safety and quality improvement activities; and
- (e) Support the professional development of faculty and other caregivers.

Note: Application under the Educational Innovation RFP requires a **higher level of institutional and program support and demonstrated commitment** than application under the other GME Enhancement RFPs. The same facility may apply under the “Critical Needs and Emerging Specialties” or the “New Affiliations and New Sites of Care” RFPs in addition to this RFP.

(2) Facilities committed to continuous improvement in education and clinical care may request positions in **exemplary GME programs**, as evidenced by their accreditation history and an established track record of or strong commitment to innovation in the clinical learning environment.

(3) The application requires close collaboration with affiliated sponsors of accredited residency training programs. Applicable requirements of the Accreditation Council for Graduate Medical Education (ACGME) and the program-specific Residency Review Committee (RRC) must be addressed in the proposal. **Programs are encouraged not to feel restricted by existing RRC program requirements. However, any proposed innovations likely to diverge from any ACGME program requirement(s) must be identified in advance and any necessary waivers will have to be sought from the appropriate Residency Review Committee (RRC).** Applicants should explicitly delineate which requirement(s) may require a waiver from the relevant RRC. When in doubt, contact VA’s Office of Academic Affiliations (OAA) and/or the chair of the relevant RRC. If the RRC is contacted, such contact must be documented and included in the proposal. OAA will work collaboratively with applicants, the ACGME, and appropriate RRCs to seek any necessary waivers.

(4) **Program eligibility requirements** (must be documented in the application):

- (a) Must have completed 2 accreditation cycles for at least 8 years in good accreditation standing (i.e., no adverse actions such as probation or ‘accreditation with warning’) and with a current minimum of a 4-year accreditation cycle;
- (b) Must have ABMS (American Board of Medical Specialties) board examination rolling 3-year pass rate of greater than or equal to 80%;
- (c) Must agree to submit annual reports to VA, and the ACGME with analysis and summaries of outcomes of the innovations; and
- (d) Must be willing to participate in joint planning and faculty development activities involving VACO/OAA and other VA innovation sites,

(5) The application requires support from the local VA bodies that supervise GME and from the sponsoring institution’s Designated Institutional Official (DIO) and Graduate Medical Education Committee (GMEC).

(7) Requested positions should be in programs in which the facility and the affiliated program sponsor are able to fill the positions requested for AY 2010-11 (beginning July 1, 2010).

(8) Requested positions should be in areas where the facility has sufficient clinical workload, flexibility to adopt new models of care, and opportunities for educational activities to support the resident positions requested.

(9) Requested positions must be in areas where the facility and the program meet the following supervising faculty requirements:

- (a) There must be sufficient, high caliber supervising practitioners or faculty in the appropriate specialty to provide a high quality educational experience, exemplary resident supervision, and enthusiastic participation in the innovation initiative;
- (b) The facility and faculty must be committed to educational innovation and, where necessary, clinical system re-design;
- (c) Faculty should be willing to undertake professional development as needed to further their abilities to participate in the initiative; and
- (d) Faculty should be willing to work with content experts outside their respective specialty areas (e.g., educational evaluation professionals, quality improvement and patient safety experts, system-redesign specialists).

(10) Applicant facilities must be willing to provide the following:

- (a) Protected teaching time for VA-based faculty;
- (b) Support for program oversight, administration and evaluation;
- (c) Support for VA-based faculty professional development; and
- (d) Protected time for residents to engage in relevant educational activities.

2. BACKGROUND

See ATTACHMENT C.

3. FOCUS AND SCOPE

a. What is educational innovation?

For the purposes of this RFP educational innovation is viewed mainly from a continuous quality improvement perspective and may include a host of *actions that seek to improve education and the clinical learning environment*. Transformational approaches based upon a persistent or continuous approach to improving existing systems (“system redesign”) and the use of *measurable educational and clinical outcomes* are strongly encouraged. Proposed innovations should:

- (1) Demonstrably enhance both education and patient care;
- (2) Impact as many residents in the targeted GME program(s) as possible; and
- (3) Have the potential to be generalizable across the VA health care system as a whole, within programs of a specific type or multiple specialty types.

b. Examples and features of educational innovation:

Educational innovations may be focused upon one or more of the following:

- (1) Continuity of care
- (2) Patient-centered care
- (3) Patient safety and quality improvement
- (4) Interdisciplinary or “collaborative” care
- (5) Chronic care models
- (6) Simulation training

- (7) ACGME competencies
- (8) Professionalism
- (9) Participation in a Veterans Engineering Resource Center (VERC) project²

The educational innovation project (EIP) sponsored by the Internal Medicine RRC is an example of a program with transformational potential. EIP programs have been largely focused on enhancing ambulatory care experiences and continuity of care. The chronic care model of healthcare delivery has been prominently featured and there has been extensive use of health outcomes data to guide improvement efforts.

Making use of data readily available from VA's electronic health record system would be a potentially transformative innovation if feedback were provided to residents and used to guide improvements in their practice patterns. Changes of this type would allow GME programs to address the ACGME's "Practice-Based Learning and Improvement" and "Systems-Based Practice" competencies in a more satisfactory fashion than is presently possible. Moreover, having residents involved in quality improvement efforts via interdisciplinary and/or inter-professional teams can be extremely valuable for the hospital or clinic as well. Leveraging the knowledge that residents have of the weak points in the delivery system can have a powerful impact on the redesign of clinical care models.

Several successful Educational Innovation RFPs in the previous award cycles utilized similar models to those being employed by the EIP project, and several facilities (including Indianapolis and San Francisco) serve as both Internal Medicine RRC and VA innovation sites. ***Internal Medicine (and other) applicants in the present award cycle are encouraged to follow the same principles, and may want to contact present GME innovation sites for guidance.*** Lead investigators at these (and other) sites are available upon request (contact: Barbara.Chang@va.gov). ***Similarly, current EIP sites with VA affiliations who have not already done so are encouraged to consider expanding their innovation(s) to the VA.*** One of the most important outcomes of VA's Educational Innovation project is the development of a community of educators, evaluators and clinicians committed to transforming the present educational and clinical environment. A number of newly proposed ACGME-sponsored innovation pilots focus on duty hour limits and collecting data to support whether limiting duty hours actually does improve resident training and/or patient safety.

Indianapolis has developed a model program for Chief Residency in Quality and Patient Safety that includes training the Chief Resident in QI methods and attending the National VA Patient Safety Training, participation in patient safety rounds, root cause analyses, and working directly with the QI and Patient Safety managers. The Chief Resident also spends time teaching and supervising residents in patient safety and QI. Specifically, "The QI chief will also facilitate the "resident as mentor" CQI week for PGY-3s in their continuity clinic. The clinical reminders and quality indicators curriculum, including "resident report cards," will be updated annually and delivered in part by the QI chief to the residents for each PGY." Other **examples** of the Quality and Patient Safety Chief Resident curriculum include the following:

- a. "Annual review of hospital and outpatient Quality Indicators, and development/update of resident curriculum around clinical reminders
- b. Research

² Note: approved VERC sites would have to indicate how they would integrate physician residents into the VERC project.

- i. The QI chief will be expected to choose one major project under one arm of the REACH (Residency Education Advancing and Changing Healthcare) proposal along with a suitable mentor in order to produce one scholarly paper, poster, or presentation as first author.
- ii. The QI chief will be expected to collaborate on at least one other scholarly project, preferably within another area of REACH.³ This project may be with another chief resident or a faculty member.”⁴

c. How can the addition of a few residents lead to a greater focus on innovation in an entire program?

Few residency programs today allow residents the *time* to participate fully in patient safety or quality improvement activities and to participate in explicitly related educational activities. Even limited additional resources could provide the flexibility for GME programs to engage residents more fully in self- and system-improvement efforts. If programs are struggling to cover clinical service commitments within the constraints of the duty-hour rules, the addition of a relatively small number of positions might allow an entire program the flexibility to innovate. Moreover, innovation in one portion of the program might have a ripple effect on the entire program. Programs are encouraged to allow many or even all their residents to participate in a meaningful way in educational innovation. For example, the addition of a few residents could allow greater ambulatory rotations at the VA or greater time in a QI rotation or Patient Safety.

4. FACILITY AND PROGRAM EXPECTATIONS

a. Facility and Program Structure and Leadership.

Facilities approved for Educational Innovation positions must have a strong affiliation with accredited programs in good standing, creative educational leadership – both at the VA and the affiliate – and an appropriate educational infrastructure. Successful facilities must be willing to transform established educational systems in order to enhance education and patient care and meet the other eligibility requirements in 1.b. Program design, implementation and evaluation will require the active involvement of the appropriate program directors, service chiefs and departmental chairs and strong commitment from the VA facility Designated Education Officer (Associate Chief of Staff for Education or equivalent) and VA Chief of Staff. *Early and on-going support from the Medical Center Director and VISN leadership will be necessary to free up the resources necessary for the program to flourish.*

b. Program Implementation.

Facilities may apply for positions to expand training opportunities if they are willing to foster and support implementation of educational innovations for any ACGME accredited program. Non-accredited programs or non-accredited training years are NOT eligible for support under this RFP. Positions awarded will begin July 1, 2010.

³ For more information on “REACH,” see http://www.acgme.org/acWebsite/RRC_140/EIP_present/eip_Indiana.ppt

⁴ Quoted from the Indianapolis VAMC EIP program description.

c. Evaluation and post award follow-up.

Educational Innovation awardees will be viewed as pilot sites for initiatives that may ultimately have a far-ranging impact on clinical care models throughout VA. ***Educational Innovation applications should be structured as quality improvement or research projects with special emphasis on objective educational and clinical outcomes assessment.*** Desired outcomes must be viewed from the perspective of the goals and objectives of the innovation. Sites must be willing to report and communicate with OAA and the appropriate RRCs on a regular basis, and will be expected to share their results at regional and national forums and prepare them for publication.

5. PROGRAM APPLICATIONS

The facility must submit the information requested to include:

Letter of Intent (LOI) is due April 15, 2009. Submission is electronic via e-mail (see Attachment A for specific instructions).

Formal application is due July 2, 2009 using an online submission process (see Attachment A for specific instructions).

6. POLICIES

a. Governance. The Office of Academic Affiliations (OAA) maintains overall responsibility for the administration of VA's GME Enhancement Program. All programs receiving positions through this RFP will comply with the Program Requirements for Residency Education as published in the current Graduate Medical Education Directory⁵ and with VA provisions for the training of physician residents.

b. GME Program Sponsorship. All positions requested through this RFP must be in ACGME-accredited residency programs sponsored in the name of an affiliate. No new residency programs sponsored in the name of a VA facility may be initiated. Likewise, no expansion of existing VA-sponsored programs may be requested under this RFP.

c. Associated Health Program Sponsorship. All positions requested through this RFP must be in programs accredited by the appropriate discipline.

d. Appointment and Compensation of Physician Residents.

(1) **Appointment authority.** Appointments will be made under 38 U.S.C. 7406.

(2) **Stipend determination.** The stipends of individual residents will be based on their PGY levels (or equivalent per OAA policy) and on VA stipend rates based on the local indexed hospital. Resident positions can be paid directly or reimbursed under a disbursement agreement only for the time spent in educational activities at the VA facility with excused absences as defined by VA policy (e.g., didactic sessions).

⁵ Graduate Medical Education Directory 2007-2008 Including Programs Accredited by the Accreditation Council for Graduate Medical Education. (Updated annually). American Medical Association. Chicago, IL 2007. Alternatively, see <http://www.acgme.org>.

e. Appointment and Compensation of Associated Health Trainees.

- i. **Appointment authority.** Appointments will be made under 38 U.S.C. 7405(a)(1)(D).
- ii. **Stipend determination.** The stipends of individual AH trainees may be requested as full-time or part-time assignments. Please check with OAA (Dr. Robert Zeiss) regarding appropriate stipend rates for specific professions.

f. VACO Support. OAA will provide funds to VA facilities for residents' stipends and fringe benefits. Funding of residents' stipends and benefits through a disbursement agreement is recommended. Disbursement agreements cannot fund administrative costs of residency training programs. Currently, VISNs receive approximately \$64,000 per year in VERA funds on behalf of their network facilities as indirect educational support for each physician resident position allocated. *Facilities applying under the EI RFP are particularly encouraged to use VERA-allocated funds in support of education (e.g., protected time for existing faculty, hiring additional faculty or administrative staff, or paying a pro rata share of ACGME accreditation fees).*

g. Liability. Residents will be protected from personal liability while providing professional services as a trainee at a VA facility under the Federal Employees Liability Reform and Tort Compensation Act, 28 U.S.C. 2679(b)-(d).

h. Expenses. Except as specified above, expenses connected to the residents' recruitment, educational activities, or research are not funded under this program. Transportation to the VA facility and housing arrangements are the sole responsibility of the selected residents.

7. EVALUATION CRITERIA FOR SELECTION OF SITES & PROGRAMS

Applications will be evaluated by a panel of peer reviewers who have expertise in GME, educational evaluation, and where appropriate, expertise in associated health training disciplines. The following criteria will be used to evaluate proposals.

a. Affiliations. The VA facility must be affiliated with a sponsoring institution (medical school, teaching hospital, or military treatment facility) that provides ACGME-accredited residency training and has ACGME institutional approval. A strong affiliation relationship and collaboration in the preparation of the application must be evident in the proposal as evidenced in the support letters (see Appendix A).

b. Site Characteristics. The facility must provide evidence of committed leadership, appropriate clinical and educational activities, and sufficient workload to support a culture of excellence in graduate medical education. The site must demonstrate the following:

- (1) Willingness to modify and re-design established educational & clinical systems using a transformational approach [document in the Core Narrative & facility support letters] to:
 - a. Enhance the quality of care and education
 - b. Support the professional development of faculty and ancillary staff
 - c. Incorporate residents into inter-disciplinary models of care
 - d. Actively engage residents in systems-based quality improvement activities

- (2) VISN, facility, and clinical leadership commitment to build and sustain an outstanding learning environment. Flexibility and commitment to innovation in education and clinical care delivery is essential. [To be documented in the support letters and the core narrative.]
- (3) Strong leadership by the VA facility's Designated Education Officer (DEO) and Chief of Staff. The DEO (ACOS/E or equivalent) must have appropriate qualifications and experience. The Chief of Staff must be committed to educational and clinical re-design efforts, and must be prepared to champion the innovations with facility and VISN leadership. [Support letters & all components of the proposal.]
- (4) A strong partnership between the VA facility and its academic affiliate(s), with a record of committed leadership by the academic program director(s) and department chair(s). [Support letters, Program Narrative Description, & core narrative.]
- (5) Past experience providing excellence in graduate medical education, including outstanding GME training programs and advanced learning opportunities at the site.
- (6) Past experience with or commitment to patient-centered care, continuity of care delivery and interdisciplinary and inter-professional training.
- (7) Educational and administrative infrastructure to support an expanded GME program.
- (8) Appropriate clinical activities and workload to support expanded training programs.

c. Program Characteristics. The program must provide evidence of committed leadership, appropriate clinical and educational activities, and sufficient workload to support a culture of excellence in graduate medical education. The site must demonstrate the following:

- (1) Program eligibility criteria as outlined in **1.b.(4)** must be documented. **If the eligibility criteria are NOT met or if they are NOT explicitly stated as being met, then the proposal will not be considered for review.** [This information should be provided in the Letter of Intent (LOI) and the Program Narrative Description.]
- (2) Applications will be judged by the extent to which the proposed innovations have the potential to transform clinical education and whether the program meets the eligibility criteria for this RFP. Specifically, the innovations proposed must be:
 - (a) Designed to have an impact and will be evaluated according to:
 - i. How creative or innovative the proposal is
 - ii. How the innovation will make training better
 - iii. How the innovation will make clinical care better
 - iv. Whether a local culture of innovation is likely to be sustainable
 - v. Whether evaluation methods are linked to the educational objectives (as described in 7. c. (4) below.
 - (b) Generalizable to other sites and will be evaluated according to:
 - vi. The extent to which the proposal is applicable to other training programs in the same specialty

- vii. The extent to which the proposal is applicable to other sites throughout the VA system
- (3) Appropriate expertise to carry out the proposed innovation at the site or links to other units with such expertise.
- (4) Evidence of sound strategies for learner evaluation and assessment of educational innovation on clinical care delivery, and expressed willingness to participate in data collection about the process and outcomes of innovation. [Program Narrative Description.] Evaluation plans will reviewed for⁶:
 - i. Correspondence to the educational objectives
 - ii. Educational outcomes (both subjective and objective)
 - iii. Clinical performance outcomes
 - iv. Faculty and/or staff satisfaction with the program for examination of short-term impact
- (5) Willingness to participate in OAA meetings and venues to promote and share innovations with other VA sites.

d. Justifications for each specialty requested. See Attachment A for a description of the online application process and instructions.

8. REVIEW PROCESS

a. Review committee. An ad hoc, interdisciplinary review committee designated by the Chief Academic Affiliations Officer will assess the merits of the applications. The committee will have expertise and leadership in graduate medical education and educational evaluation and experience in educational and clinical system redesign.

b. Letter of Intent. *A letter of intent (LOI) to apply under this RFP is requested by April 15, 2009.* The purpose of the LOI is to permit a preliminary review and, where necessary,

⁶ **Examples** (not intended to include all of the elements listed above) of evaluation methods that might be used to assess the impact of the program include:

Educational Outcomes Analysis: evaluation of the trainees by preceptors, evaluation of preceptors by the trainees, performance on standardized tests, and impact on competency assessment.

Clinical Outcomes Analysis: such measures as wait times, hospitalization rates, adverse events, incidence of procedure complications, and 'no show' rates. Also, *Quality Improvement Measures:* National, VISN-level and local quality improvement performance measures and monitors related to the impact of training expansion – routinely reviewed with plans for improvement when indicated.

Workload Assessment: Data workload management information analyzed to assure the overall workload for trainees is adequate while not being excessive.

Meetings with Clinical and Academic and Clinical Leaders: the DEO will meet on a regular basis with the academic and clinical leaders to obtain feedback and to review all implementation and facility impact issues related to the residency training expansion:

Surveys (VA, Affiliate, and Departmental): Survey feedback will be obtained from sources such VA national surveys, survey information collected by the affiliate, and facility surveys.

Reports to Leadership: All information obtained above is routinely reported back through the administrative infrastructure already in place at both the VAMC and the affiliate. Committees which will receive reports on the impact of implementation will include the VAMC Affiliations Partnership Council, VAMC Clinical Leadership Meeting, and the affiliate Graduate Medical Education Committee.

initiate discussion with the ACGME and relevant RRC(s). Feedback from OAA will be provided by May 15, 2009. Sites will be informed of whether their proposals meet the criteria and intent of the RFP and offered suggestions for improvement, if appropriate. Interested facilities and programs can then decide whether to submit a full application for the July 2 deadline.

c. Scoring of Applications. Applications will be scored according to the selection criteria for sites and the justification(s) provided for each specialty requested. In particular, over half of the evaluation will be centered on whether the proposal is transformative of education and clinical care and whether the proposed innovation is transferable (i.e., applicable to other sites). See Evaluation Criteria in 7 above.

9. SCHEDULE

March 2009	OAA sends request for applications to eligible facilities, VISNs, and appropriate Central Office officials. RFPs published on OAA website.
April 15, 2009	Facility letter of intent (LOI) is due in OAA.
May 15, 2009	Feedback to facilities submitting LOIs.
July 2, 2009	Applications are due in OAA via ONLINE process.
August 2009	Review committee reviews applications and makes recommendations for approval of allocations to the Chief Academic Affiliations Officer.
Late September/early October 2009	OAA notifies facilities about the approval or disapproval of their applications.
October – November 2009	Facility and VISN planning for AY 2010-2011
December 2009	OAA makes final allocations for AY 2010-2011.
July 1, 2010	Resident training begins.
February 2010 (tentative)	Meeting in OAA to review phase 4 proposals (pre-implementation) and to review progress on phase 3 projects (post-implementation)
October 1, 2011	First annual progress reports due to OAA.

10. OAA CONTACT PERSONS

General information. Please contact **Barbara K. Chang, MD, MA** at (505) 256-6425 or by e-mail to barbara.chang@va.gov ; or Joanne Pelekakis, MLS at (202) 461-9593 or by e-mail to joanne.pelekakis@va.gov.

Technical information regarding the online submission process: Email the OAA Help Desk (oaahelp@va.gov) or contact David Bernett at (314) 894-5760, ext 5, david.bernett@va.gov.

11. SUBMISSION INSTRUCTIONS

a. Preparation of applications. OAA recommends that considerable thought and dialogue with affiliates precede the actual drafting of an application. VA and affiliate needs should be reconciled and questions of institutional support for programs, positions and educational and clinical infrastructure addressed candidly. Affiliate program directors, the sponsoring institution's Designated Institutional Official, appropriate VA educational and clinical leadership (e.g., VA site directors) and VA senior leadership (Chief of Staff) should be involved in these discussions. *The VA DEO should be focal point for coordination of the application and collation of information from the various programs seeking additional positions and for preparation of the application.* Questions of accreditation status and whether Residency Review Committee (RRC) approval will be needed must be addressed (e.g., for additional residents or for waivers of program, institutional, or common requirements).

b. Online submission instructions. Applicants will submit proposals using an OAA Support Center password protected web portal, similar to the submission of other OAA reports. A special application entry point has been set up for submission of applications in response to this RFP. The same password used to access the OAA Support Center may be used. If you have new staff that requires a password, go to <http://vaww.oaa.med.va.gov/Login.aspx>, then select "I need to register." The requested numbers of positions by specialty and other specialty-specific information will be entered directly into the database; other portions of the application will be entered (uploaded) as files. See ATTACHMENT A for full instructions. All applications will be submitted by the office of the local DEO (not the program or site director's office).

c. Faxed or mailed applications will NOT be accepted.

ATTACHMENT A

APPLICATION INSTRUCTIONS

1. GENERAL INSTRUCTIONS

- a. General.** See **Checklist** for submission of items in ATTACHMENT B. Word or pdf files formats may be used. Letters must include a signature (i.e., they must be a scanned copy of an original, signed document).
- b. Font and margin sizes.** Font size must be 10-point or larger, with 12 point preferred for narrative portions. Margins must be at least one inch all around (excluding headers and footers).
- c. Letter of Intent (LOI).** A LOI should be submitted by the facility DEO electronically via the online GME Enhancement application system by logging onto <http://vaww.oaa.med.va.gov/Login.aspx> and going to the “GME Enhancement Application” data entry section; select the “LOI for Educational Innovation” and upload your file **by April 15, 2009**. LOIs may be addressed to Dr. Chang, Director of Medical & Dental Education. Limit LOIs to 3 pages and include the following:
- (1) A statement regarding the present GME program accreditation status and cycle length [Note: must be at least 4 years.]
 - (2) A statement regarding your prior accreditation status and cycle length [Must have 2 cycles with at least 8 years in good accreditation status.]
 - (3) Your program’s ABMS (American Board of Medical Specialties) board examination rolling 3-year pass rate [Must be $\geq 80\%$.]
 - (4) Your agreement to submit annual reports and to participate in OAA-sponsored meetings of participants from each approved Educational Innovations site.
 - (5) A brief description of what innovations are being proposed,
 - (6) The goals and objectives (or specific aims) of the proposed innovations,
 - (7) How many physician resident positions, and if appropriate, how many associated health trainee positions by discipline will be requested, and
 - (8) How the innovations will impact
 - i. the residency training program,
 - ii. clinical care, and
 - iii. other VA sites (medium to long-term).
 - (8) State your opinion as to whether any waivers of ACGME program accreditation standards will be needed. Provide sufficient detail to allow OAA to determine whether any waivers of ACGME accreditation standards might need to be sought.
 - (9) Describe any AH discipline positions for which you may apply.
 - (10) Provide contact information for the DEO to facilitate feedback on the LOI.
- Feedback on the LOIs will be provided around May 15, 2009.

d. RFP Online submission Process.

Submit **each required element** of the application **in an electronic format** by logging onto <http://vaww.oaa.med.va.gov/Login.aspx> and going to the “GME Enhancement

Application” data entry section. Deadline for submission is **July 2, 2009**. **Incomplete applications** (i.e., those lacking in one or more elements) **will not be considered** by the review panel. The GME Enhancement database will be **open from May 1, 2009** and ready to accept applications, which may be changed or modified up to the closing date for applications. We encourage you to begin to collect the necessary files as early as possible. Only authorized individuals from the DEO’s office may upload files into the application database.

2. FACILITY APPLICATION PACKAGE INSTRUCTIONS

Each facility may apply under any or all of the GME Enhancement initiatives (i.e., “Critical Needs/Emerging Specialties,” “New Affiliations/New Sites of Care,” or “Educational Innovation” provided the facility meets the eligibility requirements. Regardless of the number of RFPs under which a facility is applying, only one “core narrative” and only one set of institution-level support letters need to be submitted. The following elements and information must be submitted in the appropriate location in the GME Enhancement Application database online submission site:

a. CORE UPLOAD – Core narrative: Page limits & format. The core institutional proposal narrative or “core narrative” **must not exceed 5 pages** in a pdf or Word document **file**. **If a facility is applying for more than one RFP, the core narrative only needs to be submitted once.** The core narrative is intended to give the reviewers an overview of the educational environment at the facility level. Program-specific information should be included in the specialty program requests. The core narrative should follow the outline provided below:

- i. An overview of the facility and the population served
- ii. A brief history of the local facility affiliations
- iii. Describe the extent of participation and support from affiliated academic institutions; include information on the institutional accreditation status of the sponsoring affiliated institution(s)
- iv. A general description of the educational environment and culture fostering innovation
- v. Describe the scope and the degree of integration of the training programs offered at the VA (include the number and type of programs and number of resident positions represented at the VA)
- vi. Clinical resources available to support training objectives
- vii. Highlights of any unique educational or clinical strengths or opportunities in the facility’s environment. For example, describe any experience with inter-disciplinary or inter-professional care models and indicate the extent to which trainees, especially physician residents, are included as team members.
- viii. Delineate the methods that you will use to evaluate the success of the GME Enhancement positions *from an institutional perspective*.

b. SPECIALTY or DISCIPLINE REQUEST:

For EACH GME specialty or AH discipline program in which positions are requested, complete a Specialty/Discipline Program Request according to the following outline.

NOTE: each item must be entered separately into the online request. Entries marked with “[list]” imply that there will be a pull-down list or menu of options from which to

choose. You should have the requested information available at the time EACH specialty request is entered. However, if you are missing some information, the system will save your answers and you can edit or enter additional information up to the closing date for the application.

- i. Facility priority [whole number, NTE 2 digits]
- ii. Accrediting body [ACGME vs. AOA vs. applicable AH accrediting body] *Note: only ACGME or AOA-accredited programs may apply for physician resident positions under the RH RFP. Only accredited AH programs may apply for additional positions under this RFP.*
- iii. GME Specialty/Subspecialty or AH Discipline - Name of program [list; for sites applying for a Chief Resident in Quality & Patient Safety, select “Chief Resident – Internal Medicine” or “Chief Resident – Other”]
- iv. TYPE of program application: [“Critical Needs/Emerging Specialties” vs. “New Affiliations/New Sites” vs. “Educational Innovation”]
- v. # of positions requested [number, decimal fraction or whole, NTE 3 digits]
- vi. Affiliated sponsoring institution [list] (if appropriate)
- vii. Institutional Accreditation status [list; or N/A for AH positions]
- viii. Program Accreditation Status [list of options]
- ix. Accrediting body Approved total # of positions [number, whole, NTE 3 digits; N/A for AH]
- x. AY 2009-10 total # of filled VA positions in the program in the specialty or discipline in which positions are requested [number, decimal fraction or whole, NTE 3 digits]
- xi. AY 2009-10 total # of filled positions at all sites for specialty program or AH discipline (includes VA and non-VA positions) [number, whole, NTE 3 digits]
- xii. AY 2009-10 total # base allocation of VA positions in the program for which positions are requested [number, decimals allowed]
- xiii. AY 2009-10 total # of filled VA positions in the program for which positions are requested [number, decimals allowed]
- xiv. If the requested VA positions are approved, would the program require an increase in the # of approved positions from the Accrediting body? [yes/no or N/A for AH]
- xv. Program Director (sponsoring institution) [free text, 1 line]
- xvi. Please indicate if the program director is also the VA Site Director [yes/no]
- xvii. VA Site Director [free text, 1 line]

c. SPECIALTY/DISCIPLINE UPLOADS – enter (upload) the following documents per GME specialty or AH discipline program request. Note: All Letters must be signed and in Adobe pdf, image, or Word document file formats.

- i. **Program Narrative Description** (note: must follow the outline provided): [file upload in **pdf** or **Word format – not to exceed 5 pages**]
 - (a) Present as concisely as possible your educational rationale and objectives – be as rigorous as possible in defining your specific goals and objectives as these will drive your evaluation methods and choice of desired outcomes
 - (b) Delineate the nature of your proposed educational innovation (i.e., describe why what you are proposing is “innovative”, how the innovation will impact education

and clinical care, and whether and the extent to which the proposed innovation is generalizable to other VA sites or within the specialty)

- (c) Describe the planned educational activities (clinical, didactic, research) that will result from having the requested position(s)
 - (d) Elucidate how the additional position(s) will enhance the educational experience for all residents in this residency training program or other programs or will otherwise impact other trainees or training programs (i.e., describe how all residents in the program will benefit from the proposed innovation)
 - (e) Identify any barriers to successful educational and clinical innovation as proposed and how might they be overcome
 - (f) Explain how you will evaluate the educational and clinical outcomes of the initiative in relationship to the objectives of your proposal (note: interventions in GME should be approached from the perspective of educational quality improvement and/or similar to a research project); you should be as rigorous as possible in detailing how you intend to assess whether you are achieving your educational, programmatic, organizational, and system goals. [See 7.c.(4) above.]
 - (g) For facilities that are requesting **additional associated health positions, describe how the inclusion of associated health trainees will be integrated** into collaborative care, interprofessional models for training the physician residents and the associated health trainees.
 - (h) For facilities requesting a non-accredited position for a “**Chief Resident in Quality and Patient Safety,**” outline a specific curriculum with teaching functions assigned to the Chief Resident, similar to that developed by Indianapolis or with additional elements. You may wish to contact the ACOS/Education at either Indianapolis (Cheryl Stultz, MSN) or Omaha (Joann Porter, MD) for further details and examples of curricular elements and assignments that may be included in this role. Also, applicant sites must have a minimum of 8 funded resident positions in the accredited program with which the chief resident will be involved.
- ii. **Program Director’s Letter of Support** [file upload – 1 for each program in which positions are requested].
- (a) Describe your current ACGME accreditation status, any citations, and their resolution
 - (b) Attest to your accreditation cycle length for the past 8 years and state your current cycle length
 - (c) Provide the most recent rolling 3-year board pass rate for graduates of your program
 - (d) Provide evidence of Departmental support for the additional VA positions
 - (e) Comment on the quality and availability of VA-based faculty to supervise additional residents at the VA
 - (f) Comment on your level of enthusiasm for and participation in making the proposed educational innovations a part of your training program and how you see these impacting the overall training experience of residents

iii. **VA Site Director's Letter of Support** [file upload – 1 for each program in which positions are requested]

- (a) Describe the Service or Section support available for the requested positions
- (b) Provide a list of VA-based attendings who can supervise residents in the specific training program; indicate whether or not they have faculty appointments with the affiliated sponsoring institution
- (c) Describe any unique aspects of your program (e.g., inter-disciplinary or inter-professional venues) incorporated into your VA-based training for the specialty requested
- (d) Attest to your enthusiasm for and participation in the proposed educational and clinical innovations

d. SUPPORT UPLOADS: Support letters – enter (upload) only once per site (regardless of the number of programs or the number of RFP applications)

Support letters in the following categories may be entered (**uploaded**) as **pdf, image files, or Word files**. Outlines for each support letter provide specific information that reviewers would like to see in these letters in order to evaluate the proposals more objectively. Limit each letter to two pages. The letter should be addressed to “Malcolm Cox, MD, Chief Academic Affiliations Officer (14).”

i. Medical Center Director's Letter

- (a) Indicate support for requested additional positions and for faculty development and protected time to participate in the project
- (b) Describe any resource support that would be provided to enhance the educational infrastructure in general or specifically to facilitate the success of the EI project.
- (c) Provide an assessment of the relationship with affiliate(s)
- (d) Indicate whether the GME Enhancement proposal for requested positions was approved by the Affiliation Partnership Council (formerly, Deans' Committee)

ii. Chief of Staff's Letter

- (a) Comment on the clinical & educational environment
- (b) Comment on the relationship with the affiliate(s)
- (c) Assess the 'value' of additional residents to the facility

iii. Designated Education Officer (DEO) Letter

- (a) Provide a personal statement of commitment to the proposal and to GME programs and, if applicable, AH education in general
- (b) Detail your vision for educational enhancement at the VA
- (c) Briefly describe your individual achievements and initiatives at the facility and/or VISN levels in the field of education
- (d) Describe your specific roles and responsibilities at the affiliate (e.g., faculty status, member of the GME Committee, member of the Affiliations Partnership Council)
- (e) Provide your contact information: title, business address, telephone and fax numbers, and e-mail address

- iv. **Network Support Letter** (From the Network Director, through the VISN Chief Medical Officer and the Network Academic Affiliations Officer – **only 1 letter from the VISN for each applicant facility is required**)
- (a) Describe the relevance of the facility proposal to the VISN's education and clinical missions.
 - (b) Specify your rationale for wanting additional positions (VISN perspective)
 - (c) Assess the VISN's ability and the specific facility's to train additional physician residents and if applicable, AH trainees
 - (d) Indicate the VISN-level support for additional positions (if any)
 - (e) Describe the unique contributions the facility and VISN can make to the GME Enhancement Program
 - (f) Elucidate the perceived merits of the facility proposal from the VISN and national perspective, if applicable
 - (g) Identify the Network POC, the Network Academic Affiliations Officer
- v. **Designated Institutional Official (DIO), sponsoring affiliated institution, letter [NOTE: not applicable for Associated Health positions]**
- (a) Indicate your institutional affiliation support for the VA application
 - (b) Discuss any accreditation issues involving the institution or the programs in which positions are requested
 - (c) Provide assurance of institutional approval of requested additional positions, including GME Committee approval if applicable
 - (d) Describe any matching of institutional support (e.g., additional positions in the same specialty program to ensure appropriately balanced training opportunities)

ATTACHMENT B

APPLICATION SUBMISSION CHECK LIST

INSTRUCTIONS: Incomplete applications will not be considered by the review committee. The following list is to assist your planning and represents the required sections for this application. See ATTACHMENT A for detailed instructions and outlines.

- Letter of Intent – submit by April 15, 2009 (not to exceed 3 pages)
- CORE UPLOAD: Core narrative (not to exceed 5 pages) – need to submit only once
- SPECIALITY/DISCIPLINE REQUEST: GME Specialty and AH Discipline Program Request (must enter online for each specialty program requested) - includes:
 - Facility priority
 - Program application type (Critical Needs/Emerging Specialties vs. New Affiliations/New Sites vs. Educational Innovation)
 - Other basic program information (including accreditation status)
- SPECIALITY/DISCIPLINE UPLOADS: (must submit for each specialty program requested)
 - Program Description (not to exceed 5 pages for the Educational Innovation RFP)
 - Program Director's letter (one for each specialty program requested; limit 2 pages)
 - VA Site Program Director letter (one for each specialty program requested; limit 2 pages)
- SUPPORT UPLOADS: Letters of Support (facility/VISN/DIO letters: need to submit only once):
 - Medical Center Director (limit 2 pages)
 - Chief of Staff (limit 2 pages)
 - VA Designated Education Officer (DEO) (limit 2 pages)
 - Network Director (through VISN Chief Medical Officer and the Network Academic Affiliations Officer) (limit 2 pages)
 - Academic Affiliate (sponsoring institution) Designated Institutional Official (DIO) (limit 2 pages)

ATTACHMENT C:

BACKGROUND

a. Federally Chartered Advisory Committee on Resident Education. This external Advisory Committee of national GME leaders met in late 2004 to look critically at VA resident education. The Advisory Committee was charged with examining both the philosophy and the deployment of VA's residency training positions (including the total number of positions, the specialty mix of resident physician training positions, and the geographic distribution of positions) and undertook a broad assessment of graduate medical education in relationship to veterans' future healthcare needs.

b. Innovation in GME. Calls for innovation in GME have become more persistent since the 2003 report of the Institute of Medicine (IOM) entitled, *Health Professions Education: A Bridge to Quality*,⁷ which concluded that: "All health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics." Similar themes have been expressed in *Educating Doctors to Provide High Quality Medical Care – A Vision for Medical Education in the United States*.⁸

Beginning in 1999, the ACGME defined six core competencies and, through a project of phased implementation, mandated that programs not only teach these competencies, but provide evidence through periodic, program level-specific evaluation, that residents have attained them. The ACGME competencies include⁹:

- a. **Patient Care** that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health
- b. **Medical Knowledge** about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care
- c. **Practice-Based Learning and Improvement** that involves investigation and evaluation of their own patient care, appraisal and assimilation of scientific evidence, and improvements in patient care
- d. **Interpersonal and Communication Skills** that result in effective information exchange and teaming with patients, their families, and other health professionals
- e. **Professionalism**, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population
- f. **Systems-Based Practice**, as manifested by actions that demonstrate an awareness of and responsiveness to the larger context and system of healthcare and the ability to effectively call on system resources to provide care that is of optimal value

In 2003, ACGME required programs to meet the 2003 duty-hour restrictions.¹⁰ The emphasis on competency-based education and duty hour restrictions posed new challenges for the clinical education environment in VA as in all academic settings. However, VA may be

⁷ IOM, April 2003. [<http://books.nap.edu/books/0309087236/gifmid/2.gif>] (page 4).

⁸ Report of the Ad hoc Committee of Deans, Association of American Medical Colleges, July 2004. [https://services.aamc.org/Publications/index.cfm?fuseaction=Product.displayForm&prd_id=115&prv_id=130&CFID=246136&CFTOKEN=55287b3-2dec05eb-5c31-4960-a7ad-180e24796c43]

⁹ See <http://www.acgme.org/outcome/comp/compMin.asp>

¹⁰ See the ACGME Common Program Requirements at http://www.acgme.org/acWebsite/dutyHours/dh_dutyHoursCommonPR.pdf.

ideally positioned to respond to these changes given its clinical transformation over the past decade. The Institute of Medicine (IOM) released its report, *Resident Duty Hours: Enhancing Sleep, Supervision, and Safety*, on December 2, 2008. The recommendations include retention (with no reduction) of the 80-hour average duty week and a limitation on any consecutive ‘shift’ to 16 hours without a mandatory 5-hour protected sleep period between 10 pm and 8 am. Other recommendations include a reduction in internal and external moonlighting, increased days off-duty and time off between shifts. The IOM report also recommends other steps, including greater supervision, focus on structured hand-offs, and reporting of medical errors and ‘near misses’ that will “optimize the delivery of safe, high-quality care and the training of new doctors.” The ACGME and other stakeholders in GME will be reacting to the IOM report over the next 2 years. Coping with restricted duty hours and maintaining continuity of care and a quality educational experience may prove challenging for many programs. The report highlights the need for a fresh look and innovative approaches to the design of residency training.

Since the passage of the Veterans' Health Care Eligibility Reform Act in 1996, VA has been expanding access to primary care via hospital-based clinics and community-based outpatient clinics (CBOCs) that emphasize comprehensive, continuity care for defined panels of patients. The number of veteran enrollees treated increased from 2.6 million in 1994, to 6.4 million in 2002, VA's bed utilization fell from an average daily census of 39,953 in 1995 to 19,000 in 2002. By FY 2005, VA enrollees had increased to 7.5 million, an 85% increase compared to 1999.

Eligibility reform and management changes permitted VA to focus more on long-term improvements in and a more integrated approach to the delivery of healthcare. Through emphasis on measurable performance indicators and outcomes, VA has become the benchmark for other healthcare systems by exceeding quality standards in the private sector and in local geographic practice communities,^{11,12,13,14,15,16}

VA has implemented models of care that are uncommon or non-existent in more traditional academic medical centers. The shift in focus to primary care has been credited with improvements in chronic disease management,¹⁷ a critical but often missing component of most GME programs at the present time. Although VA's emphasis on “advanced access” in outpatient care delivery is beginning to be used in teaching clinics, implementation lags behind

¹¹ Ashish, KJ, Perlin JB, Kizer KW, et al. Effect of transformation of the Veterans Affairs Healthcare system on the quality of care, *NEJM* 348: 2218-2227, 2003.

¹² Kerr, EA, Gerzoff, RB, Krein, SL et al., Diabetes care quality in the Veterans Affairs Health Care System and commercial managed care: the TRIAD Study. *Ann. Int. Med.* 14 (4): pp 227-281, August 2004.

¹³ Editorial: Greenfield S, Kaplan SH. Creating a culture of quality: the remarkable transformation of the Department of Veterans Affairs Health Care System. *Ann. Int. Med.* 14 (4): pp 316-318, August 2004.

¹⁴ Fooks C, Dector M. The transformation experience of the Veterans Health Administration and its relevance to Canada. *Healthcare Papers* 2005; 5: 60—64.

¹⁵ Asch S, Asch SM, McGlynn EA, Hogan MM, et al. Comparison of quality of care for patients in the Veterans Health Administration and patients in a national sample. *Ann Intern Med.* 2004; 141: 938-945.

¹⁶ Perlin JB, Kolodner RM, Roswell RH. The Veterans Health Administration: Quality, value, accountability, and information as transforming strategies for patient-centered care. *Am J Manag Care.* 2004; 10: 828-826.

¹⁷ Jackson GL, Yano EM, Edelman D, et al. Veterans Affairs primary care organizational characteristics associated with better diabetes control. *Am J Manag Care.* 2005; 11: 225-37.

that seen in non-teaching VA primary care clinics due to logistic and resident scheduling problems.¹⁸

VA's electronic medical record has long been available for the training of over a third of all US residents annually in computerized health records, but VA's leadership in medical informatics, patient safety and system improvement have not yet been effectively translated into the clinical learning environment. Overall, VA's clinical transformation appears to have had relatively little impact on resident education.

Recently, the American College of Physicians (ACP) and the Association of Program Directors in Internal Medicine have added their voices to calls for reform.^{19,20} The basic thrust of these papers is that residency education has not kept pace with changes in the practice environment, and they reiterate the familiar call for moving away from service needs driving the clinical experiences of residents to a design based upon educational needs of residents integrated with clinical care delivery. Recurrent points of contention include the current under-emphasis of ambulatory training, the need for team-based approaches to care, and the importance of setting a high value on "professionalism and [...] a lifelong commitment to learning, self-reflection, and quality improvement."

The various calls for innovation and reform of residency education not only target present educational models but also include implied and explicit critiques of the clinical learning environment itself. Thus, most observers of GME have called not only for educational innovation but also for new clinical care models that would provide the essential fabric for experiential learning.²¹

The ACGME, through its Committee on Innovation and its recently launched Learning Innovation and Improvement Project (LIIP), has sought to identify best practices, exemplary institutions and programs, and the attributes of institutions that succeed in improving their learning environment. Several themes have already emerged, including that: (a) support from institutional leadership at all levels (CEOs, department chairs, clinic managers, and the like) is critical; (b) well-designed innovations, especially in healthcare delivery (such as chronic care models) can improve both healthcare and financial outcomes; (c) innovation can be accomplished without large infusions of staff and money, especially if one focuses on redesigning processes to make them more efficient by reducing waste and improving continuity; and (e) teamwork at the micro- and macro-system levels is important for significant, sustainable change.

¹⁸ Chang, B.K., Murawsky, J., Feldman, J., Holland, G.J., Kashner, T.M., Pincus, S.H., and Sanders, K.M. Resident Education in Ambulatory Settings: Organization, Continuity, and Advanced Access in VA Physician Resident Primary Care Clinics. *Federal Practitioner*: 35-54, May 2007.

¹⁹ Weinberger SE, Smith LG, and Collier VU. Redesigning Training for Internal Medicine. *Ann Int. Med.* 2006; 144: 927-932.

²⁰ Fitzgibbons, JP, Bordley DR, Berkowitz LR, Miller BW, and Henderson MC. Redesigning Residency Education in Internal Medicine: A position paper from the Association of Program Directors in Internal Medicine. *Ann Int Med.* 2006; 144: 920-926.

²¹ Stevens, David. Presentation to the Committee on Innovation in the Learning Environment, ACGME, February 11, 2007.