The Report of the Blue Ribbon Panel on VA-Medical School Affiliations

Transforming an Historic Partnership for the 21st Century.

Veterans Health Administration
Office of Academic Affiliations

The Report of the Blue Ribbon Panel on VA-Medical School Affiliations:
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Executive Summary

The Blue Ribbon Panel on VA-Medical School Affiliations (Panel) was established in 2006 to advise the Secretary of the Department of Veterans Affairs (VA) on a "comprehensive philosophical framework to enhance VA's partnerships with medical schools and affiliated institutions". The Panel received numerous background presentations and issue papers on topics relevant to its deliberations and undertook two national surveys of the present state of VA-Medical School affiliations.

The Panel believes that the current crisis in the U.S. healthcare system offers a unique opportunity to explore fundamentally new and better models of patient care, education and research. Given its enduring partnership with the academic community, its past and present investments in academic infrastructure and its particular expertise in clinical system redesign, VA is uniquely well-positioned to take a leadership role in educating the future healthcare workforce, advancing medical science and helping to transform the healthcare system for the 21st century.

The Panel reaffirms the vital importance of academic affiliations and recommends that **VA's partnership with the academic community be strengthened in order to further enhance health care for Veterans and lead the transformation of the U.S. healthcare system.** Capitalizing on synergies between VA and its academic partners will assure the continued development and maintenance of an effective and diverse healthcare workforce, both for VA and for the Nation. To do so, however, will require significant changes in the organization and governance of the partnership.

Currently available mechanisms for meaningful dialogue between VA and the academic community are inadequate. Relationships could be greatly improved by having more effective forums for discussion, strategic planning and decision making. To realize the full potential of the partnership, the Panel recommends that **VA and its academic affiliates establish more effective national, regional and local management structures.**

To be effective, a national governance body must provide a forum for substantive discussion and negotiation and have the authority to provide ongoing advisory input to both VA and the national academic community. Accordingly, the Panel recommends that **VA establish a National Academic Affiliations Council, organized as a standing committee under the Federal Advisory Committee Act (FACA) and advisory to the Secretary of Veterans Affairs.**

To promote the delivery of comprehensive, cost-effective health care to Veterans and their dependents, the Panel recommends that **the National Academic Affiliations Council be charged with developing mechanisms whereby VA-Academic Medical Center partners could form local or regional strategic alliances and/or joint ventures.** Such alliances would be ideally positioned to model ways that the Nation's overall health care system might be transformed.

VA's Integrated Service Networks (VISNs) oversee strategic planning, funding and operations within their individual regions. However, with few exceptions, academic affiliations appear to receive only nominal oversight or support. In order to promote more effective affiliations, the Panel recommends that **VA's regional networks assume greater accountability for VA's academic mission and the quality of academic partnerships within their individual jurisdictions.**

Given that affiliation relationships are fundamentally local in nature, the Panel believes that local Academic Partnership Councils (previously known as "Deans Committees") must continue to serve as the key governing body for individual partnerships. To do so effectively, however, they must expand their agendas beyond information sharing and be held accountable for joint strategic planning. Accordingly, the Panel recommends that **local affiliation governance be restructured so that expectations are raised and all parties are made more accountable for their actions and interactions.**

In addition to questions of governance, the Panel also addressed many other facets of the partnership. The Panel commends VA for its national leadership in addressing the supply of health professionals. VA's Graduate Medical Education Enhancement Initiative is presently the sole federal effort directed at physician workforce expansion and the VA Nursing Academy is a new and creative approach to ameliorating the national nursing shortage. The Panel recommends that **VA and its academic partners continue to address workforce shortages by expanding health professional training opportunities.**

Providing patient-centered, cost-effective care will require that future generations of clinical providers have advanced skills in leadership, teamwork and care coordination. Given its expertise in system redesign, medical informatics and quality improvement, VA is ideally positioned to lead a collaborative effort with its academic partners in transforming the clinical practice and learning environment to promote the development of these skills. To prepare an appropriately skilled healthcare workforce for VA and the Nation, the Panel recommends that **VA and its academic partners increase investments in the development and testing of innovative educational programs to better align health professions education with healthcare needs.**

Without rigorous attention to educational infrastructure, innovation in clinical education will fall short of that needed to transform patient care. To reaffirm VA's statutory educational mission and continue its seminal role in shaping the future health care workforce, the Panel recommends that **VA conduct a comprehensive inventory of its educational assets, including the adequacy, distribution and use of the Veterans Equitable Resource Allocation (VERA) educational supplement.** The Panel further recommends that **national policy standards governing the utilization of the VERA educational supplement be developed and that the *indirect* costs of education be more equitably shared between VA and its academic affiliates.**

The panel also commends VA for its seminal contributions to the Nation's biomedical research enterprise. In addition to its long-standing excellence in basic, clinical and prosthetics research, VA has the potential to excel in new or emerging areas of investigation vital to the present and future healthcare system, including educational research, healthcare informatics and genomic medicine.

Transformative medical research requires investigators with disparate expertise. Moreover, many research questions are best addressed collaboratively. To enhance the translation of biomedical science into improved health care, the Panel recommends that **VA and its academic partners redouble their efforts to develop new knowledge through collaborative research**. The Panel endorses the need for a strong VA intramural research program, but cautions that policies limiting more dynamic collaboration with affiliated institutions may ultimately undermine the quality of the Nation's overall research enterprise.

The Panel notes with concern the aging of VA's research infrastructure, which significantly limits its ability to conduct an efficient and effective biomedical research program. To accelerate the pace of health-related discovery and enhance the care of Veterans and the Nation, the Panel recommends that **VA conduct a comprehensive inventory of its research assets, including the state of its laboratory facilities.** The Panel further recommends that **VA enhance its research facilities through new construction and renovation of existing research space and by fully exploiting opportunities to share core resources with its academic affiliates.**

As a healthcare system within a department of the U.S. government, VA is understandably subject to special scrutiny. Dealing with a well-intentioned but exceedingly complex system of checks and balances is proving to be increasingly stressful, both for VA and for its academic partners. Particular exasperation has been expressed over recent policy changes affecting each of the following: information security and privacy; contracting for shared medical services; conflict of interest; part-time physician time and attendance; and mandatory training. To reduce the overall regulatory burden, the Panel recommends that **VA review and, wherever possible, modify policies and procedures that limit effective collaboration with its academic affiliates in patient care, education and research.**

Background

In September 2006, the Secretary of the Department of Veterans Affairs (VA) approved the establishment of a federally chartered advisory committee – the "Blue Ribbon Panel on VA-Medical School Affiliations" – to advise the Department on VA's long standing partnerships with the academic community (Appendix 1).

The Panel's charter solicited advice on a "comprehensive philosophical framework to enhance VA's partnerships with medical schools and affiliated institutions" (Appendix 2). Specific goals included: reaffirming "the importance of the partnership between VA and academic medicine"; reviewing the "overall health of the partnership in light of the significant changes in medical practice since the signing of policy Memorandum #2 in 1946"; describing "present and future opportunities for expanding the relationship for the mutual benefit of both partners"; and categorizing "barriers affecting effective and cordial relationships".

The Panel was staffed by the Veterans Health Administration's Office of Academic Affiliations and assisted throughout its deliberations by an Internal Advisory Committee composed of VA medical care facility (VA facility) and Veterans Integrated Service Network (VISN) leaders with extensive experience in managing VA's academic relationships (Appendix 3). The Panel received numerous background presentations and issue papers on topics relevant to its deliberations and undertook two national surveys of the present governance (Appendix 4) and effectiveness (Appendix 6) of VA-Medical School affiliations.

Introduction

Academic affiliations promote the delivery of quality health care to Veterans

The enduring partnership between VA and the Nation's academic health professions community ensures that Veterans receive the highest quality health care while providing unique educational and research opportunities for successive generations of healthcare providers. Education and research imbue VA's entire clinical operations with a spirit of inquiry, a critical component of safe and effective health care and an irreplaceable advantage in recruiting and retaining outstanding clinicians.

A jointly appointed faculty expands available clinical expertise, ensuring Veterans access to a full spectrum of clinical services. VA's affiliations with academic medical centers provide real-time access to advances in biomedical science, thereby expanding the scope and effectiveness of its own clinical care and research programs. At the same time, academic medical centers and university faculty practices have become a close and reliable source of contracted care for many VA facilities, including both primary and specialty care. For example, in FY 2008, VA purchased medical care worth $1.26 billion from medical school and academic medical center affiliates in just the four Veterans Integrated Service Networks (VISNs) participating in VA's Project HERO (Healthcare Effectiveness through Resource Optimization).[1] System-wide, this translates to some $4 to $5 billion of contracted care with affiliates annually.

VA clinical training promotes interest in VA careers. Health professions trainees who have spent time at VA are much more likely to consider a VA career than peers who have not (Appendix 8). That heightened interest translates into enhanced VA staff recruitment is supported by data from the Veterans Health Administration's 2009 All Employee Survey. For example, 59% of all staff physicians responding to the survey report that they had trained at VA; for both medicine and psychiatry, fully two-thirds report prior VA training (Appendix 9). And some non-physician health professionals, most notably psychologists and optometrists, report even higher rates of VA training experiences (Appendix 9).

Trainees make up a substantial portion of VA's overall clinical workforce. For example, the 33,000 medical residents who receive training in VA annually participate intimately in almost 40% of VA's medical care overall, and in an even higher percentage of inpatient care (Appendix 10). Dentistry, podiatry, psychology, optometry and pharmacy residents are likewise important components of VA's clinical workforce (Appendix 10).

VA's partnership with the Nation's universities is a cornerstone of health professions education and biomedical research

VA has had affiliations with the Nation's medical schools for over 60 years. General Omar Bradley, the Administrator of VA at the time, developed this pioneering partnership to address a national shortage of physicians and the limited capacity of VA to care for the large numbers of new Veterans returning from World War II. Chartered on January 30, 1946 by VA Policy Memorandum Number 2 (Appendix 11) to jointly support patient care, education and research, this bold move changed the face of VA and of medical education in the United States. Partnerships with other health professional schools soon followed.

VA is currently the largest single provider of clinical training in the United States, hosting over 100,000 health professions trainees annually in disciplines ranging from medicine, dentistry and nursing to a wide variety of other health professions. Over the years, VA's educational affiliations have developed into the largest public-private partnership in VA's history and have become a cornerstone of American health professions education.

Presently, 120 of 153 VA medical centers host physician trainees from 107 of 129 allopathic and 15 of 26 osteopathic medical schools. Additionally, 132 VA facilities have more than 5,000 affiliation agreements with some 1,200 other health professional colleges or universities serving over 40 health professions.

In Fiscal Year 2009, VA provided $653 million in direct support of health professions education, approximately eighty percent of which was devoted to graduate medical education. VA is second only to Medicare and Medicaid in directly supporting graduate medical education. In addition, VA is presently the only federal agency increasing its support for medical residency training.

Serving as a national model for translational research, VA's Research and Development Program takes full advantage of its unique position within an integrated healthcare system with a state-of-the-art electronic medical record to foster the development and deployment of evidence-based clinical decision-making. Much of this work is conducted in close collaboration with scientists at VA's academic affiliates.

In FY 2008, VA supported approximately 3,000 investigators in over 90 facilities and successfully leveraged a relatively modest research appropriation of $480 million into a diversified portfolio of over $1.6 billion. The opportunity to conduct top quality, pioneering research within an integrated healthcare system promotes excellence in both clinical investigation and clinical care. As evidence of the high quality of VA research, VA investigators have, to date, won three Nobel prizes and six Lasker awards.

VA's seminal role in health professions education has been the subject of numerous studies and commentaries. [1 2 3 4 5 6 7 8 9 10 11 12] One recent testament to the value of VA's partnership with academic medicine is provided by the Affiliations Effectiveness Survey (AES) conducted jointly by VA and the Association of American Medical Colleges (AAMC) (Appendix 6). This survey of VA facility and medical school/university hospital leaders was designed to: (1) assess the influence of a wide variety of factors affecting affiliations, both globally and more specifically in the domains of education, research, clinical practice and faculty affairs; (2) permit an analysis both by primary site of the respondents' professional activities and by leadership level; and (3) solicit opinions about the present state of affiliation governance.

VA and medical school respondents alike overwhelmingly endorsed the value of affiliations (Appendix 7, Figure 4). The Panel views this expression of support as a solid foundation for further enhancing the partnership and for overcoming present and future obstacles. In the same survey, a majority of respondents reported overall satisfaction with their local affiliation relationship (Appendix 7, Figure 5) and even larger majorities indicated their personal commitment to the partnership (Appendix 7, Figure 6).

In contrast, respondents expressed the view that both VA and medical school *senior executives* were less committed to the relationship than lower level institutional leaders (Appendix 7, Figure 6). Whether reflecting reality or mere perception, the Panel notes this finding with concern. Trust in and by executive leadership is an essential prerequisite for the effective functioning of any complex enterprise, and certainly of one with the stresses and strains inevitable in a wide-ranging public-private partnership.

Findings and Conclusions

The continued success of the historic relationship between VA and academic medicine is critical for maintaining the highest quality health care for Veterans and the Nation

Some may be tempted to take a narrow view of VA's partnership with the academic community as a "marriage of convenience" between one party (VA) needing to staff a large and complex healthcare system at reasonable cost, and the other party (the medical school) needing to expand its venues for clinical training and its sources of support for research. While this narrow view might have been justified, at least in part, at the beginning of the partnership in 1946, it is certainly not an apt characterization today. The Panel recognizes that VA and the academic community possess complementary expertise in patient care, education and research and strongly encourages the two partners to utilize their unique capabilities synergistically to enhance the health not only of Veterans but of the broader American public as well.

VA's transformation into a national model of integrated system-based care provides important lessons for academic medicine and for reform of the U.S. healthcare system

Recognizing VA's steadfast commitment to continuously improving the health and well-being of its patients and to systematically redesigning its processes of care, the Panel believes that academic medicine and the U.S. healthcare system as a whole have much to learn from today's VA. The Panel applauds VA's long-standing efforts to expand primary care services; its implementation of collaborative team-based care; its establishment of myriad patient and community outreach programs (including nearly 800 community-based outpatient clinics and 230 Veterans Centers); and its recent efforts to extend care to homeless Veterans and to Veterans living in rural and remote locations. These initiatives are compelling examples of VA's determination to provide its patients with a more accessible and comprehensive array of health services.

VA is recognized and widely commended for its national leadership in quality measurement, performance improvement, patient safety and medical informatics. The development and enterprise-wide deployment of a sophisticated electronic health record, arguably VA's most tangible recent achievement, has facilitated a shift from hospital to ambulatory care and has ensured coordination of care in an increasingly decentralized system.

Less widely recognized perhaps is VA's leadership role in several other critical areas, including geriatrics, long-term care, spinal cord injury, polytrauma and rehabilitation. Especially noteworthy is VA's comprehensive array of mental health services, which have set the standard for the Nation in dealing with patients suffering from substance abuse, post-traumatic stress disorder and traumatic brain injury. The VA also has established novel, advanced fellowship programs in patient safety, medical informatics, quality improvement and leadership

development (the latter in collaboration with the Robert Wood Johnson Foundation's Clinical Scholars Program).

The Panel believes that VA's future achievements will depend, in part, on the development and testing of entirely new models of care delivery that are even more patient-centered and more collaborative in nature. Integrated, system-based care models (e.g., the patient-centered medical home) are beginning to be tested in VA and the broader academic community. VA's experience with system redesign and continuous quality improvement will be invaluable in developing and testing new models of healthcare delivery; a case in point is VA's innovative new partnerships with the academic community in the form of VA Engineering Resource Centers (VERCs). The Panel commends VA for its outreach to new academic partners such as Schools of Engineering, and strongly supports VA's efforts to develop new patient-centered, integrated and comprehensive care models. Such efforts have the potential to truly transform VA health care for decades to come.

Academic affiliations are integral to healthcare workforce development for VA and the Nation

VA's Graduate Medical Education Enhancement Initiative is adding 2,000 additional medical residents to the national pool at a time of increasing calls for expanding the U.S. physician workforce. Moreover, this expansion has allowed for realignment of VA's training positions to areas of the country such as the south and southwest where demand for healthcare services is greatest, without limiting much needed expansion of specialty and subspecialty positions elsewhere or the development of training programs in new or previously non-affiliated medical schools and teaching hospitals (Appendix 12). More recently, in collaboration with VA's Office of Rural Health, health professions training positions have also been targeted to rural communities.

Another new initiative, the VA Nursing Academy, is promoting VA-nursing school partnerships and increasing the Nation's capacity to train baccalaureate-level nurses. In addition, VA's expansion of mental health services and recent investments in psychology education has renewed interest in VA careers in mental health. The Panel emphasizes that without VA's longstanding collaboration with the academic community, none of these initiatives would have been possible. Looking ahead, by capitalizing on the synergistic experience of VA and its academic partners, the continued availability of an effective and diverse healthcare workforce, both for VA and for the Nation, can be assured.

Workforce expansion alone is but one of the elements needed to reshape healthcare delivery. The Panel believes that providing patient-centered, integrated and comprehensive care will require that future generations of clinical providers have advanced skills in leadership, teamwork and care coordination. Given its expertise in system redesign and quality improvement, VA is ideally positioned to lead a collaborative effort with its academic partners in transforming the clinical learning environment to promote the development of these skills. Such efforts have already taken root in a series of small pilot programs testing the feasibility of new graduate medical education training models (e.g., continuity-based medical resident rotations) and methods (e.g., enhanced use of simulation in clinical skill acquisition and evaluation).

VA's internationally respected Heath Services Research program is in an enviable position to rigorously evaluate potentially transformative initiatives, and has recently provided funding for a series of projects predicated on demonstrating linkages between educational innovation and improved patient or system outcomes. VA's introduction of System Redesign Capability Awards, the recently implemented VA Engineering Resource Centers (VERCs), and VA's commitment to becoming a Learning Organization provide additional building blocks for large scale system redesign and evaluation efforts. The Panel endorses enhanced collaboration between VA and the academic community in support of all these seminal efforts.

Investments in the education of non-physician health professionals are insufficient to support transformative change

Some two-thirds of VA's $653 million trainee stipend budget supports graduate medical education. The proportion of the budget devoted to graduate medical education is not surprising given the size of VA's training programs, its seamless integration with the Nation's medical schools and academic medical centers, and the substantial role of medical residents in the VA's patient care mission. The Panel commends VA on its recent additional investments in medical education and believes that, with a physician shortage already looming, such investments should continue for the foreseeable future.

At the same time, however, the Panel emphasizes that additional investments in the education of non-physician health professionals are essential if VA is to continue to build the team-based healthcare system of the future. The VA Nursing Academy, which represents a $40 million investment in the future of nursing education and practice, is one notable accomplishment in this regard. Though smaller in magnitude, the recent expansion of psychology training is likewise important. However, the Panel believes that significant additional investments in many if not all of the 40-plus non-physician health professions will also be necessary.

VA's educational infrastructure must be strengthened to support transformative change

Human and financial capital is the stuff of both workforce development and system redesign. The Panel commends VA for its investments in clinical workforce expansion, its support of new initiatives to promote system redesign, its recent support of educational research, and its efforts to transform VA into a learning organization. However, the Panel believes that without rigorous attention to educational infrastructure, many if not all of the promising initiatives already underway are unlikely to be sustained and future innovation will fall short of that needed to truly transform patient care.

***Educational assets should be inventoried*:** The Office of Academic Affiliations, which has overall responsibility for trainee education, is hampered in its ability to effectively align training programs with national priorities. For example, the Office has no authority to appoint or even confirm the appointment of facility Designated Education Officers, only very limited *operating* funds to deploy at its own discretion, and essentially no influence over facility educational operating budgets.

Moreover, operating resources available to the educational leadership in the field appear to be unevenly distributed and insufficient in the aggregate; field educational leadership includes Designated Education Officers, who oversee all local educational programs, and Site Directors, who manage specific educational programs in collaboration with university-based Program Directors.

No policy standards presently exist by which the adequacy of national or field educational resources can be measured. The Panel believes that a comprehensive inventory of educational assets would be a first step towards determining the adequacy of support for the education mission. The learning resource inventory developed by the National Leadership Board's Human Resource Committee may be a useful model, in that it seeks to provide, in an integrated fashion, a comprehensive picture of the entire VA learning community, including both staff and trainee education. The Panel also believes that a similar assessment is warranted of the adequacy of the resources available to educational leaders at the academic affiliates.

Indirect costs of education should be addressed: The Panel notes VA's enlightened policy of supporting the *direct* costs of education (i.e., trainee stipends and benefits) at rates equivalent to those established by the academic community, without which a true partnership in education would be difficult. However, the *indirect* costs of education have risen significantly in recent years and have now reached the point of requiring urgent attention.

In FY 2008, the Veterans Equitable Resource Allocation (VERA) educational supplement provided an additional $600 million of non-stipend support to VA facilities. However, the overall adequacy and method of calculation of VERA educational funds needs reevaluation and its distribution (from networks to facilities) and use (by individual facilities) appears to be inconsistent system-wide. Indeed, national policy standards governing the distribution or utilization of these funds are lacking.

The Panel is also concerned that some indirect costs of education, perhaps most notably escalating institutional and program accreditation costs, are presently borne exclusively by affiliates. A more equitable distribution of such costs between the two partners is needed.

VA has the potential to excel in several important new areas of research

In addition to its long-standing excellence in basic, clinical and prosthetics research, VA has the potential to excel in several new or emerging areas. Three areas of investigation seem particularly relevant to VA's mission: educational research, healthcare informatics and genomic medicine. VA's Health Services Research and Development (HSR&D) Program has long been an integral component of its ongoing efforts in system redesign. More recently, in collaboration with the Office of Academic Affiliations and the Employee Education System, the HSR&D Program has launched a new initiative in support of provider education to enhance patient care outcomes. The Panel commends VA for emphasizing the importance of linking learning to patient outcomes and notes that this pioneering program has the potential to fill a significant funding gap in health professions educational research.

A critical component of any modern healthcare system is the ability to integrate biomedical knowledge with technology to improve public health surveillance, decision-support systems for

patient care management, evidence-based practice, collaboration and continuity of care among practitioners, and real-time practitioner education. With its enterprise-wide, integrated electronic health record, VA is ideally positioned to set new standards in healthcare informatics. The Panel applauds the recent launching of a new HSR&D initiative in healthcare informatics, which is intended to support safe and effective clinical practice, health system redesign and VA's new genomics and personalized medicine initiative. The Panel likewise commends VA for its support of an advanced fellowship in medical informatics.

Despite these positive developments, the Panel notes with concern the aging of the software platform for VA's highly-regarded electronic medical record and the chilling effect of information technology budgetary restrictions and recent organizational changes on its future development. Organizational changes that essentially separate those most responsible for innovation (so-called "end-users", spread out in VA facilities across the country) from VA's centralized information technology management team are of special concern. Given the quickening pace of technologic change and the rapid advances now occurring in the private sector, VA is in imminent danger of losing its position as the nation's leader in the critical area of medical informatics. Absent a state-of-the-art electronic medical record with the requisite analytical and computational ability, transformational changes in patient care, education or research can not be achieved.

In 2006, VA's Office of Research and Development launched the VA Genomic Medicine Program to apply the rapidly expanding knowledge of the human genome to medical practice and, in particular, to examine the potential of emerging genomic technologies for improving medical care for Veterans. Although genomic medicine carries the promise to revolutionize medicine by "personalizing" care to the level of the individual, complex ethical, technical and organizational challenges require solution before widespread adoption of genomic medicine in clinical care is warranted. Nonetheless, the Panel applauds VA's entry into this revolutionary new field and notes that VA's expertise in population-based care and large-scale clinical trials and academic medicine's expertise in basic genomic research provide significant new collaborative opportunities.

More dynamic research collaboration with the academic community will promote transformative change

Academic medical centers conduct a significant fraction of the Nation's biomedical research. VA's research programs in general, and the Career Development program in particular, have long served as research workforce "incubators". Because much of modern biomedical research requires investigators with disparate expertise, many research questions are best addressed collaboratively. While realizing the advantages of an intramural research program, the VA Research and Development program has recognized the need to embrace close affiliations with academic institutions. And it has fostered strong collaborations with other federal agencies as well as private industry sponsors. The Panel strongly endorses these collaborative arrangements. Collaboration allows VA's research enterprise to leverage resources, to accelerate the translation of research findings to clinical application and to strengthen VA's national research and development impact.

In recent years, as the federal government has adopted much stricter standards for information systems and data security, barriers have been erected that are inadvertently inhibiting the free

flow of information. Whereas widespread concern exists about its adverse impact on overall affiliation relationships, the new information security mandates are especially troubling to the research community; almost 80% of VA facility and nearly 60% of medical school research leadership responded negatively when polled about this aspect of the partnership (Appendix 7, Figure 7).

The Panel applauds recent joint efforts by VA and the Association of American Medical Colleges (AAMC) to address these issues, but urges both parties to establish a more aggressive timetable for finding acceptable solutions. Doing so is essential if VA and its academic partners are to maintain and enhance their highly successful collaborative research enterprise.

For similar reasons, closer attention is needed regarding policies governing *where* VA-funded research is conducted and *by whom*. Nearly 60% of medical school deans felt that the restriction of VA research funding to faculty appointed at the 5/8th level or higher hindered collaboration (Appendix 7, Figure 8). While the Panel endorses the need for a strong intramural research program, it cautions that policies limiting more dynamic collaboration can ultimately undermine the quality of both research and patient care. The Panel is confident that appropriate guidelines and safeguards could be established to ensure that new models of enhanced research collaboration will uphold the fundamental intent of the VA research program – to enhance the care and well-being of Veterans.

VA's research infrastructure must be improved to support transformative change

Aging research facilities significantly limit VA's ability to conduct an efficient and effective biomedical research program. Adequate funding to modernize and maintain its physical facilities is essential if VA research is to remain competitive. Given the high cost of such capital investment and the fact that many academic affiliates currently have excess laboratory space, the Panel believes that joint ventures between VA and its academic affiliates would be mutually advantageous. Examples of joint ventures that might be considered include leasing of laboratory space, sharing of expensive equipment, co-location of VA- and university-based investigators and joint access to core services.

Working in a scholarly environment that offers opportunities for engaging in and benefiting from research and discovery provides an attractive career option for young physicians. Hence, increased investment in research infrastructure not only advances knowledge but also supports the preparation of a new generation of healthcare professionals, thereby enhancing VA's ability to recruit and retain a high quality, diverse clinical workforce.

Establishing educational and research productivity metrics and assessing leadership performance will promote the academic mission

The Panel commends VA on the development and testing of models of clinical productivity. However, the Panel was disturbed to find that no analogous system for measuring educational or research productivity has been adopted enterprise-wide, despite the increasing use of such metrics in the broader academic community for purposes of resource allocation and mission-based budgeting. Indeed, it appears that *clinical* productivity measures are being utilized as measures of *overall* productivity. While certainly valuable in its own right, an emphasis on clinical productivity to the exclusion of VA's statutory academic mission sends a strong message to clinicians, educators and investigators alike that VA leadership values clinical but not academic accomplishments.

VA is rightly renowned for its use of performance measures to improve the process and quality of patient care and enhance program management and policy execution. However, the Panel finds it remarkable that over many years and with several hundred performance measures currently in place, only two (learner satisfaction and resident supervision) have specifically related to VA's academic mission.

Holding executive leadership at all levels of the organization more accountable for educational and research outcomes would be a major step forward. Given VA's "culture of performance", the Panel believes that the adoption of a select number of measures of academic achievement and overall "affiliation effectiveness" would go a long way to building widespread confidence that VA truly values its partnership with the academic community.

Attention to academic professional development will promote collaboration

Several current realities appear to have weakened the academic bonds between VA and its affiliates. In VA's organizational structure, the Chief of Staff functions as the local facility's "chief academic officer", yet many individuals currently serving in this position (as well as many other senior leaders in VA) have limited experience in or familiarity with the academic world. The Panel believes this state of affairs poses a significant obstacle to advancing academic partnerships and should be remedied. A partial remedy, at least in the short run, might be to offer an "academic affiliation" curriculum as part of, the executive development program for present and future Chiefs of Staff (and other VA senior executives) who lack the requisite academic background.

In general, academic affiliates have more involvement in the selection of VA facility leadership than VA has in the selection of medical school senior executives (Appendix 7, Figure 9). Similarly, VA Central Office (VACO) academic program offices are not routinely included in the recruitment and selection of VA field executives. Colleagueship among VA and academic leaders might be enhanced if search committees and selection panels for these and other key positions had broader representation.

Recent years have witnessed a regrettable reduction in attendance by VA senior leadership in AAMC's national and regional meetings and other executive-level professional development programs. The Panel strongly encourages VA's academic leaders to participate in such activities and applauds recent efforts by the Office of Academic Affiliations to emphasize attendance by VA Designated Education Officers (DEOs) at the annual meeting of the AAMC's Group on Resident Affairs (GRA) and participation in the GRA's Leadership Development course.

"Regulatory overload" limits collaboration with academic affiliates

As a healthcare system within a department of the U.S. government, VA is understandably subject to special scrutiny by Congressional Committees, the Government Accountability Office, the Office of Management and Budget, and the media. VA's internal oversight bodies include: the Office of the Inspector General, which has general auditing authority and whose Inspector General reports jointly to the Secretary and Congress; the Office of Information and Technology, which assures compliance with federal security and privacy regulations; the Office of General Counsel, which interprets and provides guidance on federal conflict of interest policy and regulations; the Office of Research Oversight, which assures compliance with federal, state and other regulations concerning human and animal research; and the Office of the Medical Inspector, which is authorized to conduct investigations into issues involving medical care.

Dealing with a well-intentioned but exceedingly complex system of checks and balances is proving to be increasingly stressful for VA and its academic partners alike. Particular exasperation has been expressed over recent policy changes affecting each of the following: information security and privacy; contracting for shared medical services; conflict of interest; part-time physician time and attendance; and mandatory training (Appendix 7, Figures 7, 10, 11 and 12). The Panel believes that simplifying policies and procedures in these five crucial areas would go a long way to lessening the regulatory burden and the resulting tensions it creates between VA and its academic partners.

Information technology (IT) connectivity with academic affiliates: The ability to freely share information is the foundation for successful relationships. By restricting information sharing, present IT policies and procedures constrain VA's patient care, educational and research programs. The Panel believes that VA's IT policies and procedures should be reformulated to consistently and explicitly support the business requirements of its clinical and academic missions while maintaining appropriate safeguards over private and sensitive information.

Sole source contracting with academic affiliates: Existing statutory authority to contract with affiliated academic medical centers adds breadth and value to VA's clinical programs, thereby enhancing Veterans' health care. However, sole source contracting authority has been eroded in recent years by audits, opinions, policy interpretations and complex operational oversight by the VA Office of the Inspector General (OIG), among others. The Panel believes that within a general framework of accountability for public funds, sole source contracting policies and procedures should be simplified to maintain and enhance patient care and promote rather than restrain collaboration with the academic community.

Chief of Staff conflict of interest: As a VA facility's senior clinical and academic official, the Chief of Staff must have the credentials and skills to fully engage with the academic community. However, government ethics rules work at cross-purposes with this imperative, making operational and strategic planning difficult and significantly impairing affiliation relationships. The Panel believes that VA's policies and procedures should be modified to signify the need for the Chief of Staff to have a stake in the success of both VA *and* its academic partner(s).

Part-time physician time and attendance: Academic relationships often are built on a "shared faculty" model, in which the physician has an employee relationship with multiple institutions. Flexibility in assignments is an essential component of a "shared faculty" model. At variance with this model, VA has adopted rigid time-keeping policies and procedures which inadvertently but unquestionably detract from the goal of excellence in patient care. To continue to reap the benefits of academic partnerships, the Panel believes that VA should reexamine part-time physician "time and attendance" policies and simplify their implementation with an eye toward greater flexibility, while maintaining appropriate accountability for public funds.

Mandatory training: VA currently requires all employees, including "shared" and even unpaid faculty and trainees, to undergo many hours of mandatory training, generally without evidence of effectiveness. In many if not most cases, such training is duplicative of the academic affiliate's own required training. The Panel believes that VA and its academic affiliates should examine the quality and effectiveness of mandatory training and work towards a system that provides joint training and training reciprocity.

In addition to recommended changes in policies and procedures, the Panel emphasizes that clear and frequent communication is also important in lessening regulatory burden. Matters that have the potential to affect academic partnerships should be discussed at national, regional and local levels prospectively rather than after the fact. Consultation and, where possible, appropriate negotiation with the academic community prior to finalizing and issuing new or revised policies should be the norm rather than the exception. In return, national academic leadership must assume responsibility for disseminating and explaining projected VA policy changes to the academic community.

Existing partnership governance limits effective communication and joint problem solving

VA and the academic healthcare community share the same foundational values: a commitment to providing high quality care; recognition of the interdependence of patient care, education and research; and a strong public service ethic. In addition to shared values, mutual trust is also a key feature of successful partnerships. Trust, in turn, requires mutual understanding, which can only be achieved by frequent and clear communication.

Absent clear communication, relatively minor differences, whether based in reality or in perception, may escalate into significant confrontations. Trust can rapidly evaporate if, for example, a VA hospital director appears unconcerned about accreditation costs borne by the affiliate; if a chief executive officer of an academic medical center views VA's new physician pay bill only in terms of what it might do to his own staffing opportunities; if a medical school dean sees VA's collaboration with the Department of Defense as a turning away from the academic

community; or if sufficient attention is not given to aligning differing faculty reward and recognition systems.

Each of these examples are illustrative of countless issues that can be amicably resolved by trusting partners through substantive discussion in appropriate venues. Partners must respect each other's fiduciary obligations and responsibilities, seek pre-decisional input into policies under development, recognize each others contributions and accomplishments, be committed to the success of the other partner, and be willing to compromise in order to enhance the effectiveness of the relationship.

The Panel is concerned that currently available mechanisms for communication are inadequate to the task and is convinced that VA's relationships with the academic community could be greatly improved by having effective forums for discussion, planning and decision making at national, regional and local levels.

National governance: At the present time, the sole national forum for discussing affiliation issues is the VA-Council of Deans Liaison Committee, an informal body convened by the Association of American Medical Colleges (AAMC). In addition to a small group of medical school deans, this committee includes the Under Secretary for Health and other senior VA managers and typically meets two or three times annually. A similar body convened by the American Association of Colleges of Nursing (AACN) had its inaugural meeting earlier this year.

Neither of these bodies has the authority to move beyond information sharing to joint strategic planning. Nor do they have the supporting infrastructure to conduct in-depth analyses between infrequently scheduled meetings. In order to facilitate joint strategic planning and problem solving, these bodies should be strengthened or replaced with more authoritative groups.

To be effective, a new national governance body must provide a forum for *substantive* discussion and negotiation and should be authorized to provide ongoing advisory input to both VA and the national academic community. The Panel envisions a consultative/advisory body charged with reviewing those VA and university policies and procedures with significant potential to affect affiliation relationships and with developing and recommending ways to eliminate or mitigate impediments to collaboration. Such a body might take the form of an overarching committee, comprising representatives from key academic stakeholders, including schools of medicine and nursing, and would carry out its work through ad-hoc subcommittees or task groups focused on particular issues.

Regional governance: VA's Integrated Service Networks (VISNs) have responsibility for oversight of strategic planning, funding and operations within their individual regions, including by inference VA's academic mission. However, with few exceptions, only nominal oversight of or support for academic affiliations is evident. Lack of regional oversight may be explained in a number of ways – lack of an appropriate governance structure, lack of appropriate expertise or sufficient resources, the press of other work, especially fiscal and clinical operations, and so on. Whatever the cause, however, the Panel believes that absent strong support at the regional level in a system that is heavily dependent on decentralized operations, it will be very difficult to maintain and enhance VA's relationships with the academic community.

In order to promote effective affiliations, VA's regional networks need to assume greater accountability for the academic mission and responsibility for the quality of academic partnerships within their individual jurisdictions. The Panel emphasizes that it is *not* suggesting

that networks duplicate either the structure or the work of local affiliation councils, but rather that they assume oversight of affiliations within their networks, thereby serving as an essential link between academic operations at the local facility level and VA Central Office.

The Panel believes that such oversight would be most effectively managed if each VISN had an appropriately qualified individual (such as a Network Academic Affiliations Officer) with *sufficient authority and resources* to assure local accountability for affiliation effectiveness. Specific, affiliation-related performance standards, which would hold VISN leadership accountable for proficient regional oversight, should also be developed.

Local governance: Because affiliation relationships are fundamentally local in nature, the Panel believes that the local Academic Partnership Council (previously known as the "Deans Committee") must continue to serve as the key governing body for individual partnerships. While some local councils appear to be functioning well, others are poorly attended (Appendix 5), are engaged predominantly or exclusively with information sharing, and are not empowered to do joint strategic planning. (Appendix 7, Figure 13).

Most current councils have more than 20 members (Appendix 5, Figure 1), which is not conducive to substantive discussion. Moreover, the rigid council structure imposed by current VA policy thwarts the expressed desire of VA and medical school leaders to use this forum for effective problem-solving and planning (Appendix 7, Figure 14).

The absence of effective local governance is a major obstacle to envisioning and implementing improvements in affiliation relationships. Local affiliation governance must be restructured in such a way that expectations are raised and all parties are made more accountable for their actions and interactions. Only then will the full potential inherent in the VA's academic affiliations be realized.

Recommendations

The current crisis in the U.S. healthcare system offers a unique opportunity to explore fundamentally new and better models of patient care, education and research. Given its enduring partnership with the academic community, its past and present investments in academic infrastructure and its particular expertise in clinical system redesign, VA is well-positioned to take a leadership role in educating the future healthcare workforce, advancing medical science and helping to transform the healthcare system for the 21st century. However, to achieve its full potential requires that VA first address organizational and policy impediments which significantly limit the effectiveness of its relationships with the academic community.

The Panel urges VA and its academic affiliates to seize this opportunity and respectfully offers the following recommendations for consideration by the Secretary of the Department of Veterans Affairs.

1. VA's partnership with the academic community should be strengthened in order to further enhance health care for Veterans and lead the transformation of the U.S. healthcare system.

1.1. To improve the health of Veterans and the Nation, VA and its academic partners should increase investments in the development and testing of clinical programs designed to support patient-centered, evidence-based, integrated and comprehensive care.

1.1.1. VA and its academic partners should develop local and regional VA-Academic Medical Center strategic alliances and/or joint ventures to provide comprehensive, cost-effective care for Veterans and their dependents, thereby modeling ways that the Nation's health care system might be transformed.

1.1.2. VA and its academic partners should accelerate clinical system redesign focused on models of care of particular relevance to Veterans (e.g., inter-professional team-based care for the management of chronic illness, post-traumatic stress disorder, polytrauma).

1.1.3. VA and its academic partners should promote the interoperability of electronic health records to support collaborative care (both within VA and between VA and its academic affiliates). This effort would advance and complement present initiatives to enhance electronic communication between the VA and Military healthcare systems.

1.1.4. VA and its academic partners should work towards the development of joint electronic information systems to support learning and provider performance. This effort should be focused, in part, on providing clinicians with real time, evidence-based decision support and on developing appropriate benchmarks to monitor individual and team performance over time.

1.2. To prepare an appropriately skilled healthcare workforce, VA and its academic partners should increase investments in the development and testing of innovative educational programs to better align health professions education with the healthcare needs of Veterans and the Nation.

1.2.1. VA and its academic partners should strengthen their collaborative efforts to prepare a diverse and culturally-sensitive clinical workforce with the competencies to deliver high quality, safe and effective patient care. These efforts should include joint ventures between VA and selected health professions to design and test new models of inter-professional education, expansion of existing relationships with minority health professions schools, and the implementation of trainee exchange programs with the Military healthcare system.

1.2.2. VA and its academic partners should fully utilize VA's diverse and innovative clinical environments to expand opportunities for health professions education and facilitate leadership development. These efforts should include joint ventures with the academic community in further enhancing geriatric, mental health, polytrauma and rural health care. Expansion of existing professional development opportunities in clinical and educational system redesign, provider performance measurement and healthcare informatics would be especially worthwhile.

1.2.3. To meet projected physician workforce needs, VA and its academic affiliates should increase the number of graduate medical education (GME) positions it supports beyond the 5-year period covered by VA's present GME Enhancement Initiative. This expansion would not only address VA and the Nation's physician workforce shortages but also promote the design and testing of innovative new educational models with the potential to transform the content and process of medical education.

1.2.4. To meet other healthcare workforce needs, VA and its academic partners should develop a comprehensive plan to expand training in the non-physician health professions. This plan should address VA and the Nation's non-physician health workforce shortages and promote the design and testing of new models of partnership with the Nation's health professions schools. The recently established VA Nursing Academy offers an example of such a model.

1.2.5. VA and its academic partners should disseminate their experiences with new curricula and learning strategies broadly to the country's health professions educators.

1.3. To enhance the translation of biomedical science into improved health care, VA and its academic partners should redouble their joint efforts to develop new knowledge through collaborative research.

1.3.1. VA should enhance research funding in order to accelerate the pace of health-related discovery. Efforts should be directed at increasing VA's research appropriation, facilitating industry funding for clinical trials and promoting transfers from other federal agencies to support areas of joint interest (e.g.,

from the Department of Defense to support research in traumatic brain injury).

1.3.2. VA and its academic partners should expand collaborative and joint research activities. Promising areas for collaboration include preventive medicine, rehabilitative and regenerative medicine, health services research, educational research, healthcare informatics, genomic studies and personalized medicine.

1.3.3. VA should further increase merit review grant funding levels, expand the career development award program (especially for junior investigators), secure adequate protected time for researchers, and enhance core research facilities through new construction and renovation of existing research space.

1.3.4. VA and its academic partners should fully exploit opportunities to share research resources, including laboratory space, instrumentation, core facilities, computational software and statistical expertise.

1.3.5. VA and its academic partners should disseminate new research findings broadly throughout the U.S. healthcare community and beyond.

1.4. To foster transformative educational and research programs, VA and its academic partners should:

1.4.1. Conduct comprehensive inventories of VA's educational and research assets.

1.4.2. Develop national policy standards for assessing the adequacy of financial and administrative support for the academic mission and for ensuring transparency in the distribution and use of Veterans Equitable Resource Allocation (VERA) funds for education and research.

1.4.3. Establish mechanisms for sharing the indirect costs of education equitably.

1.4.4. Establish educational and research productivity metrics to promote the academic mission.

1.4.5. Develop performance standards and measures that support the academic mission, including measures of leadership performance and overall affiliation effectiveness.

1.4.6. Define the competencies needed to manage academic affiliations effectively and develop senior executive professional development programs focused on academic affiliation management.

1.4.7. Include appropriate individuals from each partner on search committees for all senior executives and key affiliation managers.

1.5. To optimize the effectiveness of its academic partnerships, VA should modify policies and procedures that currently limit collaboration. Among the most important policies and procedures in question are:

1.5.1. Information technology (IT) connectivity. VA's IT policies and procedures should be reformulated to consistently and explicitly support the business requirements of its clinical and academic missions while maintaining appropriate safeguards for private information.

1.5.2. Sole source contracting. Within a general framework of accountability for public funds, VA's sole source contracting policies and procedures should be

modified to promote rather than restrain collaboration with the academic community.

1.5.3. Chief of Staff conflict of interest. VA's conflict of interest policies and procedures should be modified to signify the need for the Chief of Staff to have a stake in the success of both VA *and* its academic partner(s).

1.5.4. Part-time physician time and attendance. To optimize the benefits it receives from its academic partnerships, VA should modify existing "time and attendance" policies to allow for more flexible implementation while maintaining appropriate accountability for public funds.

1.5.5. Mandatory training. VA and its academic affiliates should examine the quality and effectiveness of mandatory training and work towards a system that provides joint training and training reciprocity.

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2. To realize the full potential of the partnership, VA and its academic affiliates should establish more effective national, regional and local management structures.

2.1. VA should establish a National Academic Affiliations Council, organized as a standing committee under the Federal Advisory Committee Act (FACA) and advisory to the Secretary of Veterans Affairs. The National Academic Affiliations Council should:

2.1.1. Develop a joint statement of values and principles to guide relationships with the academic community;

2.1.2. Set expectations and establish guidelines for joint strategic, tactical and operational planning by VA and its academic affiliates;

2.1.3. Establish effective communication with relevant stakeholder organizations;

2.1.4. Develop mechanisms to expand mutually advantageous affiliations with the academic community;

2.1.5. Identify opportunities to better align missions and operations at national, regional and local levels;

2.1.6. Identify policy, regulatory and administrative impediments to effective affiliation management;

2.1.7. Recommend the level of investments in administrative and support services needed to advance the academic mission;

2.1.8. Develop and test performance standards and measures to optimize academic productivity and affiliation management; and

2.1.9. Develop mechanisms to facilitate the development of local and regional strategic alliances and/or joint ventures between VA and Academic Medical Centers.

2.2. Veterans Integrated Service Networks (VISNs) should facilitate local affiliation relationships to promote VA's academic mission. VISNs should:

2.2.1. Work actively to enhance affiliation relationships that support VA's patient care and academic missions;

2.2.2. Ensure implementation of National Academic Affiliation Council recommendations in affiliated facilities within their jurisdiction;

2.2.3. Review annually the effectiveness of local academic affiliations; and

2.2.4. Report annually the effectiveness of local affiliation relationships and leadership performance to VA Central Office (VACO) officials.

2.3. VA and its academic affiliates should establish more effective local affiliation management. Local Academic Partnership Councils should:

2.3.1. Promote a joint vision for the future and actively enhance affiliation relationships;

2.3.2. Implement National Academic Affiliation Council recommendations;

2.3.3. Oversee joint planning and dispute resolution processes;

2.3.4. Review at least annually the effectiveness of affiliation relationships and leadership performance; and

2.3.5. Report annually the effectiveness of local affiliation relationships and leadership performance to Veterans Integrated Service Network (VISN) and School/University officials.

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Appendices

Appendix 1 Blue Ribbon Panel Committee Membership

Appendix 2 Blue Ribbon Panel Charter *9/25/2006* and Extension *8/28/2008*

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Appendix 1

Committee Membership
Blue Ribbon Panel on VA - Medical School Affiliations

Jordan J. Cohen, M.D., Chair
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Professor of Medicine Emeritus
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President & CEO
Baylor College of Medicine
Houston, TX

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Secretary, Council on Medical Education,
American Medical Association
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Appendix 2

Blue Ribbon Panel Charter
9/25/2006

DEPARTMENT OF VETERANS AFFAIRS
CHARTER OF THE
BLUE RIBBON PANEL ON VA-MEDICAL SCHOOL AFFILIATIONS

A. OFFICIAL DESIGNATION: Blue Ribbon Panel on VA-Medical School Affiliations.

B. OBJECTIVES AND SCOPE OF ACTIVITY: The Blue Ribbon Panel on VA-Medical School Affiliations will advise the Secretary of Veterans Affairs and the Under Secretary for Health on the formation of a comprehensive framework for guiding VA's affiliations with medical schools and academic medical centers.

C. PERIOD OF TIME NECESSARY FOR THE PANEL TO CARRY OUT ITS PURPOSE: The Panel will terminate 18 months after its first meeting.

D. OFFICIAL TO WHOM THE PANEL REPORTS: The Panel will report to the Secretary through the Under Secretary for Health.

E. OFFICE RESPONSIBLE FOR PROVIDING THE NECESSARY SUPPORT TO THE PANEL: The Office of Academic Affiliations, Veterans Health Administration, Department of Veterans Affairs, will be responsible for providing support to the Blue Ribbon Panel on VA-Medical School Affiliations.

F. DUTIES OF THE PANEL: As part of the 60th anniversary of Policy Memorandum #2 (Association of Veterans' Hospitals with Medical Schools), the Blue Ribbon Panel on VA-Medical School Affiliations will provide advice and consultation relating to a broad re-assessment of these partnerships in light of changes in medical education, shifting research priorities, and current and future veterans' health care needs. The Panel will be guided by VA's strategic planning initiative to ensure equitable, harmonious, and synergistic academic affiliations.

The Panel will engage in the following activities:

- Assess the principles governing VA's relationships with medical schools and academic medical centers
- Review Policy Memorandum #2 and make recommendations to either reaffirm its provisions or update them as necessary
- Provide national guidance for enhancement of VA-medical school affiliations based on projected changes in medical education, research, and patient care services

The Panel will be comprised of approximately fifteen (15) members. Several members will be Regular Government Employees (RGE), but the majority of the Panel's membership will be Special Government Employees (SGE). In selecting members, the

Secretary will appoint individuals who can effectively express the views of large and small medical schools which are involved in the principal affiliation activities (research, patient care, and education).

G. ESTIMATED ANNUAL OPERATING COSTS IN DOLLARS AND STAFF-YEARS: Estimated annual operating costs for the Blue Ribbon Panel on VA-Medical School Affiliations are $94,000 which includes 0.5 staff years. Members will receive travel expenses and a per diem allowance in accordance with Federal Travel Regulation for any travel made in connection with their duties as members of the Panel.

H. ESTIMATED NUMBER AND FREQUENCY OF MEETINGS: The Panel is expected to meet up to twice annually. The Designated Federal Officer (DFO), a full time VA employee, will approve the schedule of Panel meetings. The DFO or a designee will be present at all meetings, and each meeting will be conducted in accordance with an agenda approved by the DFO. The DFO is authorized to adjourn any meeting when he or she determines it is in the public interest to do so.

I. PANEL TERMINATION DATE: The Panel will terminate 18 months after its first meeting.

J. DATE CHARTER IS FILED:

Approved: _____ Date: 9/25/06
R. James Nicholson
Secretary of Veterans Affairs

Blue Ribbon Panel Extension *8/28/2008*

DEPARTMENT OF VETERANS AFFAIRS
CHARTER OF THE
BLUE RIBBON PANEL ON VA-MEDICAL SCHOOL AFFILIATIONS

K. OFFICIAL DESIGNATION: Blue Ribbon Panel on VA-Medical School Affiliations.

L. OBJECTIVES AND SCOPE OF ACTIVITY: The Blue Ribbon Panel on VA-Medical School Affiliations will advise the Secretary of Veterans Affairs and the Under Secretary for Health on the formation of a comprehensive framework for guiding VA's affiliations with medical schools and academic medical centers.

M. PERIOD OF TIME NECESSARY FOR THE PANEL TO CARRY OUT ITS PURPOSE: The Panel will terminate not later than September 30, 2009.

N. OFFICIAL TO WHOM THE PANEL REPORTS: The Panel will report to the Secretary through the Under Secretary for Health.

O. OFFICE RESPONSIBLE FOR PROVIDING THE NECESSARY SUPPORT TO THE PANEL: The Office of Academic Affiliations, Veterans Health Administration, Department of Veterans Affairs, will be responsible for providing support to the Blue Ribbon Panel on VA-Medical School Affiliations.

P. DUTIES OF THE PANEL: As part of the 60th anniversary of Policy Memorandum #2 (Association of Veterans' Hospitals with Medical Schools), the Blue Ribbon Panel on VA-Medical School Affiliations will provide advice and consultation relating to a broad re-assessment of these partnerships in light of changes in medical education, shifting research priorities, and current and future veterans' health care needs. The Panel will be guided by VA's strategic planning initiative to ensure equitable, harmonious, and synergistic academic affiliations. The Panel will (a) assess the principles governing VA's relationships with medical schools and academic medical centers; (b) review Policy Memorandum #2 and make recommendations to either reaffirm its provisions or update them as necessary; and (c) provide national guidance for enhancement of VA-medical school affiliations based on projected changes in medical education, research, and patient care services.

The Panel will be comprised of approximately 15 members. Panel members shall be appointed by the Secretary and shall serve as objective advisors, not as representatives of any organizations for which they may otherwise be serving. Several members may be Regular Government Employees (RGE), but the majority of the Panel's membership will be Special Government Employees (SGE). The Panel's membership will include individuals who can effectively express the views of large and small medical schools which are involved in the principal affiliation activities (research, patient care, and education).

Q. ESTIMATED ANNUAL OPERATING COSTS IN DOLLARS AND STAFF-YEARS: Estimated annual operating costs for the Blue Ribbon Panel on VA-Medical School Affiliations are $94,000 which includes 0.5 staff years. Members will receive travel expenses and a per diem allowance in accordance with Federal Travel Regulation for any travel made in connection with their duties as members of the Panel.

R. ESTIMATED NUMBER AND FREQUENCY OF MEETINGS: The Panel is expected to meet at least twice annually. The Designated Federal Officer (DFO), a full time VA employee, will approve the schedule of Panel meetings. The DFO or a designee will be present at all meetings, and each meeting will be conducted in accordance with an agenda approved by the DFO. The DFO is authorized to adjourn any meeting when he or she determines it is in the public interest to do so.

S. PANEL TERMINATION DATE: The Panel will terminate not later than September 30, 2009.

T. DATE CHARTER IS FILED:

Approved: _____ Date: 8/28/08
James B. Peake, M.D.
Secretary of Veterans Affairs

Appendix 3

Internal Advisory Committee
to the Blue Ribbon Panel on VA - Medical School Affiliations

Peter Almenoff, M.D.
Network Director VISN 15
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David C Aron, M.D.
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Grant Cannon, M.D.
ACOS/Academic Affiliations
VAMC Salt Lake City
Salt Lake City, UT

Jeannette Chirico-Post, M.D.
Network Director, VISN 1
VA New England Healthcare Network
Bedford, MA

Timothy Flynn, M.D. (Chair)
(Member of Blue Ribbon Panel)
Professor of Surgery and Associate Dean
Graduate Medical Education
University of Florida
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Sheila C. Gelman, M.D.
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VA Connecticut Healthcare System
West Haven, CT

Raymond Joehl, M.D.
Chief Surgical Service
VAMC Hines
Hines, IL

Sheri Keitz, M.D. Ph.D.
Chief of Medicine
VAMC Miami
Miami, FL

James R. McCormick, M.D.
Network Academic Affiliations Officer VISN 9 and
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Gordon Starkebaum, M.D.
Chief of Staff
VA Puget Sound Health Care System
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Appendix 4

Affiliation Governance Survey (AGS) Instrument

Introduction/Background/Instructions:

The Office of Academic Affiliations is conducting the present survey of its teaching facilities in order to determine the structure and functioning of existing governance committees involved in the administration and management of affiliation relationships with medical schools. Only those facilities with medical school affiliations for physician residency training should complete the survey. The survey is conducted as part of the ongoing review of academic affiliations that is being undertaken in support of the VA's Federally-chartered Blue Ribbon Panel on VA-Medical School Affiliations.

A governance committee is defined as a council or group of educational and clinical leaders and managers that meets periodically and has membership representing the VA facility and the primary academic affiliates of the VA facility.

Only one response per facility will be accepted for the survey. Consolidated facilities with a single governance structure need only submit one response. Those individuals with facility-level access to the OAA Support Center Database may complete the survey.

Affiliation Governance Survey

Three Preliminary Questions:

1. Please Update your Facility Designated Education Officer (DEO) Information.
   (Prefilled for your facility)

2. OAA records indicate you have affiliations with the following sponsors of undergraduate and graduate medical education. Please verify these affiliations and add any other affiliated sponsors of medical education.
   (Prefilled for you facility with the option to deselect and/or add additional sponsors.)

3. VA facilities also have affiliations with a number of other health professions schools. Please check all disciplines in which you have current active affiliations:
   (Prefilled for you facility with the option to deselect and/or add additional disciplines.)

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1. Do you have a formal governance committee or council to assist in the management of the relationship between the VA and its affiliated institutions?

   - Yes
   - No

   (If Yes)

   * What is the name(s) of your governance committee or council?

   - Academic Affiliations Partnership Council
   - Deans Committee
   - Other Name *(Text Box Entry)*

   (If No)

   *Please explain what other mechanisms or structures you use to manage your affiliation relationships: *(Text Box Entry)*

2. How many meetings of the governance committee have occurred during the past year?

3. How many total members (VA and non-VA) are appointed to your governance committee?

4. What has been the average attendance at your governance committee meetings during the past year?

Affiliation Governance Survey

5A. Select the organizational titles that best represent the titles of the members appointed to your governance committee: (Select all that apply)

Category	Organizational Title
Allied Health	Dean School of Allied Health
Dentistry	Dean School of Dentistry
Medicine	Dean School of Medicine
Medicine	Associate Dean for GME
Medicine	Department Chair, Internal Medicine
Medicine	Department Chair, General Surgery
Medicine	Department Chair, Psychiatry
Nursing	Dean School of Nursing
Optometry	Dean School of Optometry
Pharmacy	Dean School of Pharmacy
Podiatry	Dean School of Podiatry
Public Health	Dean School of Public Health
StakeHolders *(other interested)*	Representative, VA Non-Profit Corporation
StakeHolders *(other interested)*	VSO Representative
VAMC	Director
VAMC	Chief of Staff
VAMC	Associate Chief of Staff for Education *(Designated Education Officer)*
VAMC	Associate Chief of Staff for Research
VAMC	Associate Director for Patient Care Services *(Nursing Executive)*
VAMC	Associate Director
VAMC	Service Chief, Internal Medicine
VAMC	Service Chief, General Surgery
VAMC	Service Chief, Psychiatry
VAMC	VISN Representative
VAMC	Add Another *(Text Box Entry)*

5B. Please provide the organizational titles that best represent the titles of the members for OTHER ACADEMIC SCHOOLS. You can enter one or more.

- Other Academic Schools *(Text Box Entry)*
- Title of Members *(Text Box Entry)*

6. Please enter the organizational title(s) of the Chair (Co-Chairs) of the governance committee:

   - Enter Co-chair(s) if applicable *(Text Box Entry)*

7. Do you have limited or unlimited terms of service for governance committee members?

   - Limited
   - Unlimited

   If governance committee terms of service are limited, what is your standard term of service for the Chair or Co-Chairs?

   If governance committee terms of service are limited, what is your standard term of service for members?

8. Do you keep minutes of governance committee meetings?

   - Yes *(If Yes, for how long in years?)*
   - No

9. In the last year, have you had any sub-council's/sub-committees, task forces or working groups aligned under your overall council/committee?

   - Yes *(If Yes, go to Question 10)*
   - No

Affiliation Governance Survey

10. What is the name(s) that comes closest to your sub-council/sub committee or task force. (Check All that Apply).

    If not a formal named group, please fill in area of interest by filling in the text box below the grid in Part 1 and clicking "Add another". *(This example shows the first one checked.)*

Part 1
Medical (physician) Education Sub-Council
Nursing Education Sub-Council
Continuing Education Sub-Council
Research Sub-Council
Information Technology Sub-Council
Add Another *(Text Box Entry)*

Part 2 - Click **Edit** for each row to input your answers for each item selected above.

	Name(s)	Total Members *1	Avg Attendance *2	Meetings Per Year *3	Title of Chairs *4
Edit	Medical (physician) Education Sub-Council	0	0	0	

1. How many total members (VA and non-VA) are appointed to the sub-council/sub-committee?
2. What is the average attendance at the sub-council/sub-committee meetings?
3. How many meetings of the sub-council/sub-committee/task force/working group do you schedule per year?
4. What is the organizational title(s) of the Chair (Co-Chairs) of the sub-council/sub-committee?

Affiliation Governance Survey

11A. In the past 2 years, have any of the following items been on the agenda of the governance committee or any of its sub-council/sub-committees (please check all that apply):

Education
Implementation/expansion of medical student training programs
Implementation/expansion of graduate medical education programs
Implementation/expansion of dental training programs
Implementation/expansion of nursing training programs
Implementation/expansion of other associated health training programs
Implementation/expansion of VA's Special (Advanced) fellowship programs
Training program accreditation requirements
Remediation of accreditation body citations or concerns
Administrative costs of physician residency program accreditation
Physician resident disbursement agreement administration
Nomination of candidates for training positions
Trainee educational credentialing policy or procedures
Trainee orientation policy or procedures
Requirements for mandatory training (e.g., ethics, traumatic brain injury)
Inter-professional teamwork training opportunities
Information technology support for educational programs
Physician resident duty hours
Physician resident supervision policy or procedures
Physician resident position allocation by VA Central Office
Physician resident position distribution by the local VA facility
Role of VISN in physician resident position distribution
Qualifications of the ACOS for Education
Responsibilities of the ACOS for Education
Administrative resources available to the ACOS for Education
Role of VISN in affiliations management
Add Another *(Text Box Entry)*

Affiliation Governance Survey

11B. In the past 2 years, have any of the following items been on the agenda of the governance committee and/or subcommittee/subcouncil? *(Please check all that apply)*

Research
VA's overall national research budget
Distribution of VA research funding by major programs locally
Merit Review Program funding caps
Capital expenditures for space and equipment
Utilization of VA research space and facilities
Eligibility for VA research funding
Information technology support for research programs
VA-affiliate research collaboration
Indirect cost recovery policy or procedures
Institutional Review Board (IRB) policies or procedures
Human research accreditation standards
Research effort reporting
Intellectual property rights
Research data security policy or procedures
Cooperative Research and Development Agreements (CRADA)
Non-Profit Research Foundations
Qualifications of the ACOS for Research
Responsibilities of the ACOS for Research
Administrative resources available to the ACOS for Research
Role of VISN in research managements
Add Another *(Text Box Entry)*

11C. In the past 2 years, have any of the following items been on the agenda of the governance committee and/or subcommittee/subcouncil? *(Please check all that apply)*

Faculty Affairs
Recruitment or staffing issues
Credentialing and privileging procedures
Nomination of candidates for professional staff positions
Appointment or nomination of VA professional staff for affiliate faculty positions
Conflict of interest policy or procedures
Extended educational leave (sabbatical) policy or procedures
Foreign travel policy or procedures
VA's physician pay structure
Part-time physician time and attendance policy or procedures
Physician promotion and tenure issues
Protected educational time for attending physicians
Protected research time for physician investigators
Role of VISN in faculty affairs management
Add Another *(Text Box Entry)*

Affiliation Governance Survey

11D. In the past 2 years, have any of the following items been on the agenda of the governance committee governance committee and/or subcommittee/subcouncil? *(Please check all that apply)*

VA Clinical Practice Environment
Availability of primary care
Availability of specialized consultation or care
Medical sharing agreements (contracts for clinical services)
Fee-basis care
Standardization of evidenced-based clinical protocols between VA and affiliate(s)
Availability of nursing support
Clinical performance measures
Clinical system redesign
Availability of ancillary or technical staff in pathology/lab
Availability of ancillary or technical staff in radiology
Availability of ancillary or technical staff in other clinical areas
Role of VISN in clinical practice management
Add Another *(Text Box Entry)*

11E. In the past 2 years, have any of the following items been on the agenda of the governance committee and/or subcommittee/subcouncil? *(Please check all that apply)*

General
Strategic Planning – new clinical initiatives or focus areas, environment, infrastructure; new educational or research initiatives
Major VA or affiliate policy changes
Major VA or affiliate budget reports
VA Budget – Local or National
Role of VISN in affiliation relationship(s)
Major VA or affiliate construction projects
JCAHO (or other audit) results and recommendations
Security clearance policy or procedures
Add Another *(Text Box Entry)*

Affiliation Governance Survey

12. Are there other governance or administrative structures or committees that oversee the academic affiliation which have not been addressed in this survey? If so, please describe.
(Text Box Entry)

13. Please share your opinions on what constitutes an effective governance committee or council.
(Text Box Entry)

Appendix 5

Summary of Findings from the Affiliation Governance Survey (AGS)

Affiliation Agreements between VA and their partner schools of medicine emanated from VA's 1946 Policy Memorandum Number 2 that established the concept of a "Deans Committee", and the subsequent impact of laws, policies and regulations governing "medical sharing", contracting for clinical services, conflict of interest and information security. Of special importance to local VA-School of Medicine governance has been the legal requirements of the Federal Advisory Committee Act that defines how a federal agency can (and cannot) solicit input and advice from the non-federal sector.

OAA conducted an internal VHA survey of VA-affiliate governance at the local facility level. The specific goals of the VA Affiliation Governance Survey (AGS) were to characterize existing formal governance structures, to assess current functioning and concerns about these structures, and to provide supplementary information for the VA-AAMC "Affiliations Effectiveness Survey" (AES).

The AGS was an online survey of all VA facilities with GME training programs, with one response permitted per facility submitted by local VA leadership. The AGS was open between November 15 and December 21, 2007. All 119 VA facilities with School of Medicine (SOM) affiliations completed the AGS, for a 100% response rate.

VA facilities were asked to verify their existing SOM and associated health affiliations. VA involvement with the academic community is extensive: 119 facilities reported 171 active affiliations with SOMs (allopathic and osteopathic) and teaching hospitals, as well as 1,772 other health professional school affiliations.

Information was collected about the composition, size and focus of the Academic Affiliations Partnership Councils (formerly known as "Deans' Committees"), as well as their structure, membership and processes and the scope of Committee discussions. Highlights of these inquiries indicated: (1) 87% of 119 responding VAs have a formal governance council; (2) most meet three to four times a year; (3) about one third have 11-20 members, but 57% have greater than 21 members; (4) two-thirds of meetings typically have attendance of about half of the membership; (5) most (69%) are chaired by SOM Deans; (6) about half have co-chairs, usually VA Chiefs of Staff or Facility Directors; (7) almost all (98%) have unlimited membership terms; (8) 92% keep minutes; and (9) other committees and informal arrangements are seen as integral to affiliation management in over a third of facilities.

Respondents were asked to identify which topics had been on the agenda of their governance committee (and any subcommittees) in the past two years. Responses covered a wide range of academic and VA interests, with 33% of the identified topics falling into the category of education; 21% research; 16%, faculty affairs; 14%, clinical practice; and 16% classified as general. Over 75% of respondents reported discussing the following topics: recruitment and staffing; implementation/expansion of GME programs; strategic planning; physician resident supervision policies and procedures; local or national VA budget developments; major VA or affiliate construction projects; clinical performance measures; and Joint Commission (or other audit) results and recommendations.

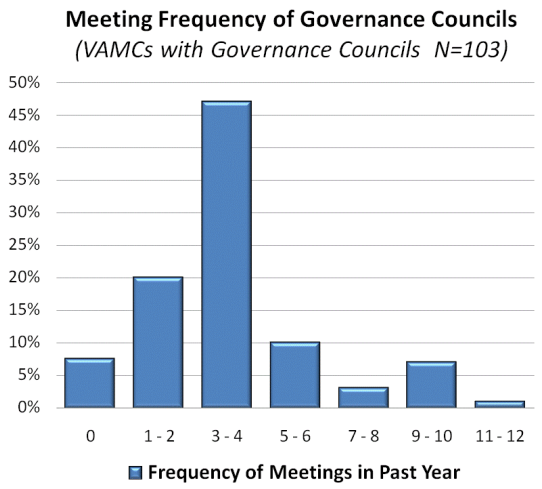
Respondents were given the opportunity to provide free text opinions about what constituted an effective governance committee or council. 67 VA facilities provided a total of 178 opinions. The key themes were: having the 'right' people at the table; the need for active, frank and open participation; shared values; overlap of interests; and willingness to work together. Respondents expressed opinions that "less is more" (meaning that smaller committees are more effective); that "nimble" (meaning flexible) approaches work better than bureaucratic approaches; that a strategic (vs. operational) focus is preferred; that expectations of regular attendance and participation are important; and that informal communication lines continue to be important, if not critical.

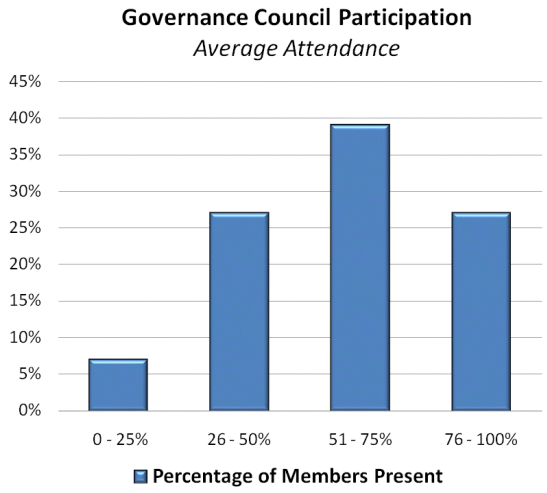
Suggestions for improving the effectiveness of affiliation governance committees included: having key parties engaged; keeping membership small; regular communication, including open informal channels; shared or overlapping values; and a shared commitment to excellence.

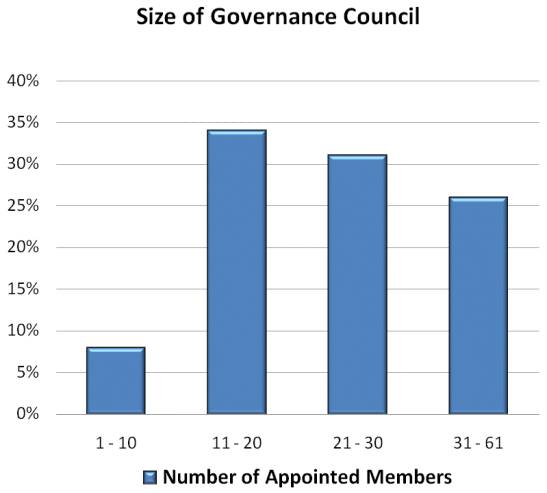
Selected data are shown on the next page:

VA-School of Medicine Affiliations Governance Survey:

1. *How many meetings of the governance committee have occurred during the past year?*
2. *How many total members (VA and non-VA) are appointed to your governance committee?*
3. *What has been the average attendance at your governance committee meetings during the past year?*







Appendix 6

Affiliation Effectiveness Survey (AES) Instrument

Project Overview

The Veterans Health Administration (VA) and the Association of American Medical Colleges (AAMC) would like to solicit your help in assessing the quality of the relationship between VA Medical Centers (VAMC) and their affiliated Schools of Medicine and in identifying major issues of concern that affect these relationships. This survey has the full endorsement of both organizations.

The information you provide will be used by the federally chartered Blue Ribbon Panel on VA-Medical School Affiliations. The Blue Ribbon Panel is engaged in a detailed analysis of the enduring value of the relationship between the VA and the academic medicine community, how this relationship has evolved over the past 60 years, the strengths which support continuation of the relationship and the issues contributing to present tensions in the relationship. The Panel's overall goal is to define organizational principles and models that will guide future relationships.

The survey seeks input from both the VA and Medical School leadership communities. We encourage you to participate fully. Your contributions will be invaluable, and will inform ongoing efforts to improve this vital strategic relationship.

Risks and Benefits of Participation:

This study involves a minimal level of risk. The principal risk is that a breach of AAMC data systems would, potentially, enable the identification your responses. Data classified by the Association as confidential has never been breached, so this scenario is extremely unlikely.

The collection of these data has the potential of improving the relationships between medical schools and VA medical centers, improving the care provided to veterans, and improving the educational environment and experiences for medical students, residents, faculty, and VA staff.

Confidentiality and Voluntary Nature of the Project:

All responses to the survey will be classified as "**Confidential**" in accordance with AAMC data release policies. As such, no data will be released on an individually identified basis. As a part of follow-up procedures, the Blue Ribbon Panel has instructed AAMC staff to provide deans and VAMC directors with a list of roles for which no responses have been received midway through survey administration. However, AAMC staff will not provide deans and VAMC directors with a final report regarding participation by role at their organization.

In order to provide management and benchmarking data, the leadership of participating medical schools and VAMC's will be provided with reports based on the aggregate data for their organization and their affiliated partner. Reports based on aggregate data will also be shared with the VHA Office of Academic Affiliations.

Your participation in this study is entirely voluntary. It is not anticipated that your decision whether or not to participate will affect your current or future relations with your organization and the Association of American Medical Colleges.

II. Current Leadership Role

Please check the boxes that best describe your current leadership roles (you may choose more than one)

School of Medicine (SOM) Roles

- ❑ SOM Dean
- ❑ SOM Associate Dean – Clinical Affairs (or head of SOM faculty practice plan)
- ❑ SOM Associate Dean – Research
- ❑ SOM Associate Dean – Undergraduate Medical Education
- ❑ SOM Associate Dean – Graduate Medical Education
- ❑ SOM Associate Dean – VA Affairs
- ❑ SOM Department Chair – Internal Medicine
- ❑ SOM Department Chair – General Surgery
- ❑ SOM Department Chair – Psychiatry
- ❑ SOM Clerkship Director – Internal Medicine
- ❑ SOM Clerkship Director – General Surgery
- ❑ SOM Clerkship Director – Psychiatry
- ❑ SOM Residency Program Director – Internal Medicine
- ❑ SOM Residency Program Director – General Surgery
- ❑ SOM Residency Program Director – Psychiatry
- ❑ SOM Faculty Member

VA Medical Center (VAMC) Roles

- ❑ VAMC Director
- ❑ VAMC Chief of Staff
- ❑ VAMC Associate Chief of Staff for Research
- ❑ VAMC Associate Chief of Staff for Education (Designated Education Officer)
- ❑ VAMC Service Chief – Internal Medicine
- ❑ VAMC Service Chief – General Surgery
- ❑ VAMC Service Chief – Psychiatry
- ❑ VAMC Site Director – Internal Medicine Clerkship
- ❑ VAMC Site Director – General Surgery Clerkship
- ❑ VAMC Site Director – Psychiatry Clerkship
- ❑ VAMC Site Director – Internal Medicine Residency Program
- ❑ VAMC Site Director – General Surgery Residency Program
- ❑ VAMC Site Director – Psychiatry Residency Program
- ❑ VAMC Staff Member (Paid or Unpaid)

III. Overall Satisfaction and Level of Integration

Please respond to the following questions about the current state of the SOM-VAMC affiliation relationship <u>at your local site</u>.

	Very Unsatisfied	Unsatisfied	Neutral	Satisfied	Very Satisfied	Don't Know/ NA
What is your overall level of satisfaction with your local affiliation relationship?	❍	❍	❍	❍	❍	❍

	Not Integrated at All	Partially Integrated	Highly Integrated	Don't Know/NA
What is the overall level of integration of educational programs?	❍	❍	❍	❍
What is the overall level of integration of research programs?	❍	❍	❍	❍
What is the overall level of integration of VA- and SOM-based faculty?	❍	❍	❍	❍

	Yes	No	Don't Know/NA
Does your affiliated partner have input into the selection of candidates for your position?	❍	❍	❍
In your opinion, should your affiliated partner have input into the selection of candidates for your position?	❍	❍	❍
Does your affiliated partner have input into your annual performance appraisal?	❍	❍	❍
In your opinion, should your affiliated partner have input into your annual performance appraisal?	❍	❍	❍

	Yes	No	Not applicable to my role
Have you served or been asked to serve on a search committee to select candidates for a position at your affiliated partner's institution?	❍	❍	❍
Have you served or been asked to serve on a committee that influences policy or planning for your affiliated partner's organization (e.g., strategic planning committee)?	❍	❍	❍

IV. Affiliation Effectiveness Factors

Please rate the following factors as to their impact on maintaining an effective VAMC-SOM affiliation relationship <u>at your local site</u> over the past three to five years.

	Helped the Relationship	Hindered the Relationship	Neither helped nor hindered	Don't Know/ NA
EDUCATION				
Number of VA-funded medical resident positions	❍	❍	❍	❍
Number of CMS (Medicare)-funded resident positions	❍	❍	❍	❍
VA's resident allocation procedures and priorities	❍	❍	❍	❍
SOM/University Hospital resident allocation priorities	❍	❍	❍	❍
Educational oversight and administration at the VA	❍	❍	❍	❍
Educational oversight and administration at the SOM/University Hospital	❍	❍	❍	❍
Adequacy of educational space at the VA	❍	❍	❍	❍
Adequacy of IT support for education at the VA	❍	❍	❍	❍
Sponsorship of residency programs solely in the name of the SOM/University Hospital	❍	❍	❍	❍
VA's lack of statutory authority to pay a proportionate share of residency program accreditation costs	❍	❍	❍	❍
VA's trainee background screening policy and procedures (e.g., educational credentials, criminal and security checks)	❍	❍	❍	❍
VA's resident orientation policy and procedures	❍	❍	❍	❍
VA's mandatory education requirements for trainees (e.g., ethics, cyber security, privacy)	❍	❍	❍	❍
VA's resident supervision policy and procedures	❍	❍	❍	❍
VA's resident time and attendance policy and procedures	❍	❍	❍	❍
Uniform resident salaries and benefits (provided under VA-SOM/University Hospital disbursement agreements)	❍	❍	❍	❍
VA's management of resident disbursement agreements	❍	❍	❍	❍
SOM/University Hospital management of resident disbursement agreements	❍	❍	❍	❍
ACGME-mandated restrictions on resident duty hours	❍	❍	❍	❍
Other (list and rate up to three additional factors in the area of Education)				
1) _____	❍	❍	❍	❍
2) _____	❍	❍	❍	❍
3) _____	❍	❍	❍	❍

	Helped the Relationship	Hindered the Relationship	Neither helped nor hindered	Don't Know/ NA
RESEARCH				
VA's overall research budget	❍	❍	❍	❍
VA's Merit Review Program budget	❍	❍	❍	❍
VA's Career Development Program budget	❍	❍	❍	❍
VA's Health Services Research and Development (HSR&D) Program budget	❍	❍	❍	❍
VA's overall research priorities	❍	❍	❍	❍
SOM/University Hospital overall research priorities	❍	❍	❍	❍
Research oversight and administration at the VA	❍	❍	❍	❍
Research oversight and administration at the SOM/University Hospital	❍	❍	❍	❍
Adequacy of research space at the VA	❍	❍	❍	❍
Adequacy of research equipment at the VA	❍	❍	❍	❍
Adequacy of IT support for research at the VA	❍	❍	❍	❍
Restriction on the size of VA Merit Review awards	❍	❍	❍	❍
Restriction of VA research funding to VA-based investigators	❍	❍	❍	❍
Restriction of VA research funding to faculty appointed at the 5/8th level or greater	❍	❍	❍	❍
VA Institutional Review Board (IRB) policy and procedures	❍	❍	❍	❍
SOM/University Hospital IRB policy and procedures	❍	❍	❍	❍
Jointly-operated VA-SOM/University Hospital IRBs	❍	❍	❍	❍
VA's intellectual property rights policy and procedures	❍	❍	❍	❍
SOM/University Hospital's intellectual property rights policy and procedures	❍	❍	❍	❍
VA's indirect cost recovery policies and procedures	❍	❍	❍	❍
SOM/University Hospital's indirect cost recovery policy and procedures	❍	❍	❍	❍
VA Non-profit foundations	❍	❍	❍	❍
SOM/University non-profit foundations	❍	❍	❍	❍
Other (list and rate up to three additional factors in the area of Research)				
1) _____	❍	❍	❍	❍
2) _____	❍	❍	❍	❍
3) _____	❍	❍	❍	❍

	Helped the Relationship	Hindered the Relationship	Neither helped nor hindered	Don't Know/ NA
VA's CLINICAL PRACTICE ENVIRONMENT				
VA's overall environment of care/physical facilities	❍	❍	❍	❍
VA's emphasis on ambulatory care	❍	❍	❍	❍
VA's primary care and disease management capabilities	❍	❍	❍	❍
VA's inter-professional teamwork training opportunities	❍	❍	❍	❍
VA's integrated pharmacy management program	❍	❍	❍	❍
VA's patient safety program	❍	❍	❍	❍
VA's integrated electronic medical record (CPRS)	❍	❍	❍	❍
VA's medical sharing ("sole source contracting") policy and procedures	❍	❍	❍	❍
Local VA facility's management of medical sharing agreements	❍	❍	❍	❍
SOM/University Hospital's management of medical sharing agreements	❍	❍	❍	❍
VA's information security policies and procedures	❍	❍	❍	❍
Adequacy of primary care clinicians at the VA	❍	❍	❍	❍
Adequacy of physician subspecialists at the VA	❍	❍	❍	❍
Adequacy of physician subspecialty consultation from the SOM/University Hospital	❍	❍	❍	❍
Adequacy of nursing services at the VA	❍	❍	❍	❍
Adequacy of radiology services at the VA	❍	❍	❍	❍
Adequacy of laboratory services at the VA	❍	❍	❍	❍
Adequacy of other support services at the VA	❍	❍	❍	❍
Other (list and rate up to three additional factors related to the VA's clinical practice environment)	❍	❍	❍	❍
1) _____	❍	❍	❍	❍
2) _____	❍	❍	❍	❍
3) _____	❍	❍	❍	❍

	Helped the Relationship	Hindered the Relationship	Neither helped nor hindered	Don't Know/ NA
FACULTY AFFAIRS/MEDICAL STAFF ISSUES	❍	❍	❍	❍
Availability of SOM administrative appointments for VA Chiefs of Staff (e.g., Associate Dean for VA Affairs)	❍	❍	❍	❍
Availability of clinical department administrative appointments for VA Service Chiefs (e.g., Vice or Associate Chair)	❍	❍	❍	❍
VA's new policy prohibiting VA Chief of Staff salary supplementation by affiliates	❍	❍	❍	❍
Separate VA and SOM/University Hospital physician credentialing systems	❍	❍	❍	❍
SOM's faculty promotion and tenure policies and procedures	❍	❍	❍	❍
VA's new part-time staff physician time and attendance policy ("hours bank policy")	❍	❍	❍	❍
VA's new staff physician pay structure ("VA physician pay bill")	❍	❍	❍	❍
VA's staff physician background screening policy and procedures (i.e., criminal and security checks)	❍	❍	❍	❍
VA's mandatory staff physician education requirements (e.g., ethics, traumatic brain injury)	❍	❍	❍	❍
VA's support of scholarly activities (e.g., protected time, travel support)	❍	❍	❍	❍
Other (list and rate up to three additional factors related Faculty Affairs)	❍	❍	❍	❍
1) _____	❍	❍	❍	❍
2) _____				
3) _____	❍	❍	❍	❍

	Helped the Relationship	Hindered the Relationship	Neither helped nor hindered	Don't Know/ NA
VETERANS INTEGRATED SERVICE NETWORK (VISN) OVERSIGHT	❍	❍	❍	❍
Regional oversight of local educational programs	❍	❍	❍	❍
Regional oversight of local research programs	❍	❍	❍	❍
Regional oversight of clinical activities	❍	❍	❍	❍
Regional oversight of faculty affairs/medical staff issues	❍	❍	❍	❍
Regional oversight of local affiliation management	❍	❍	❍	❍
Regional oversight of medical sharing agreements ("sole source contracting")	❍	❍	❍	❍
Other (list and rate up to three additional factors related to VISN oversight)	❍	❍	❍	❍
1) _____	❍	❍	❍	❍
2) _____	❍	❍	❍	❍
3) _____	❍	❍	❍	❍

V. Overall Commitment to the Affiliation Relationship

Please rate the following factors:

	Not Committed	Committed	Strongly Committed	No Opinion
Your personal commitment to the SOM/VAMC affiliation relationship	❍	❍	❍	❍
Your perception of your medical school leadership's commitment to the affiliation relationship	❍	❍	❍	❍
Your perception of your local VAMC leadership's commitment to the affiliation relationship	❍	❍	❍	❍
Your perception of your VISN leadership's commitment to the affiliation relationship	❍	❍	❍	❍
Your perception of VA Central Office leadership's commitment to the affiliation relationship	❍	❍	❍	❍

VI. Academic Affiliations Partnership Council (Deans' Committee)

Please respond to the following:

1. Have you served on your local VA Academic Affiliations Partnership Council (formerly known as the Deans' Committee)?

   - ☐ Yes
   - ☐ No
   - ☐ Not applicable to my role

IF YES, GO TO QUESTION 2. OTHERWISE, SKIP TO SECTION VII

2. In your opinion, is the focus of your council/committee **[pick the best fit]**

   - ☐ Strategic (long term) planning
   - ☐ Tactical (short term, operational) planning
   - ☐ Mix of strategic and tactical
   - ☐ Information sharing only, no planning

3. In your opinion, is the culture of your council/committee **[pick one from each pair]**

☐ Friendly	☐ Hostile
☐ Collaborative	☐ Uncooperative
☐ Inconclusive	☐ Decisive
☐ Bureaucratic	☐ Entrepreneurial
☐ Autocratic	☐ Democratic
☐ Engaged	☐ Disinterested
☐ Substantive	☐ Trivial
☐ Candid	☐ Guarded

4. In your opinion, what is the optimal size of a Deans' Committee?

   - ☐ Less than 10 members
   - ☐ 11-20 members
   - ☐ 21-30 members
   - ☐ More than 30 members

5. In your opinion, what is the OPTIMAL professional mix for a Deans' Committee?

   - ☐ Physicians and administrators only
   - ☐ Physicians, administrators, and other health professionals (nursing, allied health, etc.)

6. In your opinion, what is the OPTIMAL focus for a Deans' Committee?

   - ☐ Strategic (long term) planning
   - ☐ Tactical (short term, operational) planning
   - ☐ Mix of strategic and tactical
   - ☐ Information sharing only, no planning

7. In your opinion, should a member of the VISN leadership team (e.g., Network Director, Chief Medical Officer) serve on the local VA facility Deans' Committee?

   - ☐ Yes
   - ☐ No

   Please share any additional comments on Deans' Committee membership in the box below:

8. How satisfied are you with the overall effectiveness (functioning) of your local VA Academic Affiliations Partnership Council (Deans' Committee)?

   - ☐ Very Unsatisfied
   - ☐ Unsatisfied
   - ☐ Neutral
   - ☐ Satisfied
   - ☐ Very Satisfied
   - ☐ Don't know/Not Applicable

   Please share your opinions on what constitutes an effective Academic Affiliations Partnership Council (Deans' Committee) in the box below:

VII. Direction and Value of SOM-VAMC Affiliations

Please respond to the following:

	Deteriorated	Stayed about the Same	Improved	Don't Know
How would you describe the overall trend in your local VA-SOM affiliation relationship over the past 3 years?	❍	❍	❍	❍
How would you describe the overall trend in VA-SOM affiliation relationships nationwide over the past 3 years?	❍	❍	❍	❍

	Yes	No	No Opinion
Is your VA-SOM affiliation relationship of value to your local academic community?	❍	❍	❍
In general, are VA-SOM affiliations of value to the national academic community?	❍	❍	❍
Should the structure and governance of VA-SOM affiliations fundamentally change in the future?	❍	❍	❍

Please provide any additional comments or suggestions on future directions for VA-SOM relationships in the box below:

Appendix 7

Summary of Findings from the Affiliation Effectiveness (AES) Survey

The Affiliation Effectiveness Survey was a joint VA-AAMC survey hosted on the AAMC website. Invitations to participate in the Affiliations Effectiveness Survey were issued by Dr. Malcolm Cox, VA's Chief Academic Affiliations Officer and Dr. Tom Lawley, Chair of the VA – AAMC Council of Deans Liaison Committee. Dual coordination by OAA and AAMC at the national level and at each local dyad (VA facility and School of Medicine) served to enhance response rates. The VA Facility Director and the Dean of the Medical School were asked to identify the individuals serving in selected roles in each organization and asked to forward invitations to participate. Individual responses will be held strictly confidential and data will only be released in aggregate form. AAMC and OAA staff analyzing the results did not know the identity of individuals responding to the survey and local Facility Directors and Deans do not have access to the responses of their subordinates.

The intent of the AES was to assess the influence of a wide variety of factors affecting the affiliation both generically and more specifically in the domains of education, research, clinical practice and faculty affairs. There were both VA- and School Medicine focused questions. Sections solicited opinions about the appropriate size, composition and focus for Academic Partnership Councils or Dean's Committees and satisfaction with governance of the affiliation at the local (facility) and regional (VISN) levels. Write-in comments were encouraged. The Survey was designed to provide the Panel with information on the overall effectiveness of VA-Medical School affiliations as well as between paired respondents at each organizational level within individual dyads. AAMC and VA staff worked together to create criteria to evaluate the health of VA-SOM affiliation relationships. Input on survey design and content was sought from a number of VA and AAMC focus groups.

The AES surveyed the institutional, departmental/service and educational and research leadership of VA medical centers and their affiliated medical schools on topics that included: overall satisfaction and level of integration; affiliation effectiveness factors in four domains (education, research, clinical practice and faculty affairs); VISN oversight; overall commitment to the affiliation relationship; Academic Affiliations Partnership Councils (Deans' Committees); and the direction and value of VA-SOM affiliations.

Planning for the AES began in Fall 2007; the survey was available for responses from February 19 to March 31st 2008. Sixty-five percent of SOM and 75% of VA respondents reported that they were satisfied or very satisfied with their local affiliation relationship. Unsatisfied or very unsatisfied respondents accounted for 20% of SOM and 14% of VA respondents.

An analysis was conducted on responses to questions about the governance relationship embodied in the Academic Affiliations Partnership Council model. Almost two-thirds of VA and about 40% of SOM respondents reported having served on their local VA Academic Affiliations Partnership Council. Close to half of both groups reported being satisfied or very satisfied with the overall effectiveness of their local Dean's Committee. However, fully one-third of SOM and one-quarter of VA respondents were unsatisfied or very unsatisfied with their Councils.

About 40% of both groups reported that the focus of their local Council was on information sharing with no planning; yet twice as many in both groups felt the primary focus should be a mix of strategic and tactical planning. Responses were very similar among SOM and VA respondents, when asked to select from a list of paired descriptors of the culture of their Council.

Also similar was the strong agreement that the governance committee should have no more than 20 members. When asked about membership, VA respondents were more comfortable with a mix of physicians, administrators and other health professionals than SOM respondents. When asked if a member of the VISN leadership should serve on the local Council, 57% of SOM respondents agreed compared to only 29% of VA respondents.

Both groups were committed or strongly commitment to their local VA-SOM relationships (93% of SOM and 97% of VA respondents). However, when asked if the structure and governance of VA-SOM affiliations should fundamentally change in the future, one-third of SOM and one-quarter of VA respondents answered in the affirmative.

Selected data are presented on the following pages:

Figure 1

Affiliation Effectiveness Survey

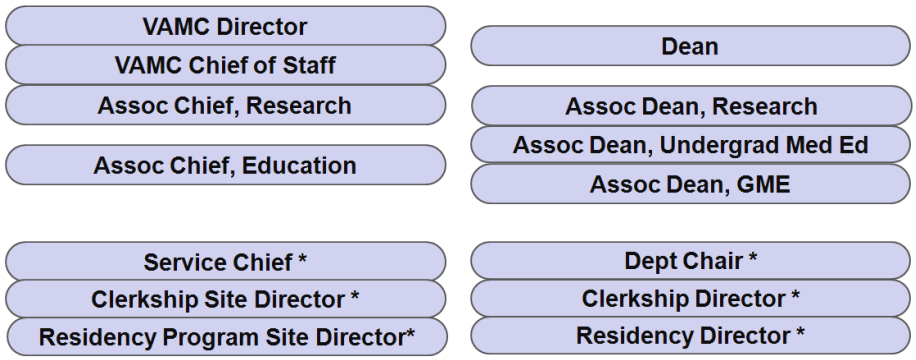
Conducted in 2008 by VA and AAMC to assess the "health" of VA-medical school relationships.

Core Domains:

- Overall Satisfaction and Level of Integration
- Affiliation Effectiveness Factors
  - Education
  - Research
  - Clinical Practice
  - Faculty Affairs
- VISN Oversight
- Overall Commitment to the Affiliation Relationship
- Academic Affiliations Partnership Councils (Deans' Committees)
- Direction and Value of VA-School of Medicine Affiliations

Figure 2

Key Leadership Categories



** Internal Medicine, General Surgery and Psychiatry*

Figure 3

Respondents

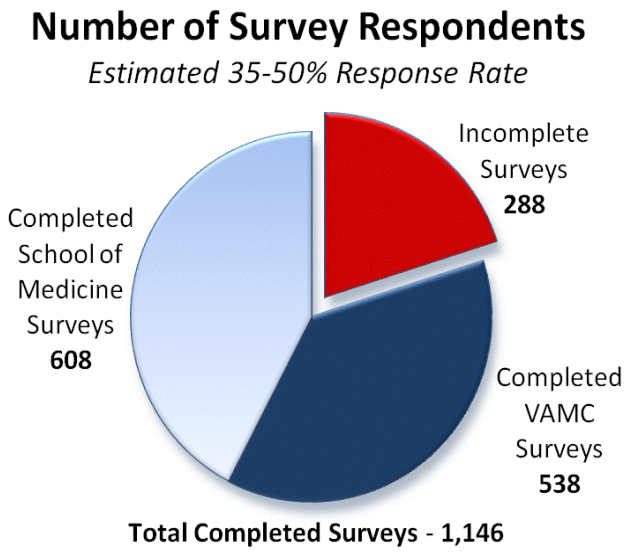


Figure 4

Value

*In general, are VA-School of Medicine affiliations of value to your **local** academic community?*

a) Yes
b) No
c) No Opinion

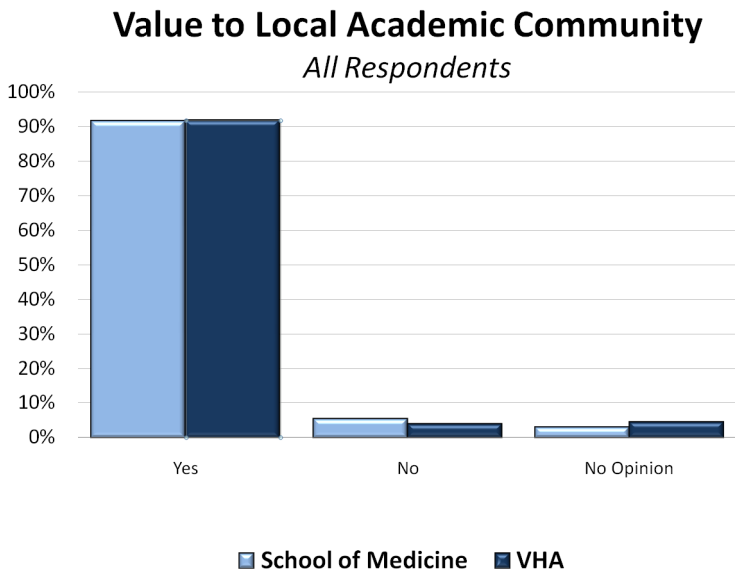


Figure 5

Satisfaction

*What is your overall satisfaction with your **local** affiliation relationship?*

a) Very Unsatisfied
b) Unsatisfied } *Unsatisfied*
c) Neutral
d) Satisfied
e) Very Satisfied } *Satisfied*
f) Don't know / Not Applicable

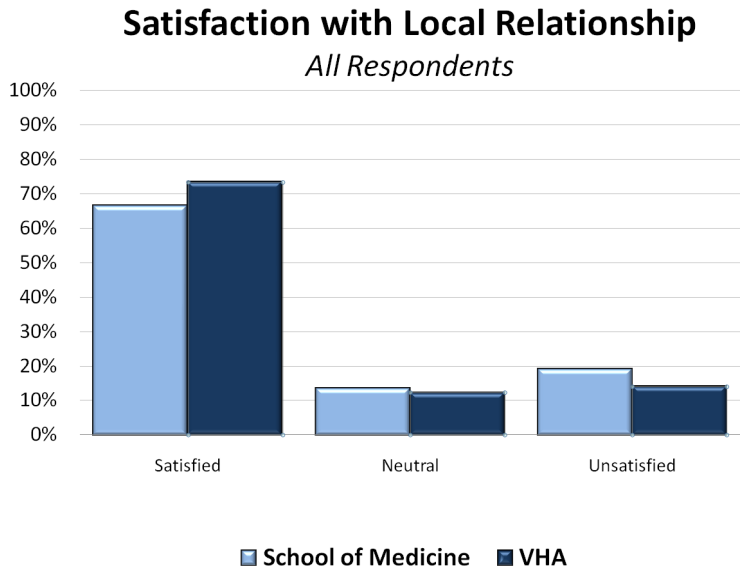


Figure 6

Commitment

What is your personal commitment to the School of Medicine / VA Medical Center affiliation relationship?

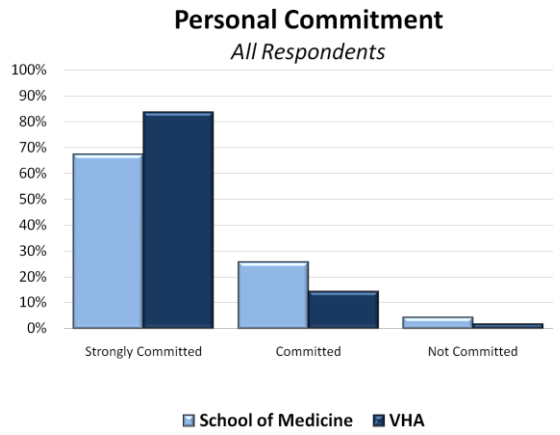
a) Not Committed
b) Committed
c) Strongly Committed
d) No Opinion

What is your perception of your medical school leadership's commitment to the affiliation relationship?

What is your perception of your local VAMC leadership's commitment?

What is your perception of your VISN leadership's commitment?

What is your perception of VA Central Office leadership's commitment?



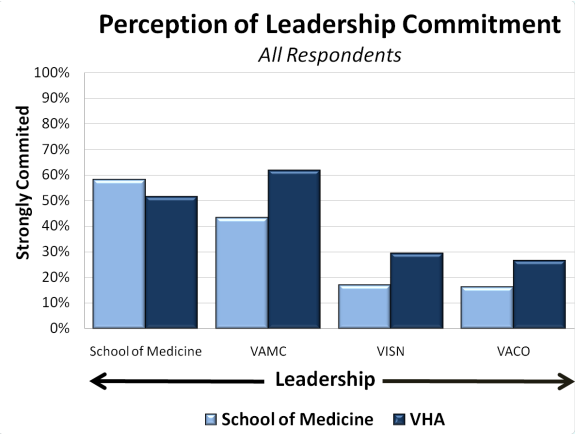


Figure 7

Information Security

VA's information security policies and procedures

a) Helped the relationship
b) Hindered the relationship
c) Neither helped nor hindered
d) Don't know / Not applicable

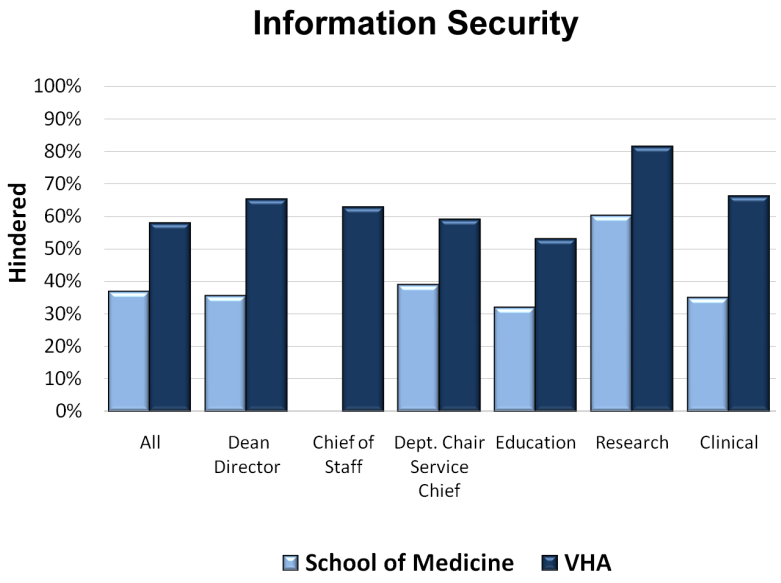


Figure 8

Research Funding

Restriction of VA research funding to faculty appointed at the 5/8th level or greater

a) Helped the relationship
b) Hindered the relationship
c) Neither helped nor hindered
d) Don't know / Not applicable

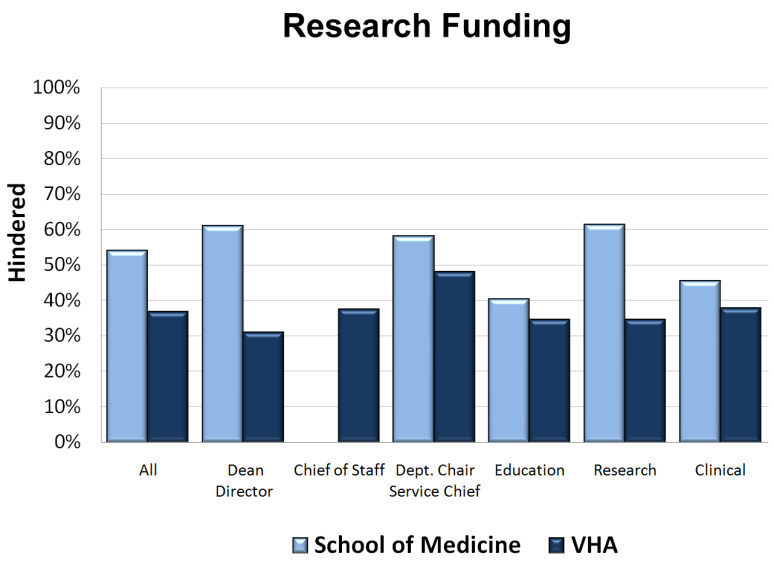


Figure 9

Shared Decision Making

Does your affiliated partner have input into the selection of candidates for your position?

Does your affiliated partner have input into your annual performance appraisal?

Have you served or been asked to serve on a search committee to select candidates for a position at your affiliated partner's institution?

Have you served or been asked to serve on a committee that influences policy or planning for your affiliated partner's organization (e.g., strategic planning committee)?

a) Yes
b) No
c) Don't know / Not applicable

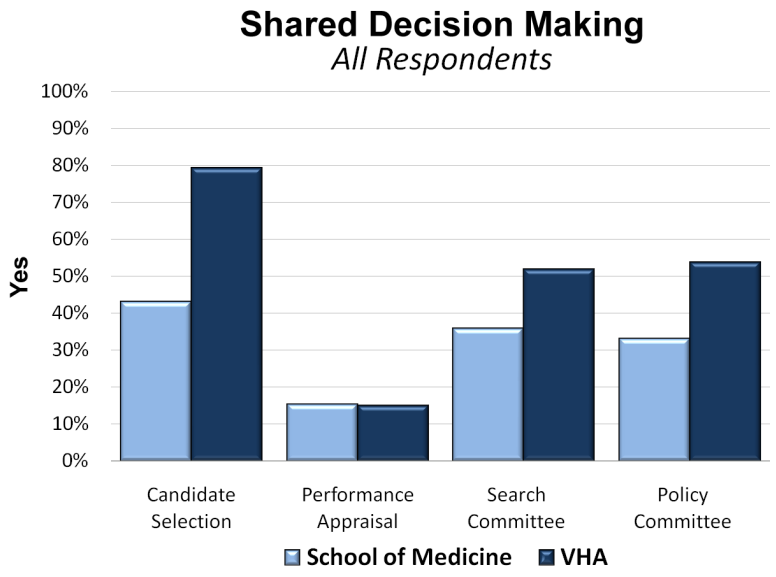


Figure 10

Conflict of Interest

VA's new policy prohibiting VA Chiefs of Staff salary supplementation by affiliates:

a) Helped the relationship
b) Hindered the relationship
c) Neither helped nor hindered
d) Don't know / Not applicable

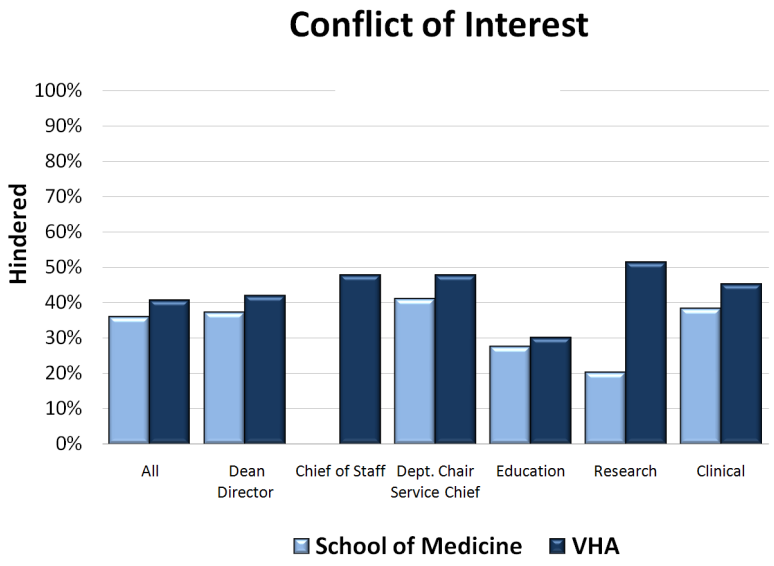


Figure 11

Time and Attendance

VA's new part-time staff physician time and attendance policy (Hours Bank Policy)

a) Helped the relationship
b) Hindered the relationship
c) Neither helped nor hindered
d) Don't know / Not applicable

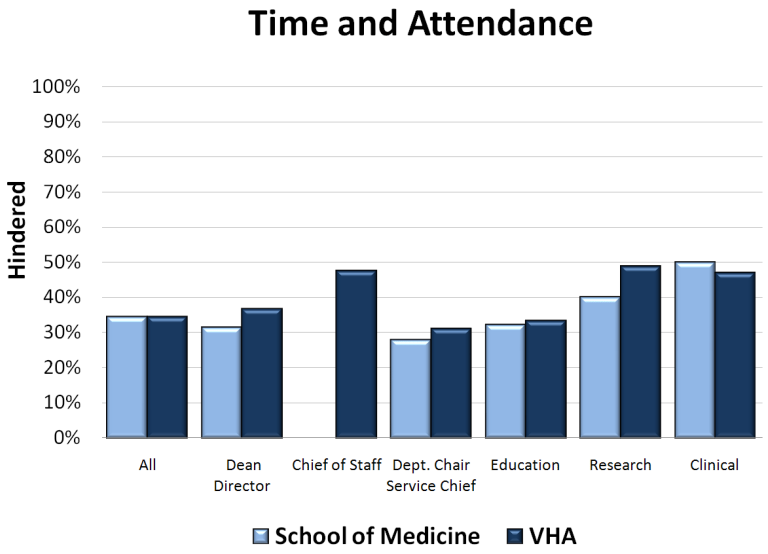


Figure 12

Mandatory Education

VA's mandatory staff physician education requirements (e.g., ethics, traumatic brain injury)

a) Helped the relationship
b) Hindered the relationship
c) Neither helped nor hindered
d) Don't know / Not applicable

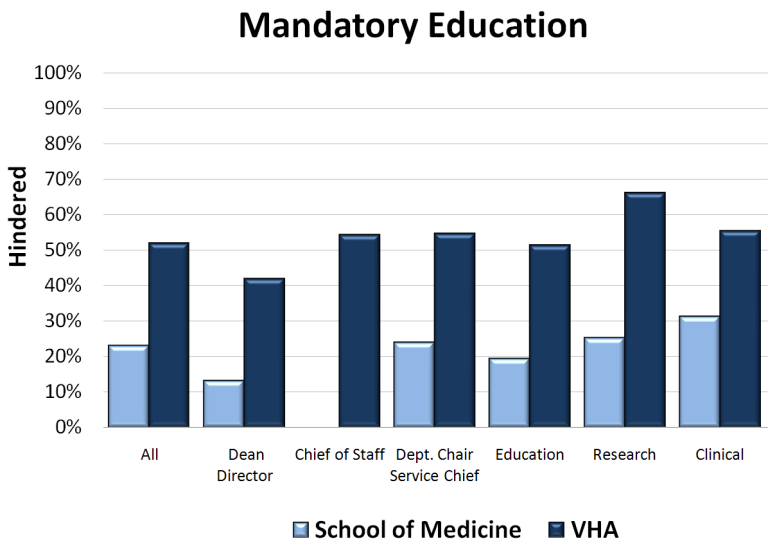


Figure 13

Focus of Deans' Committees

In your opinion, what is the actual focus for a Dean's Committee?

In your opinion, what is the optimal focus for a Dean's Committee?

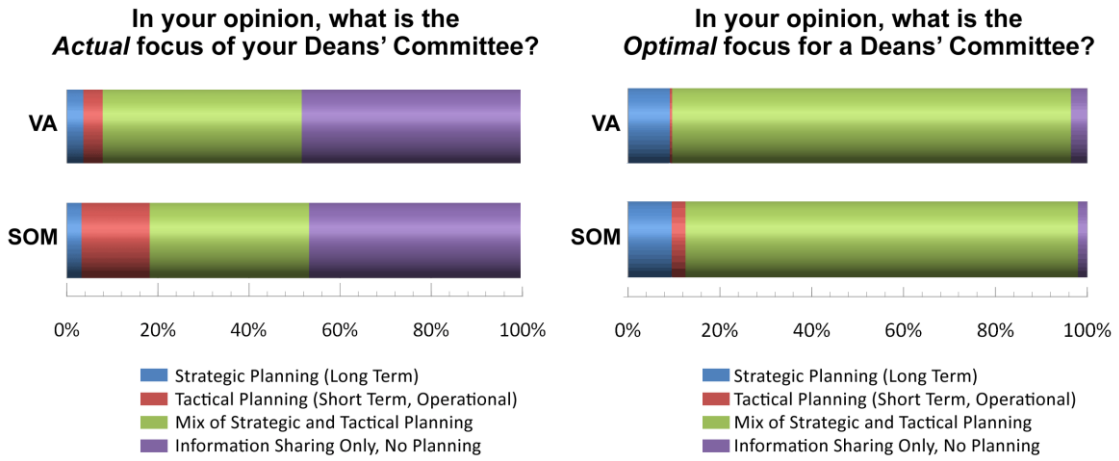


Figure 14

Effectiveness of Deans' Committees

How satisfied are you with the overall effectiveness (functioning) of your local VA Academic Affiliations Partnership Council (Deans' Committee)?

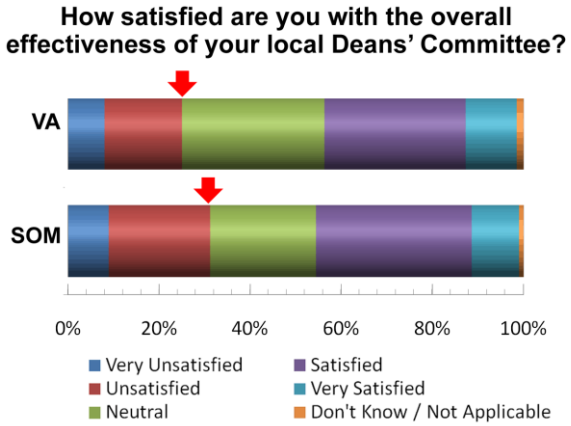


Figure 15

Top Issues Identified by Deans

Factors that Most Helped the Local Relationship over the Past 3-5 Years	VA's integrated electronic medical record (CPRS) **91.8%**	Number of VA-funded medical resident positions **85.1%**	Educational oversight & administration at the SOM/ University Hospital **80.9%**	Educational oversight & administration at the VA **76.1%**	Availability of SOM administrative appointments for VA Chiefs of Staff **74.1%**
Factors that Most Hindered the Local Relationship over the Past 3-5 Years	VA's lack of authority to pay a proportionate share of residency program accreditation costs **61.7%**	Restriction of VA research funding to faculty appointed at the 5/8th level or greater **56.5%**	Separate VA and SOM/ University Hospital physician credentialing systems **45.5%**	Restriction of VA Research funding to VA-based investigators **39.1%**	VA's information security policies and procedures **and** VA's policy prohibiting VA COS salary supplementation **32.7%**

Figure 16

Top Issues Identified by VA Chiefs of Staff

Factors that Most Helped the Local Relationship over the Past 3-5 Years	Number of VA-funded medical resident positions **96.6%**	VA's new staff physician pay structure **90.2%**	VA's integrated electronic medical record (CPRS) **89.8%**	Educational oversight and administration at the VA **87.9%**	VA's support of scholarly activities **83.6%**
Factors that Most Hindered the Local Relationship over the Past 3-5 Years	VA's information security policies and procedures **62.7%**	VA's mandatory staff physician education requirements **54.1%**	VA's trainee background screening policy and procedures **51.7%**	VA's mandatory education requirements for trainees **and** Restriction on size of VA Merit Review awards **50.0%**	VA's lack of authority to pay a proportionate share of residency program accreditation costs **48.3%**

Appendix 8

Effect of VA Training on Consideration of VA as an Employer
2008 VA Learners' Perceptions Survey

BEFORE this clinical training experience, how likely were you to consider a future employment opportunity at a VA medical facility:

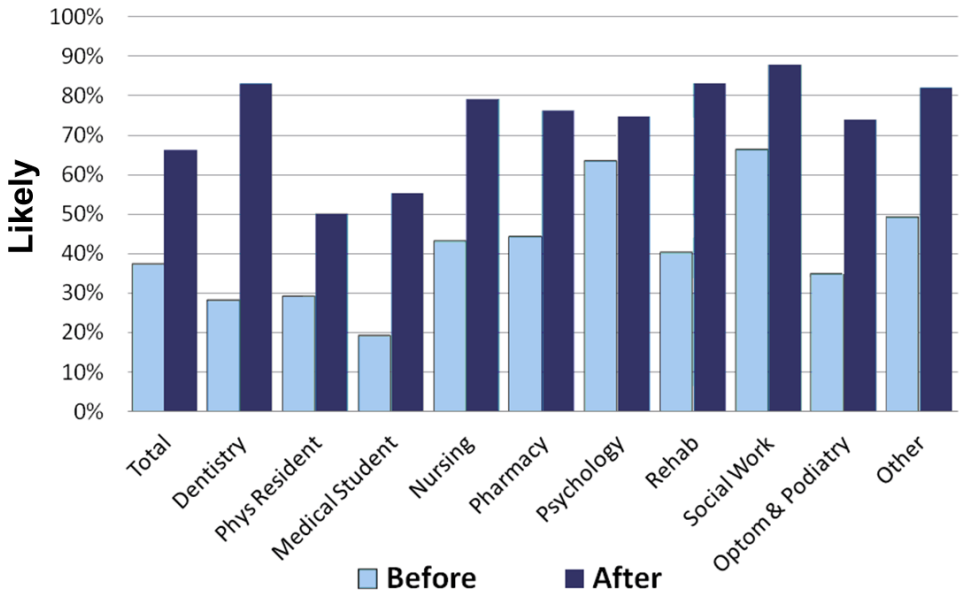
- *Very likely*
- *Somewhat likely*
- *Had not thought about it*
- *Somewhat unlikely*
- *Very unlikely*

} *Likely*

AS A RESULT of this clinical training experience, how likely would you be to consider a future employment opportunity at a VA medical facility:

- *A lot more likely*
- *Somewhat more likely*
- *No difference*
- *Somewhat less likely*
- *A lot less likely*

} *Likely*



Appendix 9

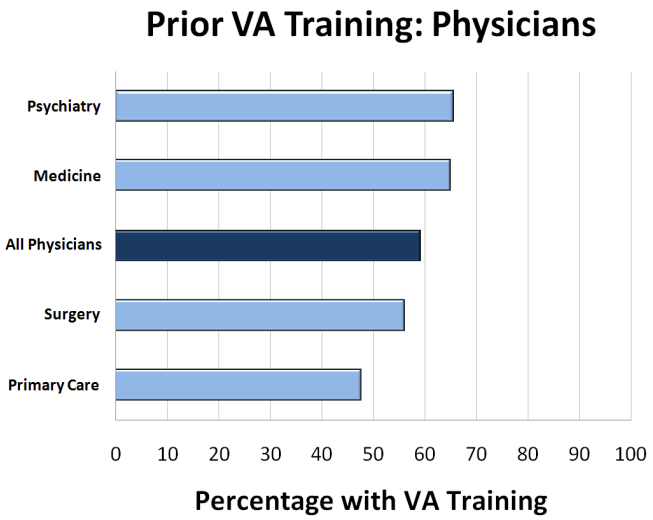
Effect of Prior VA Training on the VA Workforce

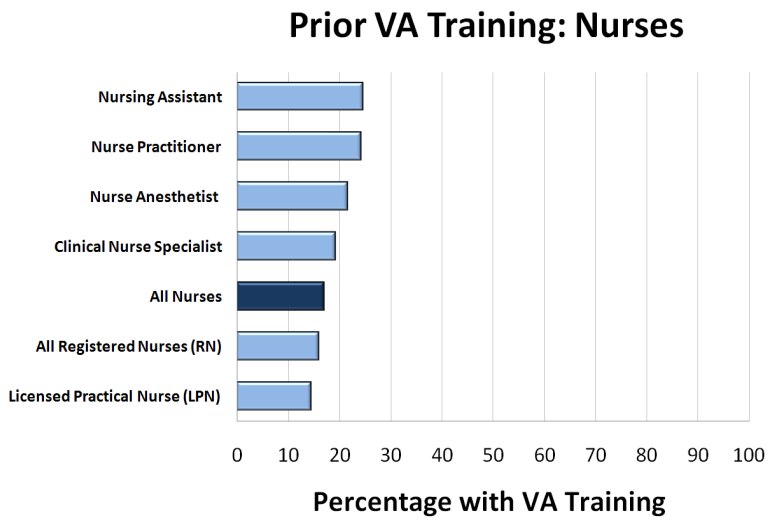
2009 VA All Employee Survey

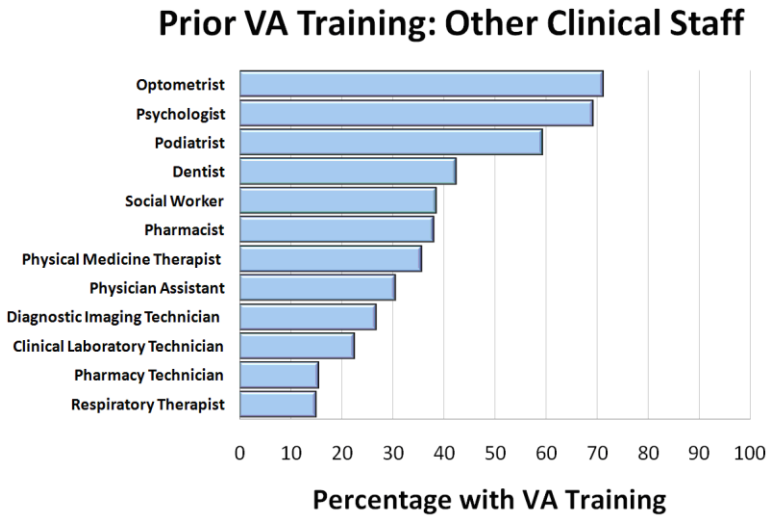
The Department of Veterans Affairs All Employee Survey is a voluntary, confidential annual survey that assesses employee job satisfaction and organizational health. Developed by the VA National Center on Organizational Development (NCOD) in 2003, the survey is composed of three discrete but interrelated elements: the Job Satisfaction Index (JSI) assesses employees' individual satisfaction with key job features; the Organizational Assessment Index assesses employee perceptions of conditions in their immediate work group; and the Culture Index assesses employees' perceptions of the atmosphere of their overall working environment). Three additional indexes (Civility, Empowerment and Engagement) are also available.

The survey has been administered annually since 2004. The average response rate for each administration is 65-70%. The 2009 AES was administered between April 20 and May 11, 2009. Employees were able to take the survey via web, phone or paper. The total number of respondents for the FY09 survey administration was 169,242.

Before becoming a VA employee, did you take part in a training or educational program based partly or entirely in VA (such as paid or unpaid internships, residencies, fellowships, or clinical or administrative rotations)?




Prior VA Training: Nurses
Nursing Assistant
Nurse Practitioner
Nurse Anesthetist
Clinical Nurse Specialist
All Nurses
All Registered Nurses (RN)
Licensed Practical Nurse (LPN)
0 10 20 30 40 50 60 70 80 90 100
Percentage with VA Training


Prior VA Training: Other Clinical Staff
Optometrist
Psychologist
Podiatrist
Dentist
Social Worker
Pharmacist
Physical Medicine Therapist
Physician Assistant
Diagnostic Imaging Technician
Clinical Laboratory Technician
Pharmacy Technician
Respiratory Therapist
0 10 20 30 40 50 60 70 80 90 100
Percentage with VA Training

Appendix 10

Residents as a Percentage of the VA Workforce in Selected Disciplines

Discipline or Occupational Category	Total Employee FTEE May 2009	Resident FTEE AY2008-2009	Total FTEE	Resident FTEE as a % of Total FTEE
Medicine	15,969	9,553	25,522	**37%**
Psychology	2,844	635	3,479	**18%**
Dentistry	847	356	1,203	**30%**
Pharmacy	5,860	405	6,265	**7%**
Podiatry	328	186	514	**36%**
Optometry	532	151	683	**22%**

Source: VHA Support Service Center and Office of Academic Affiliations

Appendix 11

VA Policy Memorandum Number 2

Policy Memorandum Number **2**

January 30, 1946

SUBJECT: Policy in Association of Veterans' Hospitals with Medical Schools.

1. GENERAL CONSIDERATIONS

a. Necessity for Mutual Understanding and Cooperation. The Department of Medicine and Surgery of the Veterans' Administration is embarking upon a program that is without precedent in the history of Federal hospitalization. It would, therefore, be most unusual if numerous problems did not arise for which no fully satisfactory solution were immediately apparent. Such problems frequently can be solved only by trial and error; and, until workable solutions are found, both parties in the program must exercise tolerance if the program is not to fail.

There can be no doubt of the good faith of both parties. The schools of medicine and other teaching centers are cooperating with the three-fold purpose of giving the veteran the highest quality of medical care, of affording the medical veteran the opportunity for post-graduate study which he was compelled to forego in serving his country, and of raising generally the standard of medical practice in the United States by the expression of facilities for graduate education.

The purpose of the Veterans' Administration is simple: affording the veteran a much higher standard of medical care than could be given him with a wholly full-time medical service.

The purposes of both parties being unselfish, and there being no conflict of objectives, there can be no serious disagreement over methods. It will be recognized that the Veterans' Administration is charged with certain legal responsibilities in connection with the medical care of veterans, which it cannot delegate, if it would. Yet the discharge of these responsibilities need not interfere with the exercise by the schools of their prerogatives in the field of education.

All medical authorities of the Veterans' Administration will cooperate fully at all times with the representatives of associated schools and other centers. It is the earnest desire of the Acting Chief Medical Director that our relations with our colleagues be cordial as well as productive.

b. General Division of Responsibility: The Veterans' Administration retains full responsibility for the care of patients, including professional treatment, and the school of medicine accepts responsibility for all graduate education and training.

2. THE VETERANS' ADMINISTRATION

a. Operates and administers the hospital.

b. As rapidly as fully qualified men can be had, will furnish full-time chiefs of all services (see par. 5 below) who will supervise and direct the work of their respective staffs, including the part-time attending staff furnished from the School of Medicine, insofar as the professional care of patients is concerned. Nominations by Deans' Committees for such full-time positions will be welcomed; and, unless there be impelling reasons to the contrary, will be approved wherever vacancies exist. These service chiefs are fully responsible to their immediate superior in the Veterans' Administration.

c. Appoint the consultants, the part-time attending staff and the residents nominated by the Deans' Committee and approved by the Veterans' Administration.

d. Cooperate fully with the Schools of Medicine in the graduate education and training program.

3. THE SCHOOLS OF MEDICINE:

a. Will organize a Deans' Committee, composed of senior faculty members from all schools cooperating in each project, whether or not furnishing any of the attending or resident staff.

b. Will nominate an attending staff of diplomates of specialty boards in the numbers and qualifications agreed upon by the Deans' Committee and the Veterans' Administration. (See 6e)

c. Will nominate, from applicants, the residents for graduate education and training.

d. Will supervise and direct, through the Manager of the hospital and the Consultants, the training of residents.

e. Will nominate the consultants for appointment by the Veterans' Administration.

4. HOSPITAL MANAGERS:

a. Are fully responsible for the operation of their hospitals.

b. Will cooperate with the Deans' Committee, bringing to its attention any dereliction of duty on the part of any of its nominees.

5. CHIEFS OF SERVICE:

a. Are responsible to their superior in the Veterans' Administration for the conduct of their services.

b. Will bring to the attention of their superior, for his action, such cases as they are unable to deal with personally of dereliction of duty or incompetence on the part of any full-time or part-time staffs under their control.

c. Will, together with the part-time attending staff, under the direction of the Manager, supervise the education and training program.

d. When full-time employees of the Veterans' Administration, will be diplomates of their respective boards and will be acceptable to the Deans' Committee and to the specialty boards concerned. It is the urgent purpose of the Veterans' Administration to place full-time fully qualified and certified chiefs of service for all services in each hospital associated with a School of Medicine. Except in cases where the chief selected has local affiliations, which might embarrass or prejudice his relations with one or another of the associated schools, his initial assignment may not be cleared through the Deans' Committee. In all cases, when it has been conclusively demonstrated that a chief of service cannot cooperate with a Deans' Committee, he will be transferred (if efficient otherwise) and replaced by another. Until this purpose can be fully accomplished, however, in order that a hospital may obtain approval for resident training by one or another specialty board, it may be necessary to appoint part-time chiefs of services who meet the requirements of the boards. This will be done; but it will be done with the understanding that the part-time chiefs will be replaced with qualified full-time chiefs as rapidly as they become available. The duties and responsibilities of part-time chiefs will be the same as those of full-time chiefs.

6. PART-TIME ATTENDING STAFF:

a. Will be responsible to the respective chiefs of service.

b. Will accept full responsibility for the proper care and treatment of patients in their charge.

c. Will give adequate training to residents assigned to their service.

d. Will be veterans unless approval in each case has been given by the Chief Medical Director.

e. Will be diplomates of their respective boards and acceptable to such boards for direction of resident training. Exception may be made in the case of a veteran who has completed the first part of his board examination, but whose completion of the examination was interrupted by the exigencies of the military service.

f. Will hold faculty appointments in one or another of the associated Schools of Medicine, or will be outstanding members of the profession of the caliber of faculty members.

7. CONSULTANTS:

a. Will be veterans unless approval in each case has been given by the Chief Medical Director.

b. Will be members of the faculty, of professorial rank, of one or another of the associated Schools of Medicine.

c. Will, as representatives of the Schools of Medicine, direct and be responsible for the educational training of residents.

d. Will afford to the Manager and the proper Chief of Service the benefit of their professional experience and counsel.

e. Will conduct their duties through, and in cooperation with, the Manager and the proper Chief of Service, and also, in matters of education and training, with the part-time Attending Staff--always, however, coordinating with the Chief of Service.

August 22, 1980

Addendum to Policy Memorandum Number 2

The following policy statement relates to the "GENERAL CONSIDERATIONS" portion of Policy Memorandum No. 2 dated January 30, 1946:

Historically the Department of Medicine and Surgery has been committed to provide quality care for its veteran constituency and to use all means possible to accomplish it. One highly desirable method, dating back to Policy Memorandum No. 2, has been to arrange mutually beneficial affiliations with medical schools. At the same time, affiliation with a medical school cannot be considered the only prerequisite for provision of quality care. High quality care can be and is provided by both affiliated and unaffiliated VA medical centers. DM&S remains committed to explore all avenues of providing quality care while continuing to contribute to the national requirement for health manpower production.

Appendix 12

VA's Graduate Medical Education (GME) Enhancement Initiative

GME Enhancement is a multi-year VA initiative to add approximately 2,000 positions to VA's pre-existing 8,900 physician resident positions and aims to increase VA's share of US resident positions from a nadir of 8.5% to 10-11%. Despite the looming physician workforce shortage and the recognized need to expand U.S. graduate medical education (GME) to accommodate increased numbers of medical school graduates, the Department of Veterans Affairs (VA) is the only U.S. Federal payer presently increasing funding for physician residents. Because of concerns about the content, context and relevance of medical resident training experiences, VA is also funding studies of innovative new approaches to medical education.

The specific objectives of the initiative are to: (1) address physician workforce shortages by expanding resident positions in specialties of greatest need to Veterans and the Nation; (2) address the uneven geographic distribution of residents to improve access to care; (3) incentivize the establishment of residency programs in new sites of care such as community-based clinics and rural sites; (4) foster innovation in medical education; and (5) enhance VA's leadership role in U.S. GME.

VA facilities and their academic partners apply for residency positions through one or more of three requests for proposals (RFPs):

(1) ***Critical Needs and Emerging Specialties***, which addresses the locally-identified needs of mid- to large-sized VA facilities for additional resident positions in existing and/or new specialties;
(2) ***New Affiliations and New Sites of Care***, which facilitates the establishment of affiliations with new medical schools, the expansion of existing GME programs in VA facilities with limited GME experience, and the development of programs in Community Based Outpatient Clinics or in rural areas; and
(3) ***Educational Innovation***, which allows facilities to request positions in programs supportive of transformational approaches to medical education and patient care.

Positions are awarded based upon peer review of the quality of the application, facility educational infrastructure and clinical training capacity.

The Office of Academic Affiliations has completed three funding and approval cycles and is now entering the fourth year of the GME Enhancement Initiative. The numbers of positions approved to date are summarized in the Table below.

Request For Proposals	GME Positions (2006-08)			
	Phase 1	**Phase 2**	**Phase 3**	**Totals**
Critical Needs & Emerging Specialties	300	294	212	806
New Affiliations & New Sites of Care	42	41	50	133
Educational Innovation	(N/A)	21	7	28
Total	**342**	**356**	**269**	**967**

The geographic distribution of these new positions substantially favors facilities located in the Southeast, Southwest and Western states.

Region	Phase 1	Phase 2	Phase 3	Totals	Percent
Northeast-Midwest-Mid-Atlantic	62	72	91	224	23%
Southeast	143	148	113	404	42%
Northwest-West-Southwest	137	137	65	339	35%
Total	**342**	**356**	**269**	**967**	**100%**

Medicine and medical subspecialties (combined) have received the largest number of new positions.

Specialty Groupings: 2006-2008 Awards	Number of Programs	Combined Total Positions	Percent of New Positions by Specialty Grouping
Generalist	3	160	17
Medicine subspecialties	19	279	29
Surgery & related specialties	16	163	17
Specialty – other	11	159	16
Mental Health	5	126	13
Rehabilitation	2	24	2
Ancillary-Diagnostic	10	55	6
Total	**66**	**967**	**100**

New approaches to medical education currently being tested in VA as a result of the GME Enhancement Initiative are summarized below.

Facility	Focus/Theme	Facility	Focus/Theme
Augusta	Patient-Centered Care (OEF/OIF)	New York Harbor	Critical Care Simulation
Bedford	Psychiatry Management & Leadership	Omaha	Quality Improvement & Patient Safety
Cleveland	Chronic Care Management	Phoenix	Surgical Simulation
Durham	Teledermatology	San Antonio	Surgical Simulation
Indianapolis	Patient-Centered Care & Patient Safety	San Francisco	Patient-Centered Care & Continuity