VA Centers of Excellence in Primary Care Education

1. PURPOSE AND OVERVIEW

a. Request for Proposals: The Office of Academic Affiliations (OAA) solicits proposals to establish VA Centers of Excellence in Primary Care Education ("Centers") that will foster the transformation of clinical education by preparing graduates of health professional schools and programs to work in and lead patient-centered interprofessional teams providing coordinated longitudinal care.

Centers will utilize ambulatory, primary care settings to develop and test innovative approaches for introducing, augmenting, and sustaining curricula related to the core competencies of patient-centered clinical practice. They will evaluate these improvement efforts for effects on desired educational and clinical outcomes, including patient, family, trainee, provider and institutional experiences.

Centers will study the impact of new educational approaches and models on the larger context of health professions education, including collaboration between different professional schools and programs, cultural shifts in educational priorities, and educational and workforce outcomes within and beyond VA.

***NOTE**: Health professions education programs may use different terms when referring to their students. Examples include: trainee, student, resident, intern, fellow, and learner. This RFP uses the term trainee to refer to the "student" of any profession at any level of training.*

b. Eligibility to Apply: All VA facilities and Independent Outpatient Clinics with patient-centered primary care practices that can accommodate trainees are eligible to apply. Centers of Excellence will be single site awards. No multiple facility or VISN applications will be accepted. However, multiple practice sites administered under the same station number will be allowed.

Successful applicants will demonstrate strong executive and programmatic leadership support and a documented record of innovation in education and clinical practice. Executive and programmatic leadership support from at least one affiliated medical school or teaching hospital *and* at least one affiliated nursing school is essential. Support from additional associated health professional schools or programs (e.g., physician assistant, pharmacy, social work, clinical psychology) is encouraged, but not required. VA facilities and academic affiliates must be strongly committed to the foundations of patient-centered education and practice as defined in this Program Announcement.

Applicants must focus their proposals on primary care training opportunities for medical (internal medicine or family medicine) residents and primary care nurse practitioner students. *Proposals that do not include medical residents and primary care nurse practitioner students will not be considered*. The inclusion of other medical or nursing trainees (medical students and undergraduate or graduate nursing students) and trainees from other associated health professions is encouraged, but not required.

c. Expected Annual Budget: Up to six Centers of Excellence will be implemented in Fiscal Year 2011. Each Center will be funded up to a maximum of one million dollars annually for core costs (e.g., personnel, consultation services, educational materials, equipment, supplies, travel). In addition, new trainee positions and stipend allocations will be provided to facilitate innovation and support the training models described. Subject to VA appropriations, Centers are expected to be funded for five years. Applicants will be expected to describe how successful programs established during this demonstration period will continue to function beyond the five-year time frame and the features that make their programs generalizable both within and outside VA.

2. BACKGROUND AND RATIONALE FOR INITIATIVE

Ongoing efforts by VA to transform its primary care delivery system require that care is: (1) *Patient-centered* (the patient is seen as a whole person; patient preferences guide care; communication between patients, families and providers is honest, respectful, reliable and culturally sensitive); (2) *Continuous* (every patient has an established and longitudinal relationship with a personal primary care provider); (3)*Team-based* (primary care is delivered by an interprofessional team led by a primary care provider using facilitative leadership skills; team members work at the top of their individual expertise; communication among team members is honest, respectful, reliable and culturally sensitive); (4) *Efficient* (Veterans receive the care they need at the time they need it); (5) *Comprehensive* (primary care serves as a point of first contact for a broad range of medical, behavioral and psychosocial needs that are fully integrated with other VA health services and community resources); and (6) *Coordinated* (the team coordinates care across venues of care including those in the private sector).

In parallel with VA's national transformation of its primary care delivery system, preparing the future health professions workforce for practice in this new environment is a priority. Current training models that emphasize separate, parallel education of health professionals and autonomous, physician-directed care delivery are viewed as being inadequate to this new practice model. Centers of Excellence in Primary Care Education will assess training models designed to more effectively align health professional education with patient-centered primary care practice models.

An essential component of patient-centered primary care practice is interprofessional teamwork. High-functioning teams require collaboration between physicians, nurses, pharmacists, social workers, clinical psychologists, case managers, medical assistants and clinical administrators, but among these physicians and nurses are cornerstone providers. In order to transform the primary care delivery system, physicians and nurses must be engaged as leaders, clinicians and educators. Their collaboration in the development of this application and in the leadership and operations of the Center of Excellence is therefore essential.

The success of new educational partnerships will be critically dependent on the organization and culture of the clinical learning environment. Patient-centered clinical practices with strongly motivated leadership and high-functioning interprofessional teams will be essential

for appropriate professional identity formation. If the existing learning environment (clinical practice setting) is not conducive to innovation, applicants must clearly document how the environment will be enhanced prior to the introduction of trainees. The acculturation of learners to practice in patient-centered, team-based models of primary care is a central feature of this initiative.

3. EDUCATIONAL GOALS AND OBJECTIVES

a. Shared Decision-Making: This educational domain links directly to VA's core requirement that health care should be patient-centered. To align clinical care with the values and preferences of patients and their families, trainees need to be introduced to the psychosocial foundations of health management and disease prevention. They must understand the influence of values, preferences, and cultural perspectives on clinical decision-making and strive for shared understanding. They must have insight into their own values and preferences, which may bias patient-centered decision-making. And they must have the requisite communication and conflict management skills to foster strong patient-provider relationships and promote patient behavior modification and self-management.

b. Sustained Relationships: This educational domain links directly to VA's core requirements that care should be patient-centered, continuous, comprehensive and coordinated. For trainees to appreciate the power of meaningful relationships with patients, they must have ongoing experiences with and responsibility for an identified patient population. Likewise, ongoing experiences with teachers foster formative feedback, effective supervision and mentoring. Curricular re-design that accommodates true continuity of care and promotes longitudinal learning relationships with both patients and teachers are foundational objectives of this initiative. Related objectives, which also promote continuity of care and longitudinal learning, include: effective coordination of primary and specialty care, including care in the private sector and across care venues; and the use of safe hand-offs at transitions of care between individuals, teams and care venues.

c. Interprofessional Collaboration: This educational domain links directly to VA's core requirements that care should be team-based, efficient, and coordinated. Generating and testing the effectiveness of interprofessional educational programs to prepare trainees to practice collaboratively in teams is a foundational goal of this initiative. Clinical role models leave indelible impressions on learners and have a critical role in professional identity formation. The development of a strong team ethic requires robust teacher-learner relationships not only within but also across professions. In this initiative, clinical educators will have multiple roles, including cross-professional role modeling for all trainees and team members and direct supervision and mentoring of trainees within their own professions.

Trainees must appreciate that varying healthcare professional perspectives influence collaboration, team work, and care planning. They must understand that effective team work requires high-order interpersonal and coaching skills, with leadership based on the particular problem at hand rather than an arbitrary hierarchy. And they must develop ease with a multi-modal array of communication techniques, including face-to-face, telephone and internet-based communication.

The importance of close communication with supporting members of the primary care team, especially RN care managers, LPN/health technicians and clerical staff, should not be overlooked. One of the biggest challenges in the current medical education system is that trainees work closely with their patients and attending/supervising staff, but not with the rest of the primary care team. If non face-to-face care is to be effective, trainees will need to learn to depend upon supporting staff (within the context of the entire team) for success. Do they partner with supporting staff to deliver patient-centered care? Do they huddle with various team members effectively? Do they round virtually with a RN care manager on their sickest patients? When appropriate, do they exert team leadership? And, when appropriate, do they relinquish leadership and defer to the expertise of others?

d. Performance Improvement: This educational domain is a general requirement for all health professional education programs, embodied most explicitly in the Accreditation Council for Graduate Medical Education's core clinical competencies. Clinicians strive to provide safe and effective ("evidence-based") care to individual patients. Increasingly, they are also required to optimize the health of populations. Trainees must be able to assess and manage the health of individual patients as well as an assigned panel of patients and must do so within the larger context of community and public health. Trainees must understand the methodology and seminal importance of process and outcome assessment and continuous performance improvement, including improvement of care at the level of individual providers, teams, practices, programs and institutions. They must also develop the skills to participate effectively in patient safety activities, such as sentinel event identification and root cause analysis.

4. EDUCATIONAL PROGRAM REQUIREMENTS

Proposals must include a cohesive plan and timeline that addresses all aspects of the educational program. **Please use Attachment A to provide this information, with particular attention to each of the items listed below. *Proposals that do not include all of the information requested in Attachment A will be excluded from consideration.***

a. Educational Objectives and Outcome Measures: An ideal learning environment cannot be put in place overnight and no individual Center will be able to mount a comprehensive response to the many potential directions this initiative could take. Rather, the proposal should *emphasize the "core" educational objectives and "critical" outcome measures that will be used to establish the effectiveness of the new curriculum.*

Under *each major educational domain* (listed below), describe a limited number of desired educational outcomes. Relate the educational outcomes to specific learning objectives, the teaching methods that will be used to achieve them, and the measures that will track progress toward the desired outcomes.

Because outcome measures may change over time, applications should concentrate on *near-term outcomes* (project year 1and perhaps year 2). Out-year outcome measures (years 3 to 5) need only be presented in more general terms in the present submission; additional specificity will be required in annual progress reports.

Emphasize the ***growth*** of the Center and its specific objectives over time by addressing how each objective will be "phased in." What will be in place immediately? What will have been achieved by the second year, and so on? For example, under "shared decision-making," applicants might say "By the end of year two, each learner in the identified cohort will have demonstrated consistent use of motivational interviewing techniques as measured by a direct observation check list and videotaped encounters completed at least once each quarter. By the end of year five, each learner will pass a standardized patient examination evaluating patient-centered communication skills."

In developing outcome measures consider also the ***minimal level of change*** in measures (for better or worse) that will be "educationally or clinically significant." For example, in the case of the standardized patient examination noted above, specify the most important outcomes ("critical measures") in the collected data set and assign each a percentage change that would be accepted as representing a substantive change in knowledge, clinical skills or behavior.

1) Shared Decision-Making: Applicants should describe how a new curriculum will be developed and implemented to address this goal, with an emphasis on experiential learning and self reflection rather than solely didactic experiences. At a minimum, proposals should address the assessment and alignment of health interventions with patients' preferences, shared goal setting, patient education, and promotion of healthy behaviors and self-management. Multi-modal communication skills, including face-to-face, telephonic and electronic communication, should be addressed.

Applicants should also describe the process and outcome measures that will be used to assess competence in these critical skills. Patient and family satisfaction will be important, but more quantitative measures of communication skills (e.g., communication stations in Objective Structured Clinical Exercises) and patient-centeredness (e.g., the Patient-Practitioner Orientation Scale) are strongly encouraged. Applicants should justify their choice of measures and survey instruments, including feasibility of use in primary care training sites.

2) Sustained Relationships: Applicants should describe how the curriculum will be restructured to support continuity of care and foster longitudinal learning relationships. How trainees will be integrated into patient-centered practices at the VA should be described as should how continuity will be maintained when trainees are not physically present. Coverage, whether by individuals or teams, should be explicitly addressed and effective means of communication between VA and other training sites delineated. How the resulting training models will support both patient-centered care to an identified patient population ***and*** longitudinal learning relationships must be considered.

Applicants should describe the process and outcome measures that will be employed to assess these efforts. Patient, trainee, preceptor and leadership satisfaction will be important, but measures directed at "continuity" itself are strongly encouraged. These might include waiting times, no-show rates, number of clinic visits, contacts by phone or over the internet, and the number of different providers seen. Metrics directed at coordination of primary and secondary care and safe and efficient care transitions will

also be important and might include decreases in Emergency Room visits and hospital admissions for preventable conditions and reductions in subspecialty clinic visits.

3) Interprofessional Collaboration: Applicants should describe how they will design curricula to foster interprofessional learning relationships, with an emphasis on experiential learning and self reflection rather than solely didactic experiences. Curricula need not be entirely "in common" between professions. Rather they should reflect prior learning experiences and expected roles in high-functioning, interprofessional primary care teams. It will be important to utilize teaching methods that address the professional and cultural differences that impede educational and practice collaboration, and to promote the attitudes, knowledge and skills needed to overcome behavior predicated on these differences. Applicants should explicitly address how trainees will engage with the primary care team despite limitations in their time and physical presence in the practice.

Applicants should describe the process and outcome measures that will be employed to demonstrate accomplishment in this critical area. At a minimum, trainee satisfaction surveys and 360^{o} evaluations should address respect for differing professional expertise and contributions, psychological safety, negotiation and conflict management skills, distributive leadership skills, the effectiveness of interprofessional learning, and the effectiveness of team-based care. Additional qualitative and quantitative measures of interprofessional behavior and skills are strongly encouraged. Applicants should justify their choice of instruments, including feasibility of use in primary care training sites.

4) Performance Improvement: Ongoing and substantial involvement in panel management and performance improvement activities must be integral components of the curriculum. Patient panels should be sufficiently large to track evidence-based care measures. Provide justification for the panels selected. Consider the size and other relevant characteristics of the panels, including basic demographics and the prevalence of common chronic diseases. Describe the current level of health services, how this might be altered through patient-centered care, and your goals and timeline for reducing undesirable, preventable outcomes.

Describe how trainees will establish, track and use quality measures. These must include a set of metrics for at least one chronic condition (e.g., diabetes, heart failure) and at least three preventive services (e.g., immunizations, cancer screening, smoking cessation, health education, self management). Provide justification for the measures selected, giving particular attention to the feasibility of their use in the identified primary care training sites. For example, the chronic condition selected should be sufficiently prevalent for trainees to learn to track process and outcome measures effectively. If necessary, multiple panels in the same clinic may be combined to achieve appropriate numbers of patients.

Describe how population health and performance improvement skills will be taught and assessed. The areas of prevention, health maintenance, disease management and resource utilization should all be covered. Keep in mind that a primary focus of the initiative is to introduce trainees to the importance of active panel management and the methodologies

employed. Changes in health outcomes as a result of curricular interventions may or may not be readily evident or easily measured.

b. Trainees: Identify the specific groups of family medicine/internal medicine residents *and* primary care nurse practitioner trainees who will serve as the primary learners in this initiative. Describe whether the program can be implemented within current trainee assignments and allocations or whether additional positions and funding will be required. OAA will provide additional positions, provided they are justified. Justification must be directly related to this initiative, but may include greater flexibility in trainee assignments or "back-filling" of key service responsibilities.

Trainee cohorts must be large enough to test and assess curricular changes and identified learner, patient and program outcomes. However, the cohort size may be ramped up over time, starting with a limited number of learners during the initial phase of the innovation and planning for subsequent expansion based on what is learned in the initial phase. Provide justification for selection of the trainee cohorts. Identify the potential availability of trainee cohorts with similar characteristics who might be used for comparison purposes.

Although the primary focus of this initiative is on family medicine/internal medicine residents and primary care nurse practitioner students, applicants are encouraged to consider the potential training opportunities for other health professional students as well. For example, medical schools may wish to take advantage of opportunities for introducing medical students to primary care practice. Similarly, the nursing community may wish to consider training opportunities for nurse residency and clinical nurse leader programs. Identify all such trainees and describe how they will be incorporated into the overall program. Also identify any implications of including these additional learners for medical residents and primary care nurse practitioner students at the training sites.

c. Training Sites: Training sites must be committed to a patient-centered, team-based delivery model for providing clinical services to Veterans. Identify the primary care practices that will serve as the training sites. For the most part these will be general medicine and women's health clinics. With strong justification, primary care geriatrics clinics may be considered but other subspecialty practices are excluded.

Training sites must have appropriate role models for medical and nursing trainees. Describe current clinical and educational roles of primary care physicians and nurse practitioners in the identified training sites. Identify whether local (state) scope of practice regulations provide for independent practice by primary care nurse practitioners. If not, describe the type of physician oversight required. Explain how primary care nurse practitioner role models will be available to all learners, including medical residents. Likewise, explain how primary care physician role models will be available to all learners, including nursing trainees.

d. Curriculum Design: At least 30% of the *overall* training time of each medical resident or nurse practitioner participating in this program must be devoted to managing the care of a defined population (panel) of primary care patients at VA. These activities may be concentrated into a particular portion of the medical or nursing curriculum or spread out over the entire duration of the training program. In all cases, the curriculum must be structured so

that trainees have an integral role in providing their patient panels with longitudinal, comprehensive care.

Identify the distribution of learning activities across the proposed training model. The majority of time must be devoted to "direct" patient care activities, such as 1:1 patient encounters, group appointments, team huddles/meetings, telephone care, secure messaging, home-based telemetry, home visits and consultation with other providers. The remainder of the time should be divided among reviews of panel health and quality improvement activities, reflective learning exercises emphasizing professional identity formation, interprofessional collaborative care and team work, reviews of team performance, and didactic seminars covering the foundations of patient-centered care and population health.

Innovative strategies for following patients across care venues (consultations, subspecialty clinics, invasive procedures, inpatient care) are encouraged but the primary focus must be the longitudinal care of a panel of primary care patients in the ambulatory setting and the "30% time requirement" must still be met.

Several models have been described in the family medicine, general internal medicine and nursing literature for meeting these training time commitments. One or more previously described models may be used as the basis for this proposal. However, the development and testing of other innovative models is strongly encouraged. Describe the basic features of the proposed model, identifying strengths and potential weaknesses. Include a description of how significant weakness will be managed.

In designing new models, applicants must consider prevailing accreditation standards for their disciplines and document whether and how the model meets accreditation standards. Identify whether the proposed model meets present accreditation standards for the targeted disciplines. Identify also whether existing ACGME-mandated medical residency caps will impact your ability to recruit additional residents. If the model fails to meet one or more accreditation standards or residency cap requirements, the applicant must so state and be willing to seek exceptions to the standards or caps. OAA will work closely with Center and affiliate leadership to document and secure such exceptions.

5. CENTER OF EXCELLENCE REQUIREMENTS

Applications for a VA Center of Excellence in Primary Care Education must meet all of the requirements listed below. **Please use Attachments A through G to describe the Center. *Proposals that do not include all of the information requested in the Attachments will be excluded from consideration*.**

a. Transformative Potential: Successful proposals will address the role of the Center within the broader context of the need to transform clinical education and the primary care workforce. Proposals may not be strong or outstanding in all areas, but should make a convincing case that investment in the Center will generate transformative change that will foster and sustain the major educational goals of the initiative.

Use **Attachment A** to describe how the Center will contribute to the transformation of clinical education and primary care practice. Explain how the educational program addresses

VA and national primary care workforce needs and trends in health care quality and cost. Describe how the educational program will continue beyond the 5-year special funding period. Identify the features of the educational program that make it generalizable within and outside VA.

b. Institutional Collaboration: Successful proposals will have clear evidence of having been developed by the major partners of a *joint* enterprise. The sponsoring VA Medical Center and relevant academic affiliates are expected to collaborate throughout the development of the proposal and its subsequent implementation and assessment. The importance of strong executive and program-level support from the identified medical and nursing schools and a determined commitment from all parties to innovation in clinical education and primary care practice cannot be over emphasized.

Use **Attachment A** to identify the academic affiliates partnering in this initiative. At least one medical school or academic medical center *and* one nursing school must be listed. Other health professional schools or programs may be included, but are not required. Briefly describe the nature and extent of the partnership, how the proposal was conceived and developed, and the commitment of each partner to the Center's success. Describe how the Center Director and Co-Director will be granted authority to lead efforts to align the training program with the principles and practices of patient-centered care. Explain how positive and negative "reactions" to the Center's work will be identified and documented, and how significant negative effects will be handled.

c. Clinical and Educational Environment: Successful proposals will identify patient-centered primary care practices able to accommodate the identified trainees or describe how such practices will be available by the required start date of July 1, 2011. And they will have identified clinical teachers on the basis of excellence in clinical practice and experience with interprofessional education, team work and continuous performance improvement. Physicians and nurses with strong teaching credentials should form the core of the Center's faculty. A record of educational scholarship is desirable, but not required.

Use **Attachment A** to describe the clinical and educational environment. Describe the extent to which your facility has adopted the principles of patient-centered care, giving special attention to the identified primary care training sites. Summarize current provider and trainee demographics for these practices. Describe the potential impact of the proposed training program on existing educational programs and service responsibilities at VA and the relevant affiliates.

Describe current and expected working relationships between educational and primary care leadership at your facility. Address how you will manage the culture changes precipitated by shifting from non-teaching to teaching primary care practices.

Describe the Center's experience with clinical education, including experience with interprofessional education and practice. Explain in detail what consultative expertise will be needed to facilitate interprofessional acculturation and effective team work. Include program design, implementation and evaluation issues.

Describe the Center's experience with educational and clinical evaluation, including panel management and performance improvement. Explain in detail what consultative assistance may be needed for educational evaluation, panel management and quality improvement activities. Include design, operational and analytical issues.

d. Center Staff: Follow the instructions in **Attachment B** to provide a staffing plan for the Center. Funding will be provided to support a core staff with key roles in developing, implementing and evaluating the Center's programs. The Center Director and Co-Director must be respected leaders in medicine or nursing, hold faculty appointments in the affiliated medical or nursing schools, and have the confidence of primary care leadership at VA and training program directors at the affiliate. If the Center Director is a physician, the Co-Director must be a nurse, and vice versa. Proposals with additional Co-Directors or Assistant Directors from other health care disciplines will be viewed favorably as long as a convincing case is made that their involvement at the leadership level will add to the Center's success.

The Program Director and Co-Director must be clinician educators willing and able to develop and maintain collaborative partnerships with academic and clinical leadership, develop, implement and assess educational programs, and support faculty and staff development. Experience with clinical outcome analysis and panel/population management is essential and a history of educational scholarship is desirable. Both of these individuals must have or be provided at least 5/8ths VA appointments. It is anticipated that each will require at least 50% protected time (0.5 FTEE) to fulfill leadership responsibilities. The specific level of protected time should be identified and included in the Center's budget.

Centers should identify at least four additional clinician educators, including both primary care physicians *and* primary care nurse practitioners, for significant teaching and mentoring roles and responsibilities in this initiative. Experience with clinical outcome analysis and panel/population management is desirable as is a history of educational scholarship. These individuals will be expected to practice in the identified training sites. They should be committed to attending and facilitating educational sessions related to team development and practice redesign. All of these individuals must have or be provided at least 5/8ths VA appointments. It is anticipated that each will require at least 25% protected time (0.25 FTEE) to fulfill teaching and mentoring responsibilities. The specific level of protected time should be identified and included in the Center's budget.

A variety of other staff may be necessary to support trainee activities. A data manager capable of extracting and analyzing clinical information for population management and quality improvement activities and a project manager capable of gathering and organizing evaluation data and providing general administrative support will be essential. Additional RN care managers may be required to support ongoing panel management in the absence of the trainee-provider. Consultation with experts in education, educational evaluation, statistics, sociology, anthropology, or other areas, may also be helpful. This initiative will fund such roles as long as the proposal clearly describes how the identified individuals will *support trainees* in their learning and clinical activities. At a minimum, Centers must identify data and project managers, and sufficient support for these individuals should be included in the Center's budget.

e. Center Budget: Use **Attachment C** to prepare the Center's first year budget. The Center's core budget will be up to $1 million annually, with the potential for annual renewal for four years beyond the start-up year. Renewals for Fiscal Year 2012 and beyond will be contingent on VA's budget allocation and the Center's performance. Funding for the Center is expected to support the activities undertaken to integrate trainee education into one or more of the facility's patient-centered primary care practices. *Center funding must not be used to support routine clinical care delivery.*

Center funds can be used for personnel, consultation services, educational materials, equipment, supplies, travel and other expenditures, as permitted by VA policy. Up to $100,000 of the first annual budget may be targeted to infrastructure expenses, primarily equipment.

In addition to the application (first year) budget, each approved Center will be required to submit an annual budget request thereafter. Guidance will be provided by OAA prior to each annual budget due date.

Budget requests must account for all leadership, teaching and administrative costs. Salary support for key individuals should be paid from Center funds, but *assurances of appropriate release time must be provided*. If contracts or Intergovernmental Personnel Act (IPA) agreements will be used to secure specialized consulting support, identify each of the functions involved and justify the use of non-VA personnel. Center funds may also be used for other operational costs, including equipment, travel and facility renovation. Information technology (IT) requests *cannot* be directly funded by this initiative. IT infrastructure needs must be separately documented and included in the facility's proposed IT spend plan.

Center activities may also be supported by other funds, including facility, VISN and affiliate resources. All contributed support must be negotiated in advance with the requisite individuals (e.g., medical center director, VISN director, medical/nursing school dean) and any agreements should be described in detail. Cost sharing may include personnel, equipment, travel and facility renovation.

f. Center Trainees: Use **Attachment D** to summarize the types and numbers of trainees associated with the Center. Trainees can be deployed from present assignments (at VA or the affiliates) or additional VA training positions can be requested. OAA will make available additional training positions and funding (including stipends and benefits) for medical residents, primary care nurse practitioner students, and other health professions trainees provided detailed justifications are provided.

g. Local and VISN Support: Medical Center and VISN leadership should have a demonstrated commitment to patient-centered care. Both must endorse the application and specifically guarantee the following: (1) 5/8ths or greater VA appointments and a minimum of 50% protected time each for the Director and Co-Directors; (2) 5/8ths or greater VA appointments and a minimum of 25% protected time for at least four clinician educators with significant teaching and mentoring roles and responsibilities in the Center; (3) sufficient administrative, clinical and educational space, including private space for small group and team meetings ; (4) fiscal and human resource support services; (5) access to health records

and related data processing capability; (6) electricity, heating, air conditioning, telephones and housekeeping support; and (7) the storage and security needs of the Center. *These assurances should be explicitly addressed in the Medical Center Director's letter of support.*

NOTE: Local facilities are *not* expected to develop local patient registry functionality for the purpose of supporting the Center's panel management and quality improvement objectives. This will be the responsibility of the Center of Excellence itself.

VA primary care leadership (e.g., ACOS for ambulatory care, primary care service line director) must also endorse the application. The letter of support should address the facility's overall commitment to patient-centered care, the degree of implementation of the patient-centered practice model in primary care (especially in the identified training sites), and the specific primary care practice requirements in the Program Announcement.

h. Center Governance: Instructions for submitting an organizational chart depicting the governance of the Center and the composition of a "steering committee" to provide local oversight of the Center are provided in **Attachment E**.

i. Affiliation Agreements: Facilities must have properly executed affiliation agreements with all educational institutions participating in the Center.

j. Reporting Requirements: Annual reports will be reviewed administratively by OAA to ensure that the Center's performance meets expectations. A standardized, web-based annual report template will be used to collect this information and ensure that the Center's major accomplishments are recognized.

k. Anticipated Awards and Funding Period: OAA expects to approve up to six proposals. Approved Centers are expected to be funded for five years beginning in *Fiscal Year 2011 (January 1, 2011) and continuing through September 30, 2015*, contingent on VA's budget allocations. Before funding is released, each Center will be required to submit an updated first-year budget plan.

l. Early Termination: If a Center demonstrates unsatisfactory performance, the Program Director will be notified. A corrective action plan must be submitted to OAA by the date specified in the notification letter. The plan must address each deficiency identified or funding will be suspended. If corrective efforts are not fully successful within a stipulated period of time, participation in the program will be terminated.

m. Centers of Excellence Coordinating Center: A separately funded Coordinating Center and Program Advisory Committee will be formed to facilitate the work of the individual Centers, foster collaboration across Centers and provide expert guidance of the overall program. The responsibilities of the Coordinating Center will include: developing common curricula, professional development programs and evaluation objectives and instruments; creating centralized databases; assisting Centers with population registry development and panel management; fostering educational evaluation and performance improvement; and communicating generalizable results of the project to the broader health professions community. The Coordinating Center will include a core staff with statistical and evaluative expertise. Consulting services to individual Centers will be provided at no cost.

The final form and function of the Coordinating Center will be determined by OAA in collaboration with the approved Centers. Members of the Program Advisory Committee will be drawn from individual Center steering committees and outside experts otherwise not affiliated with the Centers. Further details will be provided following selection of the Centers.

n. Research Opportunities: This initiative is an educational and clinical performance improvement project. Evaluative activities meant to support ongoing improvement, as opposed to producing generalizable knowledge, are normally exempted from human subject research oversight requirements. However, we anticipate that the initiative will generate ideas and opportunities for publication of observational data as well as hypothesis-driven research. Interested investigators are encouraged to contact Center Directors, the Coordinating Center or OAA to explore opportunities for collaboration. Research projects will be subject to IRB approval and funding would have to come through alternate channels. *Center funds provided as part of this Program Announcement cannot be used to support research activities*.

o. Biographical Sketches: Instructions for submitting brief biographical sketches of key Center personnel are provided in **Attachment F**.

p. Letters of Support: Instructions for submitting letters of support from VA and affiliate executive and program leadership are provided in **Attachment G.**

6. TRAINEE POLICIES

a. Physician Trainees:

1) Governance. OAA maintains overall responsibility for the administration of VA's Centers of Excellence in Primary Care Education. Academic institutions providing physician trainees to Center programs shall comply with the Program Requirements for Residency Education (as published in the current Graduate Medical Education Directory), the requirements of the Liaison Commission on Medical Education (LCME), and VA provisions for the training of medical students and residents. Applicable requirements of the Accreditation Council for Graduate Medical Education (ACGME) and the program-specific Residency Review Committee (RRC) must be addressed in the proposal.

2) Graduate Medical Education (GME) Program Sponsorship. GME positions currently allocated to the facility may be included in activities undertaken as a part of this Program Announcement. Any additional medical resident positions requested must be in residency programs sponsored in the name of an affiliate. *No new residency programs sponsored in the name of a VA facility may be initiated*. Likewise, no expansions of existing VA-sponsored GME programs may be requested.

3) OAA Support for Trainees. OAA will provide funds to VA facilities for residents' stipends and fringe benefits. Funding of residents' stipends and benefits through a

disbursement agreement is recommended. Disbursement agreements cannot be used to fund administrative costs of residency training programs.

4) Appointment and Compensation of Physician Residents.

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

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

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

6) Trainee expenses. Except as specified above, expenses connected to trainee recruitment, educational activities, or research are not funded under this program. Transportation to the VA facility and housing arrangements are the sole responsibility of the trainee.

b. <u>Nursing Trainees</u>:

1) Governance. OAA maintains overall responsibility for the administration of VA's Centers of Excellence in Primary Care Education. Academic institutions providing nursing trainees to Center programs shall be accredited by the Commission on Collegiate Education in Nursing (CCNE) or the National League for Nursing Accreditation Commission (NLNAC) and are subject to VA provisions for the training of undergraduate and graduate nursing students. Nurse practitioner training programs must comply with National Task Force Criteria for Evaluation of Nurse Practitioner Programs (2008) and graduates must be eligible for national certification used for state licensure. Applicable national certification requirements must be addressed in the proposal.

2) Nursing Program Sponsorship. All nursing trainees included in activities of the Center must be in educational programs sponsored in the name of an accredited academic affiliate. Training positions currently allocated to the facility may be included in activities undertaken as a part of this Program Announcement. Any additional nursing positions requested must be in programs sponsored in the name of an affiliate.

3) OAA Support for Trainees. OAA will provide funds to VA facilities for graduate nursing trainee stipends and fringe benefits when involved in activities of the Center.

4) Appointment and Compensation of Nursing Trainees.

a) **Appointment authority**. Appointments will be made under 38 U.S.C. 7405.

b) **Stipend determination.** The stipends for individual positions or fractions of positions will be based on educational level and geographically adjusted VA stipend rates.

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

6) Trainee expenses. Except as specified above, expenses connected to trainee recruitment, educational activities, or research are not funded under this program. Transportation to the VA facility and housing arrangements are the sole responsibility of the trainee.

c. Trainees in Other Disciplines:

1) Governance. OAA maintains overall responsibility for the administration of VA's Centers of Excellence in Primary Care Education. All "associated health" trainees (defined here as trainees not in medicine or nursing) included in activities of the Center shall comply with the Program Requirements promulgated by the respective discipline's educational accreditation bodies and with VA provisions for training in those disciplines.

2) Program Sponsorship. Currently allocated facility associated health trainee positions may be included in activities undertaken as a part of this Program Announcement. All trainees included in activities of the Center must be in programs sponsored in the name of an affiliate *or* in internships and residencies typically sponsored by the VA, such as psychology internships and postdoctoral training programs or residencies in optometry, pharmacy and podiatry.

3) OAA Support for Trainees. OAA will provide funds to VA facilities for trainee stipends and fringe benefits when involved in activities of the Center.

4) Appointment and Compensation of Trainees.

a) **Appointment authority**. Appointments will be made under 38 U.S.C. 7405.

b) **Stipend determination.** The stipends for individual positions or fractions of positions will be based on the discipline, educational level, and geographically adjusted VA stipend rates.

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

6) Trainee expenses. Except as specified above, expenses connected to trainee recruitment, educational activities, or research are not funded under this program. Transportation to the VA facility and housing arrangements are the sole responsibility of the trainee.

7. REVIEW PROCESS

a. Review Committee: An ad hoc, interprofessional review committee designated by the Chief Academic Affiliations Officer will assess the merits of applications. Reviewers will have demonstrated expertise and leadership in education, patient care and research.

b. Selection Criteria: Applications will be scored according to the following criteria:

1) Potential to change primary care education and practice, including creativity, feasibility, sustainability, and generalizability inside and outside of VA;
2) Demonstrated level of collaboration between schools of medicine or teaching hospitals and schools of nursing (and other health professional schools and programs, as appropriate) in fulfilling the intent of the Program Announcement;
3) Demonstrated commitment from the local VA facility and VISN, including executive and program management levels, to patient-centered care and the particular requirements of this Program Announcement; especially the guarantees of protected time for the core Center faculty and staff;
4) Strength of the proposed curriculum redesign, including its potential to achieve the primary objective of integrating medical and nursing trainees into high-functioning primary care teams, the inclusion of thoughtful strategies to surmount the difficulties of cross-professional endeavors, and the specificity and precision of the educational objectives and outcome measures;
5) Level of reality ("creative pragmatism") in the overall design of the project, including an honest assessment of the potential weaknesses of the Center and the solutions proposed to address them; and
6) Feasibility of the budget to accomplish the proposed project.

8. APPLICATION INSTRUCTIONS

a. Letter of Intent: VA facilities must submit a letter of intent following the instructions provided in Section 12. *Letters of must be received in the OAA e-mailbox by 11:59 pm September 22, 2010.* Letters received after this date will not be considered. Feedback will be returned to the facility by October 6, 2010. Those approved may submit a full proposal.

b. Full Proposal: Facilities selected to compete for a Center must submit full proposals following the instructions provided in Attachments A through G. *Full proposals are due by 11:59 pm November 17, 2010* using an online submission process.

c. Preparation of Applications. The VA Designated Education Officer (DEO) should be the focal point for coordination and submission of the Letter of Intent and Full Proposals. The proposed Center Director and Co-Director must assume responsibility for preparation of the application materials.

d. General: See **Application Checklist** for the required sections of the proposal.

1) **File formats.** Word, Excel, PDF or TIF files formats may be used. Letters must include a signature (i.e., they must be a scanned copy of an original, signed document).

2) **Font and margin sizes.** Font size must be 10-point or larger, with 12-point preferred for narrative portions. Margins must be at least one inch all around (excluding headers and footers).

e. <u>Online submission instructions</u>:

1) Applicants will submit Attachments A through G for their proposals using an OAA Support Center password protected web portal, similar to the submission of regular OAA reports. A special application entry point has been established for submission of applications in response to this Program Announcement.

2) VA Education Office staff should use their already established password to access the OAA Support Center. Other VA staff with roles in preparing application materials can obtain a password by going to http://vaww.oaa.med.va.gov/Login.aspx, and then selecting "I need to register."

3) Most portions of the application will be uploaded as files. See below for full instructions.

4) The Center of Excellence application site will be opened and ready to accept applications when Letter of Intent feedback is provided to facilities. Applications may be changed or modified up to the closing date for applications. Only authorized individuals may upload files or other information into the application database.

5) *<u>Faxed, mailed or e-mailed applications will NOT be accepted.</u>*

9. SCHEDULE

August 20, 2010	OAA sends Program Announcement to eligible facilities, VISNs, and appropriate Central Office officials. Program Announcement published on OAA website.
September 22, 2010	**Facility Letter of Intent due in OAA** Send to Outlook e-mail: Office of Academic Affiliations (14) (VHACOOAA@va.gov)
October 6, 2010	Letter of Intent feedback provided to facilities
November 17, 2010	**Full Proposals from eligible facilities due in OAA via an ONLINE submission process**
December 14-16, 2010	Review committee evaluates applications and makes recommendations to the Chief Academic Affiliations Officer
January 5, 2011	OAA notifies facilities about the approval/disapproval of proposals
January 2011	Center budgets negotiated
January-February 2011	Coordinating Center and Advisory Committee established
July-September 2011	Trainees begin according to respective academic cycles
October 1, 2012	First annual progress reports due in OAA

10. OAA CONTACT PERSONS

a. General information: Please contact Michelle D. Johnson at (202) 461-9492 or by e-mail (Michelle.Johnson5@va.gov) or Joanne B. Pelekakis at (202) 461-9593 or by e-mail (Joanne.Pelekakis@va.gov).

b. Technical information: For information regarding the online submission process, e-mail the OAA Help Desk (oaahelp@va.gov) or contact David Bernett at (803) 695-7935 or (314) 277-6476 or by e-mail (david.bernett@va.gov).

11. APPLICATION SUBMISSION CHECKLIST

- **Attachment A: Core Narrative (Limit 20 pages)**
  Upload Word document.
- **Attachment B: Center Staff**
  Must use table in Attachment B.
  Upload Word documents (table and narrative).
- **Attachment C: Center Budget**
  Must use table in Attachment C.
  Upload Word documents (table and narrative).
- **Attachment D: Center Trainees**
  Must use table in Attachment D.
  Upload Word documents (table and narrative).
- **Attachment E: Center Governance**
  Upload PDF or TIF document.
- **Attachment F: Brief Biographical Sketches**
  Must use VA Form 10-1313-5.
  Upload PDF or TIF documents.
- **Attachment G: Letters of Support (Limit 2 pages each)**
  Upload Word, PDF or TIF documents.
  Address to the Chief Academic Affiliations Officer (14).

12. LETTER OF INTENT INSTRUCTIONS

Letters of Intent are **due no later than 11:59 pm Eastern, September 22, 2010** and **must be sent via email** to (VHACOOAA@va.gov). They should be addressed to the Chief Academic Affiliations Officer (14).

NOTE: The letter of intent is a crucial component of the application. It should be succinct, forthright and realistic in identifying strengths and weakness, and above all thoughtful. Pro forma responses will not be sufficient. More than anything else, this project is about culture change, which is notoriously difficult. What we are looking for are "a few good Centers" to work individually and collectively to tackle a fundamental problem in clinical education. We recognize that an ideal learning environment cannot be put in place overnight and that no Center will be perfect, at the outset or even after 5 years of creative work. Please tell us what your Center would bring to this journey.

Please include the following sections in your letter and abide by the word limits. *Letters of intent that do not follow these guidelines will be excluded from consideration*.

a. Transformative Potential: Provide an overview of the principal strengths of *your* Center and how these will contribute to the transformation of clinical education and primary

care practice. Address whether the Center's educational programs will be sustainable once demonstration project funding ceases and generalizable within and outside of VA. Be realistic in your appraisal, tempering creativity with pragmatism. (Limit: 250 words)

b. Goals and Objectives: Capture the overall aim of *your* Center in a succinct mission statement. Briefly describe the "core" educational objectives and "critical" outcome measures and methodologies you will use to establish the effectiveness of the new curriculum. Include a description of how you see the Center and its specific educational objectives growing over time. (Limit: 500 words)

c. Academic Partners: Identify the medical and nursing school partners, the particular departments/programs involved, and any other proposed academic partners. Describe current and expected working relationships between VA and these entities, focusing on family/internal medicine residency and primary care nurse practitioner training programs. Be specific, indicating where authority for approving curricular change and responsibility for curriculum design and implementation reside. Identify influential individuals who will champion change. Address how you will manage the culture changes precipitated by shifting education from profession-specific to shared endeavors. (Limit: 250 words)

d. VA Support: Describe whether facility and VISN executive leadership anticipates any difficulties meeting the requirements specified in the Program Announcement. Provide solutions to any problems identified and indicate whether VA leadership has endorsed these solutions. Describe current and expected working relationships between educational and primary care leadership at your facility. Be specific, indicating where authority for approving changes to the organization and function of primary care teams and responsibility for implementing such changes reside. Identify influential individuals who will champion change. Address how you will manage the culture changes precipitated by shifting from non-teaching to teaching primary care practices. (Limit: 250 words)

e. Training Sites: Summarize the attributes of the identified primary care practices, emphasizing what make them robust educational environments for family/internal medicine residents and primary care nurse practitioner students. Describe the clinical and educational roles of primary care physicians and nurse practitioners in these sites, and indicate whether they currently serve as role models for trainees. Describe a typical patient panel and explain how panels will be modified to meet the requirements specified in the Program Announcement. (Limit: 250 words)

f. Trainee Cohorts: Describe the key trainee cohorts. Explain how training time will be modified to meet the requirements specified in the Program Announcement without negatively impacting overall training program integrity. Pay particular attention to how trainees will develop meaningful, longitudinal relationships with patients and how they will be integrated into interprofessional teams. Address whether the program can be implemented within current trainee allocations or whether additional positions and funding will be required. Address whether special exceptions to accreditation requirements will be required. (Limit 250 words)

g. Center Leadership: Identify the Center Director and Co-Director. Summarize their current clinical and educational roles at VA and the identified affiliates. Explain how their current responsibilities will be modified to provide the time required to lead this project. (Limit: 250 words)

Attachment A: Core Narrative

**** See Sections 4 and 5 for detailed descriptions of expectations ****

Upload a Word document containing the **Core Narrative (limit 20 pages).** Include specific sections addressing the following:

- **Educational Program Requirements**
  - Educational Objectives and Outcome Measures
  - Trainees
  - Training Sites
  - Curriculum Design
- **Center of Excellence Requirements**
  - Transformative Potential
  - Institutional Collaboration
  - Clinical and Educational Environment

Attachment B: Center Staff

**** See Section 5d for detailed descriptions of expectations ****

Summarize Center staffing (see example). Identify the Center Director and Co-Director by name and other key staff by position (and name, if available). Describe their qualifications, major role in the Center, and present level of VA salary support ("Present VA Effort"). For each individual, also indicate the proposed level and source of support when the Center of Excellence (COE) is established ("COE-Related Effort"). In addressing proposed support, consider three potential sources: support provided by the demonstration project itself ("COE Funded"); support contributed by the local VA facility or VISN ("VA Contrib."); and support contributed by academic affiliates ("Affiliate Contrib."). As indicated in the example, proposed support does *not* have to equal 100%. Add as many rows to the table as necessary.

Attachment B: Center Staff (EXAMPLE)
Name of VA Facility: KLM VA Health System

Name/Positions	Qualifications	Center Role	Present VA Effort (FTEE)	COE-Related Effort (FTEE)		
				COE Funded	VA Contrib.	Affiliate Contrib.
SUSAN S. SMITH,MD ACOS/Ambulatory Care, and Professor of Medicine, XYZ School of Medicine, PDQ University	Internal Medicine 32 years, teaching 17 years, clinical 16 years, research	Center Director	0.875	0.625	0.25	0
JOHN D. DOE, PhD, RN Associate Chief of Nursing Education, and Clinical Instructor ABC School of Nursing, RST University	Nursing 15 years, teaching 7 years, research	Center Co-Director	1.0	0.625	0	0
ROBERT Q BROWN, PhD Assistant Chief Mental Health and Psychology Training Director	Psychology 14 years, teaching 20 years clinical	Assistant Program Director for Psychology and Evaluation	1.0	0.375	0	0
SANDRA A. EDUCATOR, EdD Associate Professor of Education, DEF School of Education, PDQ University	Education 12 years teaching and consulting	Educational evaluation consultant	N/A	Contract or IPA	N/A	N/A
TBA		Data Manager	0	0.75	0	0.25

Attachment B: Center Staff **Name of VA Facility:**						
Name/Positions	**Qualifications**	**Center Role**	**Present VA Support (FTEE)**	**Proposed COE Support (FTEE)**		
				COE Funded	**VA Contrib.**	**Affiliate Contrib.**

<u>Contributed Support</u>: In a separate narrative, please comment on all instances of contributed support identified in the table, including support contributed by the local VA or VISN and support contributed by academic affiliates. In each instance, provide assurances that the requisite authorities have approved the arrangement. This information should be uploaded as a Word document **(Limit: 1 page)**.

Attachment C: Center Budget

**** See Section 5e for a detailed description of expectations ****

First-Year Budget Request: Use the table to prepare a first year budget request, indicating expenditures in the categories listed below. Add as many rows to the table as necessary.

a. Personnel: List all personnel costs for the first 12 months of the project.

1) For each named individual, indicate the role in the Center, VA Grade and Step, and FTEE support and salary *from the Center*.

2) Identify all contracts and Intergovernmental Personnel Act (IPA) agreements.

3) Consulting services are limited to $500 per consultation or $2,500 per year, exclusive of expenses. Higher amounts must be approved by the Secretary of Veterans Affairs or be obtained through a contract or IPA.

b. Non-Personnel: List and describe other expenses for the first 12 months of the project by major categories.

1) Equipment: List each item of equipment to be purchased. Estimated equipment costs need to be consistent with current VA procurement policies and contracts.

2) Supplies. Itemize the cost of supplies, by major category (e.g., office supplies, printing costs).

3) Learning Materials. List any planned purchases for items such as books, media or manikins.

5) Travel. Explain planed travel and its relationship to Center activities.

6) Other. List any miscellaneous expenses. Core budget requests should *not* include IT expenses. Center IT needs should be submitted separately through the Medical Center's IT budget plan.

Budget Justification: In a separate narrative provide a brief justification for each major budget category. This information should be uploaded as a Word document **(Limit: 2 pages)**.

a. Personnel: For each position, describe how Center funds will be used to provide protected time for the Center Director and Co-Director and other core staff. If necessary, describe how their current responsibilities will be redistributed to provide dedicated support to the Center.

b. Contracts and IPAs: For each contract and IPA, describe what services will be provided to the Center and why they cannot be provided by VA personnel.

c. Non-Personnel Expenses: Justify major non-personnel expenses, by category.

Attachment C: First Year Budget Name of Facility:				
Personnel	**Center Role**	**VA Grade/Step**	**% Effort (FTEE)**	**Funding Requested**
VA Employees (List by Name or TBA)				
	Program Director			
	Program Co-Director			
	Clinician-Educator			
	Clinician-Educator			
	Clinician-Educator			
	Clinician-Educator			
	Data Manager			
	Project Manager			
Contracts				
IPAs				
Consultants				
Total Personnel				
Non-Personnel	**Description**			**Funding Requested**
Equipment				
Supplies				
Learning Materials				
Other				
Travel				
Total Non-Personnel				
TOTAL REQUEST				

Attachment D: Center Trainees

**** See Sections 4b, 4d and 5f for detailed descriptions of expectations ****

Use the table to list all trainees expected to be involved in activities of the Center by discipline and level in their educational program. Enter specific categories of trainees under each major discipline heading, adding as many rows to the table as necessary. You must include medical residents and primary care nurse practitioner students; other categories of trainees are encouraged but not required.

For the purposes of this table "trainee" refers to *unique individuals* rather than training positions through which multiple individuals may rotate. We are looking for a sense of program scope rather than funding needs. OAA will work with successful applicants to more precisely define the scope of their program, its growth over time, and whether additional trainee positions and funding are needed.

To provide a sense of the potential growth of your program, please estimate trainee numbers for the 1st, 2nd and 5th years of the educational program, starting with the academic year beginning July 1, 2011. You will *not* be held to these numbers until they have been more precisely defined in subsequent discussions with OAA.

Discipline	**Program**	**Unique Individuals**		
		1st Year	**2nd Year**	**5th Year**
Medicine	Internal Medicine Residents (PGY-1)			
	Internal Medicine Residents (PGY-2)			
	Internal Medicine Residents (PGY 3)			
	Internal Medicine Chief Residents			
	Family Medicine Residents (PGY-1)			
	Family Medicine Residents (PGY-2)			
	Family Medicine Residents (PGY-3)			
	Family Medicine Chief Residents			
Nursing	Primary Care Nurse Practitioners (Masters)			
	Primary Care Nurse Practitioners (DNP)			
Pharmacy				
Psychology				
Social Work				
Other (specify)				

Attachment E: Center Governance

Upload a standard organizational chart depicting the local governance of the Center as a PDF or TIF file. The VA Medical Center Director must have ultimate authority over the Center, but the chart should include both VA and affiliate representatives and emphasize the joint nature of the initiative. The Center Steering Committee should be depicted on the organizational chart. Indicate the composition of the Steering Committee by position (and name, if available). The steering committee should include the Center of Excellence Director and Co-Director, the VA Chief of Staff and Chief Nursing Executive, and appropriate VA and affiliate educational and primary care leaders.

Attachment F: Biographical Sketches

Upload Brief Biographical Sketches for Center of Excellence Program Director and Co-Director and other key personnel and consultants as PDF files. **The biographical sketches MUST be on VA Form 10-1313-5.** Follow all instructions when completing the form. **Each biographical sketch is not to exceed 4 pages.**

VA Form 10-1313-5 can be found at http://vaww4.va.gov/vaforms/medical/pdf/10-1313-5.pdf .

Attachment G: Letters of Support

Letters of support should be addressed to the Chief Academic Affiliations Officer (14) and must be signed. They should address the key opportunities and barriers to successful implementation of the Center as seen from the special vantage point of the author. Pro forma letters are strongly discouraged. Letters should be obtained from the individuals listed below. Additional letters are welcome if they provide insights into the organization and function of the Center not already covered in the required letters. **Each letter is not to exceed 2 pages.**

- Network Director (through VISN CMO and AAO)
- Medical Center Director
- VA Chief of Staff
- VA Chief Nursing Executive
- VA Designated Education Officer (DEO)
- VA Associate Chief Nurse for Education, or equivalent
- VA ACOS/Ambulatory Care, or equivalent
- VA Training Site Practice Director*
- Center of Excellence Program Director
- Center of Excellence Program Co-Director
- Dean of Affiliated Medical School or CEO of Affiliated Teaching Hospital
- Designated Institutional Official (DIO) (for GME programs)
- Chair, Department of Internal Medicine
- Chair, Department of Family Medicine
- Dean of Affiliated Nursing School
- Director, Primary Care Nurse Practitioner Program, or equivalent
- Associated Health academic officials, as applicable

***** This letter should be from the individual with overall responsibility for primary care practice operations in the Center's proposed training sites. These will usually be "general medicine" practices. If other training sites (e.g., women's health clinics) are included in the Center's educational program, please provide letters from equivalent individuals in these sites as well.