

**U.S. Department of Veterans Affairs (VA)  
Federal Advisory Committee  
National Academic Affiliations Council (NAAC)  
Meeting Minutes for July 12-13, 2017**

**VA Central Office  
Sonny Montgomery Room  
810 Vermont Ave  
Washington, DC 20420**

**U.S. Capitol Visitor's Center  
Room HVC-201 A/B  
East Capitol St & 1<sup>st</sup> St NW  
Washington, DC 20515**

The National Academic Affiliations Council (NAAC) met face-to-face on July 12-13, 2017 at the VA Central Office and U.S. Capitol Visitor's Center in Washington, DC. A quorum was present, affording the Council the opportunity to conduct normal business.

**Attendance: See Appendix A**

**Day 1: July 12<sup>th</sup>, 2017**

**Welcome and Introductions**

Dr. Cox called the meeting to order at 9:00 AM EST and conducted the roll call of NAAC members. All Council members and guests introduced themselves.

Dr. Cox reviewed prior recommendations of the NAAC, and urged the Council to bring forward new ideas rather than repeating past recommendations. Dr. Sanders announced that the NAAC meeting is open to the public and that Mr. Stephen Trynosky, the Designated Federal Officer, is present to observe the proceedings. She requested that members of the public hold all questions until the appointed time on the agenda.

**VA Leadership Perspective**

**Guest Speaker: Mr. Scott Blackburn, Interim Deputy Secretary of VA**

Scott Blackburn, Interim Deputy Secretary of VA, spoke to the NAAC about creating more partnerships and joint ventures, updating information technology (IT) systems, and prioritizing Veteran-centric care. He acknowledged the important role of the Office of Academic Affiliations (OAA) within the Veterans Health Administration (VHA) and the need for a heightened emphasis on mental health amidst the high rate of Veteran suicides. Drs. Sanders and Cox emphasized to Mr. Blackburn that VA hosts over 120,000 trainees each year in addition to its 360,000 regular employees. This population is indispensable for VA to ensure access to care.

Mr. Blackburn outlined the top IT-related issues that the Secretary's office is currently focused on including the transition to a new electronic health record system, maintaining strong academic affiliations, and the appropriate issuance of personal identification verification (PIV) cards. VA's focus on these issues falls within its current modernization and reorganization efforts, which stress transparency and retaining a Veteran rather than an organization-centric mission. Access to suitable IT resources also encompasses VA's ability to use technology as a means to reach out to and recruit current and future health professional trainees.

The Interim Deputy Secretary also highlighted the cultural shift within VA that he hopes the department can embody through the revision of VA Directive 1663 (Health Care Resources

Contracting). He cited Directive 1663 as a way to facilitate increased action by easing the creation of external partnerships. Mr. Blackburn alluded to a current institutional “paralysis” surrounding the finalization of Directive 1663, and indicated that he would do his utmost to move this long-delayed process to completion.

### **NAAC & Blue Ribbon Panel Discussion**

Dr. Sanders gave an overview of the Blue Ribbon Panel on VA-Medical School Relationships, the predecessor to the NAAC. The Blue Ribbon Panel was a 3-year advisory committee that analyzed VA-affiliate relationships and among other recommendations, suggested the NAAC be created and chartered as a standing FACA with no sunset date. Dr. Sanders reviewed the main BRP recommendations; the full Report can be accessed at <https://www.va.gov/oaa/archive/brp-final-report.pdf>.

Dr. Cox pointed out that many past NAAC recommendations have yet to be fully addressed by the department and that this is a continuing source of frustration for the academic affiliates. He also observed that many themes discussed by the Council were issues earlier raised by the Blue Ribbon Panel and have been raised recurrently in previous NAAC meetings; some of these recurring issues are: joint ventures, IT, and, most recently, the Choice Program. Dr. Cox asked the NAAC to focus not only on how the department can implement NAAC recommendations, but also what the Council itself and VA's academic affiliates can do to see their success.

Dr. Cox felt that the future direction and changing culture of VA would be best served by internal organizational changes that allow for the streamlined communication of OAA expertise to VHA senior leadership. Given the vital national mission of OAA, the irreplaceable role of health professional trainees in facilitating access of Veterans to care, and the significant number of trainees rotating through VA each year, the Council discussed how best to enhance communication within VHA, especially as it pertains to VHA organizational structure and OAA's reporting relationship.

**Recommendation 1: As one of VA's four statutory missions, the Council emphasizes that VA's educational mission must be more strongly embraced by the Under Secretary for Health and VHA executive leadership. Accordingly, the NAAC recommends that the Office of Academic Affiliations be realigned within the VHA organizational structure to report *directly* to the Under Secretary for Health.**

### **Ethics and Advisory Committee Management Office Briefings**

In a working lunch, Mr. Jeffrey Moragne (director of the VA Advisory Committee Management Office) and Ms. Carol Borden (ethics attorney of the VA Office of General Counsel) briefed the Council members on the ethical and administrative guidelines that govern their role as Special Government Employees. Mr. Moragne and Ms. Borden explained how each member should keep in mind their two-term limit as advisory committee members and forward suggestions for their eventual replacements. The Council members were reminded to avoid common conflict of interest violations such as direct or indirect financial interests, accepting gifts, or the misuse of government title/affiliation. Mr. Moragne emphasized the importance of service on a Federal advisory committee to serve the interests of the American public.

### **Formation of an Internal Academic Advisory Committee**

The Council was informed that Secretary Shulkin had requested the NAAC to consider the utility of creating an internal VHA committee to advise him and the Under Secretary of Health on academic matters. Such a committee would work hand in hand with the (external) National Academic Affiliations Council.

The Council considered this proposal and felt that such a committee could be useful, particularly if the membership was derived from a pool of leading VHA clinical executives nominated by their academic partners. The Council emphasized that the operating relationship between the internal and external advisory committees would have to be thoughtfully structured. Two models considered were adding the chair of the internal committee as an ex-officio member to the NAAC or having the internal advisory committee function as a subcommittee of the NAAC.

**Recommendation 2: Given the central role of academic affiliates and trainees in the VA clinical workforce in maintaining and enhancing quality Veteran-centric care, the NAAC endorses Secretary Shulkin's request for an internal VHA Academic Advisory Committee to work hand in hand with the National Academic Affiliations Council. The Council requested that OAA report on efforts to establish such a committee at the December NAAC meeting.**

#### **Improving Stakeholder Relationships Panel Guest Presenters: See Appendix A**

Seven guest speakers were invited to provide comments as VA academic stakeholders in response to Secretary Shulkin's March 24, 2017 letter to VA's Academic Affiliates that invited them to provide input on improving VA-affiliate relationships. In addition to the seven invited speakers, 17 written comments from academic affiliates were submitted to the NAAC for consideration.

Dr. Ann Nattinger of the Medical College of Wisconsin (MCW) spoke about her institution's desire to co-locate research laboratory facilities for VA-funded research on campus. MCW has an active affiliation with the Clement J. Zablocki (Milwaukee) VAMC, which is about a 30 minute drive from MCW's main campus. The co-location of the two lab facilities would make it easier and more economically efficient for trainees to conduct biomedical research to advance Veteran care. Dr. Nattinger stated that the current VAMC wet lab space is outdated and a co-located lab would allow for an improved space that can attract a larger applicant pool and foster better researcher collaboration. Dr. Nattinger concluded by referencing the benefits that can be conferred to VA through a sole-source leasing arrangement with affiliates. Under Title 38 of U.S. Code 8153, VA may acquire different health care resources for its affiliates through a non-competitive process.

Dr. Sanders noted that the VA Office of General Counsel narrowly interprets this statute and has historically excluded the sole-source leasing of space from VA's recognized statutory authorities.

Dr. Stephen Shannon of the American Association of Colleges of Osteopathic Medicine (AACOM) advocated for increased communication between OAA and the Veterans Integrated Service Networks (VISNs), with an emphasis on undergraduate medical education (UME) and graduate medical education (GME) outreach, and streamlining the affiliation agreement process. AACOM established an Osteopathic Medical Education/VA Academic Affiliations Task Force to act as a liaison between VA and the osteopathic community. He provided five general recommendations, including:

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- Enhance available resources to a team within each VISN dedicated to strengthening the relationship with academic affiliates and communication with OAA leadership
- Designate someone within each VISN to provide on-the-ground support to help guide affiliates through the initial process of establishing partnerships
- Streamline the affiliation agreement process to eliminate lengthy timelines and improve the coordination with affiliates and allow individual VA facilities to establish specific requirements
- Formalize messaging and provide official written language to address any misunderstanding between local and national levels and meet GME accreditation standards
- Close the information gap in the process of creating partnership with community-based sites

Dr. Cox agreed that communication between VHA/OAA leadership and the field is an ongoing problem that the Council will continue to address in its recommendations to the Secretary.

Dr. Sealey, from Authority Health in Detroit, represented the American Osteopathic Association (AOA) and voiced his support for VA's greater collaboration and resource sharing with osteopathic medical schools, especially through the GME expansion effort. He applauded the intent of VA's GME expansion through authority conferred under the Choice Act and discussed how it enabled his program to expand by covering some trainee costs and offering residents more specialized training.

To expand the number of training slots and rotation durations for the osteopathic community, Dr. Sealey recommended that VA embed a representative of the osteopathic medicine community within OAA and incentivize VA facilities to collaborate with osteopathic training programs. He highlighted that osteopathic programs like his often place their trainees in underserved areas, with many trainees staying in these areas after they graduate. Since this outcome is consistent with the goals of the Choice Act GME expansion, he believes VA should seek stronger partnerships with osteopathic programs.

Drs. Cox and Sanders addressed AOA's concerns by outlining the background, details, and impact of the 2014 Choice Act provisions to add VA GME positions. Dr. Cox acknowledged that resource sharing among training programs was always competitive, even among allopathic schools, but emphasized that OAA's outreach efforts to the osteopathic community had significantly expanded in recent years. Dr. Chen suggested combining smaller programs under a consortium model to expand training opportunities.

Dr. Joseph Gravel spoke next on behalf of the Council of Academic Family Medicine (CAFAM). He suggested a greater integration of Veteran and non-Veteran populations, such as Veteran families, for resident training in family medicine. An emphasis on training opportunities at Community Based Outpatient Clinics (CBOCs) can further enhance the learning experience. Lawrence, MA, the site of his residency program, has no VA facility, creating a significant travel time for his patient population. However, he sees significant barriers with the current VA training model given the need for access to female and pediatric populations for family medicine residents.

Dr. Gravel advocated that OAA allocate additional family medicine GME positions, rather than its traditional emphasis on internal medicine. He also recommended that VA explore authorities to pay for all training time, as long as Veterans make up a significant portion of the training

population. This will enhance the ability to expand GME opportunities in rural and underserved communities.

The Council's discussion highlighted the constraints of current VA authorities, which generally only allow for the treatment of Veteran populations. A suggested solution was the modification of the VA Office of General Counsel's prohibition on payment for trainee time spent outside of VA facilities; creative exceptions to this ban could incentivize the establishment of family medicine training programs and increase access to care. Mr. Trynosky suggested that National Guard and Reserve TRICARE Reserve Select beneficiaries could provide a means for ensuring a more diverse patient mix for family medicine trainees as VA already has the discretionary authority to treat TRICARE enrollees on a space available basis.

Dr. Carolyn Meltzer of Emory University School of Medicine expressed her concerns over the adverse impact of VA's IT access, credentialing, and security policies on academic affiliates and other external partners. Emory University is affiliated with the Atlanta VAMC and she shared several ongoing frustrations with the affiliations process to include varying administrative regulations, room for improved communication, differences in institutional culture, and the need for better clarity of faculty expectations and roles. For example, Emory lost its video teleconferencing capabilities with VA because their prior vendor was no longer VA-approved. Emory seeks a closer administrative bond with VA, an increased emphasis on research, and new programs for both medical students and physician residents. Dr. Meltzer also said that ongoing uncertainties about sole-source contracting have made seeking joint ventures more difficult.

Dr. Terrence Flotte from the University of Massachusetts (UMASS) Medical School spoke about the possibility of "co-locating" facilities through space sharing arrangements that will optimize primary care and family medicine residency training. The UMASS Medical School is affiliated with the VA Central Western Massachusetts Healthcare System and its Worcester CBOC. Dr. Flotte envisioned a sole-source sharing agreement between UMASS Medical School and its VAMC affiliate in a joint space that can treat both Veterans and their families. This would expand clinical care and family medicine training opportunities in a single setting because of the more diverse patient population. UMASS has pursued the co-location process under a competitive bid process for a building that will replace the existing Worcester CBOC.

Dr. Christopher Colenda, the final presenter, spoke on behalf of the Association of American Medical Colleges (AAMC). He addressed the need for improved relationships and communications between VA and its stakeholders. Dr. Colenda opined on the importance of Policy Memorandum No. 2, the 1946 document that established VA's clinical education mission. A once streamlined document and collaboration between America's medical schools and VA has given way to a heavily bureaucratized system that is increasingly unable to adapt to changing environmental conditions in a timely manner.

Dr. Cox and the Council summarized what they identified as the main points of the guest presenters: the need for better communication at all levels between affiliates and VA and internally within VA itself; an urgent need for joint venture authority with academic affiliates, particularly in terms of space sharing; and an increasing need for regulatory and legislative relief to meet VA's mission. Members discussed preliminary ideas for the Council's recommendations to the Secretary. These focused heavily on ways to re-conceptualize or redefine existing VA authorities and VA's relationships with its affiliates. Dr. Cox noted that most of the issues raised by the panelists had already been identified by VA advisory committees, including the Blue Ribbon Panel and the NAAC, and that numerous potential

solutions had been identified but as yet not adopted by the department. Dr. Maffucci suggested that closer communications between OAA and Veterans Services Officers (VSOs) may better identify similar challenges faced by VA affiliates and Veterans. The Council emphasized that VA must implement an improved mechanism to communicate field and affiliate concerns to VA leadership and reiterated their strong support for recommendations 1 and 2 (above).

### **Office of Research and Development**

Dr. Rachel Ramoni gave an overview of the Office of Research and Development (ORD) and its role as an “intramural funding agency” within VA, while Dr. John Feussner provided background on the National Research Advisory Council (NRAC). Among other things, ORD conducts bench, clinical, rehabilitation and health services research, provides regulatory oversight for VA researchers, and facilitates technology transfers for new innovations. Recently, it spearheaded the Million Veteran Program, a VA-wide genomic research effort. It also funds infrastructure and research centers that conduct clinical trials.

Dr. Ramoni explained that ORD has a direct budget appropriation of \$673 million. VA's research is also funded through facility Veterans Equitable Resource Allocation (VERA) allocations, Federal grants from agencies like the National Institutes of Health (NIH), Department of Defense (DOD), and Centers for Disease Control and Prevention (CDC), as well as non-Federal sources like pharmaceutical corporations.

ORD awards internal grants to researchers who spend at least 5/8ths of their time at VA. Dr. Ramoni elaborated that this “5/8ths rule” applies to the 40-hour VA workweek. Since most qualifying individuals work longer weeks, they can still receive awards despite spending much of their time at academic affiliates. These grants are specifically reserved for clinician scientists with the aim of leveraging unique clinician insights. Awards are given through a peer reviewed process, in which 15-20 percent of proposals are approved.

VA is not allowed to directly receive Federal grants. To operationalize these funding streams, a network of VA affiliated non-profit research corporations were authorized by statute. A policy question now being discussed concerns what percentage of non-VA funds, if any, should run through the nonprofit research organizations. Dr. Ramoni has been working with Rep. Phil Roe (R-TN), Chairman of the House Committee on Veterans' Affairs (HVAC) on these issues. ORD is seeking a contractor to assess each individual grant in each VA-affiliate pair to determine where work is performed and how overhead funds are distributed.

Dr. Ramoni addressed the impact of VA funded research. There is an increasing interest in the practical impact of this research. She opined that the shifting definition of successful research has incentivized publication and possibly diverted promising research away from less prominent topics. The Council discussed the relative importance of publications and citations with Dr. Ramoni and generally agreed that there should be another, more action-oriented metric for research success besides publications. Dr. Ramoni added that the focus of VA research should prioritize benefit to the Veteran before NIH rankings. Dr. Feussner highlighted the global impact of VA research efforts by noting that the Shingles vaccine came out of VA research, which has improved the lives of countless geriatric patients, Veterans and non-Veterans alike.

Dr. Fuessner, NRAC Chairman, offered several questions for the NAAC's consideration: the extent to which VA can establish true partnerships, rather than just clinical, research or educational collaborations; the possible mutual strategic interests of VA and pharmaceutical corporations; and identifying the immediate possibilities for joint ventures over the next few

years. He stressed that the Council should establish actionable items and avoid succumbing to bureaucratic slowdown. He referenced the NRAC and the NAAC as complementary advisory committees and asked how they could best work together.

The Council discussed the feasibility of OAA and ORD regularly integrating VSOs into conversations to better connect the concerns of Veterans with advisory bodies like NRAC and the NAAC. Dr. Cox noted that the NAAC had included a panel of VSO leaders in a recent meeting and how valuable he thought that had been.

### **Public Comments and Adjournment**

There were four sets of public comments for the July 12<sup>th</sup> session (one in-person speaker and three letters submitted for the record). Dr. Perez of the Louisville VAMC articulated his opinion on the benefit provided by the increased utilization of CBOCs for residents and trainees. He mentioned, for example, that the creation of specialty CBOCs can provide trainees with extended learning space. He reiterated his sentiment from earlier in the day that the Choice Act's care in the community program threatens VA workload and volume, potentially impairing educational programs and research activities.

The first letter reviewed came from the Association of VA Psychologist Leaders. It stated that VA psychologists who manage training programs fear adverse consequences from the Choice Act, as they believe it may become more difficult to assemble integrated training teams. The letter suggests that the loss of clinical teams will reduce trainee rotations and clinical training programs.

A letter from Northwestern Memorial Hospital (Illinois), a major affiliate of Jesse Brown VAMC, identified ongoing IT concerns, specifically VA's decision to end trainee access to university e-mail accounts from VA computers. Northwestern contends that this policy makes it challenging for both faculty and trainees to coordinate between VA and their home universities.

The final letter reviewed came from the University of California Los Angeles (UCLA), which maintains VA's largest affiliated training program with over 450 medical residents. UCLA stressed the importance of maintaining and expanding relationships with VA for both the academic and research components of its affiliate relationship.

The NAAC adjourned at 4:15 PM EST.

### **Day 2: July 13<sup>th</sup>, 2017**

Dr. Cox made welcoming comments and called the meeting to order at 9:00 AM EST.

### **2017 VA Diversity and Inclusion Summit Overview and Discussion**

Dr. Monica Lyson opened the discussion, asking the NAAC to provide strategic direction to VA's clinical education diversity initiatives.

The Council welcomed Representative Sanford Bishop, Jr. (2<sup>nd</sup> District, GA). He served as the ranking member of the Military Construction and Veterans Affairs Subcommittee of the House Committee on Appropriations during the 114<sup>th</sup> Congress. The Congressman acknowledged the need for greater diversity in US medical education, especially as the Veteran population becomes increasingly diverse. He shared an anecdote about his brother-in-law's recent care at

the Montgomery, AL VAMC, which was provided by a highly diverse group of medical professionals.

The Council's discussion with the Congressman focused on ways to strengthen VA's engagement with Historically Black Colleges and Universities (HBCUs), more transparently share faculty position announcements, and identify roles for other institutions that can grow minority representation in STEM fields. Rep. Bishop reminded the Council that for historic and structural reasons HBCU institutions started behind other schools and now seek equity. He said that it is difficult when HBCU trainees are not placed in rotations proximate to their schools. This results in trainees having to travel great distances to their training sites.

Dr. Cox noted that diversity and inclusion have been a top priority for VA's Office of Academic Affiliations, but agreed with Rep. Bishop that more action must be taken for these initiatives to advance. Dr. South-Paul commented on the Congressman's opening remarks and elaborated that one issue faced by HBCUs is that traditional affiliates tend to have more institutional knowledge about mechanisms to garner resources and obtain faculty positions. Some HBCUs may lack clarity around how VA operates and the OAA affiliation process. A possible mitigating action could be to make communications more transparent in order to better accommodate HBCU affiliates.

Dr. Kellermann discussed how his institution, the Uniformed Services University of the Health Sciences (USUHS), makes similar attempts to increase diversity and inclusion, particularly with HBCUs. He asked the Congressman for his thoughts on how best to familiarize minority youth with STEM fields as a means of getting them interested in health careers. Rep. Bishop offered that this issue ultimately requires a national mobilization of resources and that the Congressional Black Caucus is working on this issue. He also described his current efforts as Ranking Member for the Agriculture subcommittee of the House Appropriations Committee to focus Federal efforts to increase rural access to advanced placement classes and STEM educators.

After Congressman Bishop's departure, Dr. Lypton gave an overview of VA's inaugural Diversity and Inclusion Summit held at Meharry Medical College in Nashville, TN on June 28-29, 2017. The summit drew 113 participants, equally divided between representatives from HBCUs and VA. In his recorded opening remarks, Dr. David Shulkin acknowledged the ongoing disparities in American healthcare that VA hopes to address. Ms. Vivieca Wright Simpson, the VA Chief of Staff, travelled to Nashville for the summit and directly heard the concerns shared by VA's affiliated HBCUs. Following the summit, OAA leaders and other VHA officials analyzed where HBCU programs currently integrate well with VA, which ones can be improved or expanded, and which local issues require immediate attention.

In response to Dr. Lypton's overview of the summit, Dr. Cox stated that the greatest current hurdle to educational diversity within VA is the lack of sufficient VA faculty positions, which limits the number of minority faculty, mentors, and advisors for minority trainees from HBCUs. He emphasized that more attention from local VA and HBCU leadership needs to be given to faculty issues rather than the present almost exclusive focus on numbers of trainee positions.

Dr. South-Paul, the Chair of the NAAC's Diversity and Inclusion Subcommittee concluded the discussion by summarizing the main opportunity areas for VA educational diversity efforts: mentorship, faculty development, open advertisement and more equitable assignment of vacant faculty positions, and raising awareness of these issues and opportunities among VISN directors and facility chiefs of staff.

The Council transitioned to a discussion of the recent activities of the NAAC Diversity and Inclusion Subcommittee. Since its establishment in February 2017, the Subcommittee held three meetings via teleconference. In addition to issues surrounding HBCUs, the subcommittee also plans to look at VA inclusion efforts with Puerto Rican affiliates and the Hispanic community overall. Dr. Edgar Colon shared his opinion that the mandate from the AAMC and Liaison Committee on Medical Education (LCME) that directed every medical school to identify a diversity officer has been beneficial.

Dr. Chen agreed with Dr. South-Paul and Dr. Colon's comments and stressed that the increased use of CBOCs as training platforms can create an extended network of community mentors and role models for trainees. The Council affirmed that VA needs a long term strategy toward creating a pipeline for a more inclusive workforce. Dr. Harper asked about the possibility of partnering with the Special Medical Advisory Group (SMAG), an advisory committee that reports to and advises the Undersecretary for Health. Dr. Cox asked Council members to provide Dr. South-Paul and her subcommittee with specific, measureable, and time sensitive recommendations.

Dr. Harper inquired about the metrics VA currently uses to collect and analyze trainee diversity information. Dr. Sanders responded that there is currently no national trainee database, and demographic information can only be received on a voluntary basis. OAA has requested VA to establish a trainee database for over a dozen years. Dr. Kellermann noted that as a Federal institution, USUHS has a similar problem and the non-response rate to voluntary demographic questions is around 70% for both staff and trainees. One suggestion offered was to track the number of faculty positions awarded to HBCU affiliates rather than the demographics of the individual faculty members. Dr. Chen shared her experience that HRSA faces challenges tracking people over long periods of time. She suggested that a partnership with AAMC could potentially solve the trainee tracking issue.

**Recommendation 3: Clinical workforce diversity, cultural sensitivity and inclusiveness are vital components of Veteran-centric care. Accordingly, the NAAC recommends that VA identify strategies that will enhance its collaboration with health professional training programs at Historically Black and Hispanic Serving colleges and universities and Hispanic Serving institutions. Such strategies should go beyond mere consultation; they must also include measurable actions that provide these affiliates with opportunities to expand faculty supervisory positions and training positions at VA medical centers and clinics.**

### **Veterans Access, Choice, and Accountability Act and Graduate Medical Education Expansion Update and Discussion**

Mr. Trynosky introduced Rep. Mark A. Takano (41<sup>st</sup> District, CA) as the Council's guest for this session. Representative Takano briefly spoke on the current shortage of physicians in his home district and elsewhere in southern California. He sees the expansion of GME opportunities in underserved areas as an important way to grow the physician workforce pipeline. Shortly after his election to Congress in 2012, the Congressman recounted a conversation with the Dean of the University of California - Riverside Medical School who informed him that Riverside County had an insufficient number of GME slots. During his first term, Rep. Takano learned about the significant role that the Federal government plays in regulating the nation's supply of doctors. The expansion of this workforce pipeline is highly dependent on the availability of Federal funds – particularly in rural and underserved areas. The Choice Act that coalesced following the

access scandal at the Phoenix VAMC presented a unique opportunity to include GME expansion provisions in the legislation. Rep. Takano worked with a Senate Counterpart, Senator Sanders (VT), to give VA the authority to add 1,500 GME position to its training portfolio.

As a three term member of the House Veterans' Affairs Committee, Rep. Takano asked the Council to identify the barriers that VA faces in filling its 1,500 new GME positions authorized under PL 113-146. Since 2014, the Congressman has personally seen significant barriers in assigning these positions. He has also witnessed the underlying challenge of placing trainees in CBOCs given the limited resources available to develop those sites as robust teaching environments.

Dr. Klink then gave an overview of the current state of the VACAA GME expansion and OAA's goal of filling all 1,500 new GME positions by 2024. She stated that OAA presently supports roughly 11,000 GME positions through which over 40,000 physician residents rotate annually. The GME expansion provisions in PL 113-146 outline priority specialties for the new positions: primary care, mental health, and certain specialties needed to ensure access. VA's priority locations include those with a high Veteran population concentration and low or no existing GME presence. Rural areas generally exemplify these characteristics. Positions have been filled slowly and methodically since expansions are being done selectively in order to meet legislative intent. In addition, Dr. Klink noted that besides affiliations with large academic medical centers, VA is now also moving to GME partnerships with smaller community hospitals or psychiatry programs with specialty areas of practice. She also mentioned how in addition to funds for GME resident reimbursement, OAA also provides planning and infrastructure grants to aid and nurture the development of new training programs.

Dr. Klink explained that when OAA's staff initially examined areas with the greatest GME need 36 VA facilities were identified as having little GME activity and 22 facilities were identified as having no GME activity. Right now, only four VA facilities have not entered the GME planning process. New GME sites include Las Cruces, NM; St. Cloud, MN; and Spokane, WA. OAA will approach 800 newly filled GME positions once the current allocation cycle is evaluated and approved. Congressman Takano appreciated this update and asked for a map outlining VA facilities, GME allocations and their locations by Congressional district.

A significant remaining challenge is to get adequate funding to support trainees in remote areas, including travel and housing costs. One idea offered during the Council's discussion was the potential for increased cross-agency cooperation with DOD and the treatment of TRICARE beneficiaries or, as Dr. Chen suggested, partnering with FQHCs. Such modifications may require new statutory authority. Dr. Kellermann asked about VA's use of the Health Professions Scholarship Program (HPSP) which is used by the military to attract the large majority of its physicians. Dr. Sanders responded that HPSP is hard to use in VA because, unlike in DOD, VA's authority lapses every two years. This makes long term planning or even the awarding of 3 or 4 year scholarships impossible. Drs. Prescott and South-Paul, both former Army physicians and HPSP scholarship recipients, contended that a modified HPSP program could benefit VA's physician recruiting and retention efforts.

**Recommendation 4: To strengthen its physician pipeline, the NAAC recommends that VA: (1) secure indefinite Health Professions Scholarship Program (HPSP) authority; expand the number and funding level of medical student scholarships; and (3) enable the proposed partnership with the Uniformed Services University Health Sciences (USUHS) for collaboration in medical student education.**

Dr. South-Paul asked if it would be possible for VA funds to be spent in conjunction with, or loaned to, other federal organizations to facilitate joint venture opportunities. Dr. Sanders responded that OAA does not currently have that flexibility for its trainee funds. Mr. Trynosky mentioned one area of flexibility within VHA: its authority to treat TRICARE beneficiaries when capacity exists. Dr. Chen also referenced HRSA programs with community health centers that are aimed at reaching rural areas that also happen to have high Veteran populations. Congressman Takano then wondered whether he should seek statutory changes that allow for interagency joint ventures as negotiations advance on the drafting of a “Choice Act 2.0.” The Council agreed that such expanded authority would be useful.

Dr. Cox then invited comments from guests and public attendees. Dr. Anthony Albanese addressed Mr. Takano’s earlier reference to interagency partnerships by reflecting on current VA/DOD collaboration in Hawaii. This limited agreement shows the potential for a more robust joint venture, but this will likely require broader statutory authority for a true joint venture to thrive.

Dr. David LaBorde, a member of the public representing Brain Trust Advisors, spoke next. He noted that although suicide prevention is a top priority for VA, most Veterans that commit suicide are not enrolled in VA health care.

Dr. Uchenna Uchendu, VA’s Chief Officer for Health Equity, asked if there was an opportunity to use diversity as a criterion for the allocation of new GME positions in a similar manner to how OAA has prioritized the allocation of GME positions to rural and underserved areas.

Congressman Takano’s final point regarded the important role that VA can play in national emergency response scenarios, particularly mass shootings. He cited how VA was previously able to offer limited assistance to non-Veterans in the wake of Orlando’s Pulse Night Club shooting and wondered what authority could allow VA personnel to work with local hospitals for extended periods to aid victims of mass violence given VA’s unique expertise in this area. Dr. Sanders noted that such assistance could potentially be permissible under VA’s fourth statutory mission of Emergency Preparedness. Mr. Trynosky noted that through Public Law 111-347, Congress gave VA the discretionary authority to enroll and treat survivors of the 9/11 attack on the World Trade Center regardless of their Veteran status. Although this dormant authority has not been exercised by VA, it could provide a model for other scenarios.

Dr. Cox thanked Rep. Takano for his commitment to VA’s educational mission and for being so generous with his time.

Dr. Cox went on to highlight the Choice Act’s narrow emphasis on GME, which unfortunately marginalizes other professions and specialties. He suggested that VA work with HRSA, DOD, and state and county public health agencies to expand health professional training opportunities more broadly. The Council discussed the barriers to VA getting legislative support to advance such initiatives in the current political and fiscal environment. Members suggested that sharing past VA joint venture success stories would be one way to gain visibility among stakeholders. Two important points, repeatedly emphasized by Council members, is that for VA to fully achieve its educational potential and the mandate provided by Congress “to educate for VA and the nation” the department must provide a streamlined reporting chain for its educational office (see Recommendation 1, above) and, above all, it must focus on enhancing Veteran health as the primary goal of all that it does.

**Recommendation 5: To build on the success of VACAA and other recent educational initiatives in nursing and mental health training, the NAAC recommends further expansion of VA's health professional training programs through interagency collaboration by partnering with the Health Resource and Services Administration, the Department of Defense, and the Indian Health Service. Partnerships would be most effective if they included a broad spectrum of professions and emphasized inter-professional training and practice opportunities.**

### **Future Directions & Discussion**

Dr. Cox highlighted some of the main themes of the Council's two day meeting, especially the issues of authority and funding for VA's educational mission. On a general level, the NAAC agreed that OAA must work even more collaboratively with other VA offices to maintain the momentum of its priority initiatives. One recurring line of thought is the need to make OAA more visible both within VA and to external stakeholders. The Council requested a detailed briefing on OAA's current and potential future capabilities: staffing, staff locations, budget, and organization to be scheduled at a future meeting.

Dr. South-Paul stated that OAA should prioritize interagency outreach to expand access to resources across the Federal sector. She added that the Diversity and Inclusion Subcommittee has identified the importance of VA gathering more robust data on its trainees. These data are essential to track trainee demographics and their post-training employment trajectories. Dr. Kellermann echoed the importance of interagency education collaboration, particularly in the arena of research. A joint meeting between the NAAC and NRAC was one suggestion to catalyze these conversations.

Dr. Cox recommended that ORD, like OAA, should report directly to the Under Secretary for Health (see Recommendation 1, above). Together, these offices oversee two of VHA's four statutory missions; both need greater visibility within the department to fully fulfill their missions. Moreover, he suggested that ORD and OAA leaders have greater high-level representation on VHA strategic governance bodies, such as the National Leadership Council and be included in regular VHA leadership meetings. He posited that elevating OAA and ORD within the VA organization will also give Congress a more direct feedback loop on priority VA research and education efforts.

Dr. Cox then revisited what he perceived as two foundational issues: funding and authority for VA clinical education programs. Dr. Cox noted that it is essential that the Council have a firm understanding of VA clinical education programs because OAA must plan for continuation and/or expiration of GME expansion authorities as well as the funding of a multitude of diverse educational programs. A review of OAA structure, function and funding is planned for a later meeting, with the goal of developing mission-based (as opposed to largely profession-based) goals for OAA's educational initiatives.

Dr. South-Paul continued this discussion by emphasizing the importance of VA establishing an improved outcomes assessment system of VA's education system focused on presenting results by their impact on population health rather than by the individual medical discipline/specialty that initiated the effort. She observed that the NAAC has historically analyzed VA training efforts in isolation from their overall population health outcomes. Dr. Sanders mentioned that these kinds of evaluations of health professions education programs are difficult to conduct. The Council ultimately agreed on the need to find appropriate metrics

that reflect the importance of VA's clinical education mission and better quantify its contributions to Veteran health.

Dr. Cox announced that Drs. Paul Cunningham and Michael Mayo-Smith (ex officio VISN Director) will rotate off the NAAC on September 30, 2017, and thanked them for their service [Subsequent to this meeting, Dr. Cunningham elected to extend his tenure on the Council through the expiration of his full membership term on September 30, 2018. In addition, Leslie Wiggins has been appointed as the ex officio VISN Director].

Dr. Cox reminded the Council of its next meeting in Fall 2017 (via teleconference) and the next face-to-face meeting in in December 2017.

### **Public Comments**

Four members of the public made statements to the Council.

Dr. Frank Royal of Meharry Medical College urged that HBCUs receive improved access to VA faculty opportunities and training opportunities in VA settings, especially in primary care and women's health. Meharry has long sent its medical residents to the Murfreesboro campus of the VA Tennessee Valley Healthcare System (TVHCS), a considerable distance from Nashville. His institution seeks greater access to training opportunities closer to campus at the Nashville campus of TVHCS. Meharry also wishes to expand its existing on-campus clinical partnership with VA. Meharry has available clinical space that it would like to use to treat the Veteran community. In closing, he underscored the diversity of Meharry students and the value that they can bring to VA. .

Dr. LaBorde from Brain Trust Advisors suggested that VA is slow to adopt communication innovations relative to other health care providers. He described his firm's efforts to work with clinical faculty to develop a standardized communication system for care transitions. Brain Trust's research suggests that its communication innovations can reduce medical errors and adverse events during care transitions. Dr. Cox suggested that Dr. LaBorde and his colleagues speak to the chief of staff or DEO at individual VA facilities if there are specific programs or affiliates with which he would like to work. This would be a more direct route than soliciting officials at VA Central Office.

Dr. Riba Kelsey-Harris from Morehouse School of Medicine (MSM) presented the NAAC with several specific faculty requests to ensure that HBCU institutions receive equitable access to VA clinical resources, faculty opportunities, and trainee rotational opportunities. Dr. Cox responded by stating that the NAAC is a strategic advisory committee and does not have operational oversight; he advised that MSM should discuss these issues with local VA facility leadership.

The final public speaker was Dr. Suzanne Miyamoto representing the American Association of Colleges of Nursing (AACN). She expressed her organization's support for inter-professional clinical teams and its concerns about filling chronically vacant VA nursing positions and addressing important nursing programs that may expire. She noted that AACN is trying to cultivate interest in these vacant positions and wants to ensure that VA's current training programs continue. The AACN sees these programs as inter-professional and innovative. Dr. Cox told Dr. Miyamoto that the Council takes her organization's message to heart and suggested that it could also be presented to the SMAG.

## **Closing Comments and Adjournment**

Dr. Malcolm Cox adjourned the meeting at 1:42 PM EST.

## **Appendix A: Attendance Records**

**Council members present:** Malcolm Cox, MD, (Chair), Retired Federal Executive, Department of Veterans Affairs; Doreen Harper, PhD, RN, Dean, School of Nursing, University of Alabama at Birmingham; Eileen Breslin PhD, RN, FAAN, President, American Association of Colleges of Nursing (AACN); Lucinda Maine, PhD, RPh, Executive Vice President and Chief Executive Officer, American Association of Colleges of Pharmacy (AACP); Edgar Colon Negron, MD, FACR, Dean, School of Medicine, University of Puerto Rico; Candice Chen, MD, MPH (Ex-Officio), Director, Division of Medicine and Dentistry, Bureau of Health Workforce, Health Resources and Services Administration (HRSA), U.S. Department of Health and Human Services; Thomas A. Cavalieri, DO, FACOI, FACP, AGSF, Dean, Rowan University School of Osteopathic Medicine; John Prescott, MD, Chief Academic Officer, Association of American Medical Colleges; Paul Cunningham, MD, Dean Emeritus, East Carolina University School of Medicine; Jeanette E. South-Paul, MD, Chair, Department of Family Medicine, University of Pittsburgh; Richard W. Valachovic, DMD, MPH, President and Chief Executive Officer, American Dental Education Association; Arthur Kellermann, MD, MPH (Ex-Officio), Dean, F. Edward Hebert School of Medicine, Uniformed Services University of the Health Sciences (USUHS), U.S. Department of Defense; and Jacqueline Maffucci, PhD, Research Director, Iraq and Afghanistan Veterans of America.

**Council members unable to attend:** Robert L. Jesse, MD, PhD (Ex-Officio), Chief Academic Affiliations Officer, Department of Veterans Affairs; Michael F. Mayo-Smith, MD, MPH (Ex-Officio), Network Director, New England Healthcare System (VISN 1), Department of Veterans Affairs; John Duval, MBA, Senior Scholar, Accreditation Council for Graduate Medical Education.

**VHA Office of Academic Affiliations staff attending:** Karen M. Sanders, MD, Deputy Chief Academic Affiliations Officer; Kenneth Jones PhD, Director, Associated Health Education; Tiana Brown, MHA, Management Analyst; Kathleen Klink, MD, FFAFP, Director, Health Professions Education; Christy Clary, MSW, (Alternate Designated Federal Officer for the NAAC) Medical & Dental Education; Stephen K. Trynosky, JD, MPH, MMAS, Staff Assistant (Designated Federal Officer for the NAAC); Edward Bope, MD, FFAFP, GME Expansion Team Lead; Monica Lypson, MD, MHPE, Director Medical & Dental Education; Anthony Albanese, MD, FACP, DFASAM, Graduate Medical Education Affiliations Officer; Ramona Joyce, Acting Executive Assistant (on detail); Sheila Jackson, Management Analyst; Mona Royal, MS, Management Analyst; John Sharpe, MSPT, MBA, FACHE, VA-DoD Liaison; John Stephen, MPH, DoD Intern; Tara Hotaling, MPP, Management Analyst; Amanda Van Gilder, MA, Management Analyst.

**VA and VHA staff attending:** Scott R. Blackburn, Interim Deputy Secretary, Department of Veterans Affairs; Carolyn Clancy, MD, Assistant Deputy Under Secretary for Quality, Safety and Value; Melissa Cooper, Management Analyst, VHA Office of Research and Development; Susan Kelly, Congressional Relations Officer, Office of Congressional and Legislative Affairs; Edward Ledford, MA, Executive Speechwriter, Office of the Secretary; Jeffrey Moragne, MS, Director, VA Advisory Committee Management Office; Carol Borden, JD, Ethics Attorney, Office of General Council, VA; Rafael Perez, MD, Chief of Medicine, Louisville VA Medical Center, Rachel Ramoni, DMD, Sc.D, Chief, Office of Research and Development VHA; Uchenna

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Uchendu, MD, Chief, VHA Office of Health Equity; Alex Ware, Congressional Relations Officer, Office of Congressional and Legislative Affairs; Leslie Wiggins, VISN 7 Director.

**Guest Presenters:** Ann B. Nattinger, MD, MPH, MACHP, Senior Associate Dean for Research, Medical College of Wisconsin; Stephen C. Shannon, DO, MPH, President of the American Association of Colleges of Osteopathic Medicine; John Sealey, DO, Director of Medical Education, Authority Health (on behalf of the American Osteopathic Association); Joseph W. Gravel, MD, Chair of Family Medicine & Community Health/Program Director Emeritus of the Lawrence Family Medicine Residency, Senior Vice President and Chief Medical Officer of the Greater Lawrence Family Health Center (on behalf of the Council of Academic Family Medicine); Carolyn C. Meltzer, MD, FACR, Chair, Department of Radiology and Imaging Sciences and Associate Dean for Research, Emory University School of Medicine; Terence R. Flotte, MD, Dean, School of Medicine and Provost and Executive Deputy Chancellor, University of Massachusetts Medical School; Christopher C. Colenda, MD, MPH, AAMC Senior Advisor on Veterans Affairs, Dean Emeritus of Texas A&M College of Medicine,; Representative Sanford Bishop, Jr., US Representative (2<sup>nd</sup> District, GA), Ranking Member, Subcommittee on Agriculture, Rural Development, FDA & Related Agencies, , House Committee on Appropriations; Representative Mark A. Takano, US Representative (41<sup>st</sup> District, CA), Member, House Committee on Veterans Affairs.

**Members of the public attending:** Matt Shick, JD, AAMC; Lodriguez Murray, AMDPS; Charles Fox, MD, Louisiana State University-HSC; Barbara Ward, Center for Minority Veterans; Amanda Eaton, Senior Legislative Assistant, Office of Rep. Mark. A. Takano; Amy Centanni, Investigative Counsel, House Committee on Veterans' Affairs HVAC; Julie Crockett, AACOM; David Lewis, MD, Louisiana State University-HSC; Colleen Leners, AACN; Suzanne Miyamoto, AACN; Kennita Carter, HRSA-DMD/BHW; John Feussner, MD, MPH, Medical University of South Carolina; Riba Kelsey-Harris, MD, Morehouse School of Medicine; Frank Royal Jr., MD, Meharry Medical College.; David LaBorde, MD, Brain Trust Advisors; Patrick Newbold, Defense Fellow, Office of Rep. Sanford Bishop.

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