



***Veterans Choice Act:
Update on the VA GME Expansion***

Kathleen Klink, MD, FAAFP
Medical and Dental Education
&
Edward Bope, MD, FAAFP
GME Affiliations Officer

**Office of Academic Affiliations
Veterans Health Administration**

Graduate Medical Education – Current Scope

- Over 40,000 physician residents rotate through 10,200 FTEE salary lines (3 to 4 residents per FTEE)
 - 1/3 of all US allopathic residents
- Over \$650 million dollars in funding
- Most complexity 1a, 1b and 1c facilities have GME programs; few complexity 2 facilities
- GME has always been seen as a “big facility” endeavor but things are changing rapidly

Veterans Access, Choice, & Accountability Act (VACAA)

- **PL 113-146:** Enacted by Congress & signed by the President on August 7, 2014 – Section 301(b)
 - Provision to expand VA GME by “up to 1,500 positions” over 5 years beginning 1 year after signing
 - Funding priorities defined (next slide)
 - Annual Congressional reporting requirements regarding the filled VACAA positions and their VA locations

Funding Priorities in VACAA

Facility Characteristics

- A shortage of physicians
- No prior GME
- Areas with a “high concentration of Veterans”
- Health Professional Shortage Areas (HPSAs) as defined by HRSA

Program Characteristics

- Primary Care
- Mental Health
- Other specialties “the Secretary deems appropriate” (interpreted as those specialties having excessive wait times for care)

Legislative Priorities Require Different GME Emphasis

- VACAA GME authority can be used as leverage to assist with US physician maldistribution and subspecialty predominance
- Working with community partners, VA GME expansion can greatly impact smaller communities and smaller VAMCs by
 - Increasing the local workforce pipeline
 - Over 60% of GME participants stay within 100 miles of their training location post-residency

Legislative Priorities Require Different GME Outreach

- VACAA GME Priorities require
 - Outreach to Osteopathic Medical Schools and OPTIs
 - Outreach to Family Medicine Community Based Programs
 - Outreach to partnerships with Federally Qualified Health Centers and Teaching Health Centers
 - Outreach to Rural Track Training Programs
 - Partnerships with Complexity Level 2 and 3 VAMCs
 - Partnerships for training in Community Based Outpatient Clinics and Health Care Centers with all size VAMCS

YEAR 1: VA GME Expansion Requests Approved for AY 2015-16

Focus	Approved Positions	% of Total
Primary Care	102.4	50%
Mental Health	57.8	28%
Critical Needs	44	22%
Total	204.2	100%

YEAR 2: VA GME Expansion Requests Approved for AY 2016-17

Focus	Approved Positions	% of Total
Primary Care	62.2	37%
Mental Health	38.2	23%
Critical Needs	67.6	40%
Total	168.0	100%

Expanding Graduate Medical Education

- VA cannot expand GME by itself - we do not create our own residency programs
- Community partners will be vital to assist with identifying expansion opportunities that meet the legislative priorities
- Smaller VAMCs may need assistance to “get into the GME game”
- OAA has budgeted for extensive financial assistance to start up fledgling GME programs

Types of Assistance

- ✓ Planning Grants
- ✓ VACAA Direct Resident Stipend and Benefit Payments
- ✓ Infrastructure Grants – to offset costs of protected time for faculty, recruitment of an experienced DEO, education office staffing, minor space modifications, faculty development
- ✓ Extensive OAA consultation
- ✓ Site Visits
- ✓ Partner Matching Services

GME – PROs and CONs

PROs

- Brings a new workforce pipeline into your facility and community – improves recruitment
- Faculty responsibilities foster recruitment of higher quality medical staff members who want to participate in education or research programs
- Allows expansion of scope of health care programs for Veterans and access for Veterans
- Academic culture enhances evidence-based practice, improving quality of care

CONs

- Current staff members may need faculty development to learn supervision and teaching skills
- New staff may need to be recruited to do GME well
- Residents may slow productivity at early stages, but improve staff productivity as they learn
- Need protected time for supervising and teaching faculty
- Need a Site Director, DEO, and staff assistance to run GME – costs \$\$

Successful Round One Case Studies

- ✓ DURHAM VAMC & DUKE Dept Fam Med, ACGME Accredited
- ✓ One FTE/year over 3 years for total expansion of 3 FTEs
- ✓ Residents participate in Academic PACT continuity clinic at the VAMC
- ✓ Documentation of PC need:
 - ✓ Increased need: encounters, unique patients, total bed days/year
 - ✓ Wait time for new PC patients > 30 d
 - ✓ High percentage of patients cared for at VAMC site (not in geographic HPSA), who live in HPSAs

Successful Round One Case Studies

- ✓ Memphis VAMC and Univ of TN College of Medicine
- ✓ ACGME Accredited
- ✓ Two positions in Round One
- ✓ VA COS wants FM due to difficulty recruiting FM to PC and VAMC's 9 CBOCs (all are in HPSAs)
- ✓ Psych and Derm rotations to alleviate long wait lists
- ✓ Supervision by VA providers

Successful Round One Case Studies

- ✓ Detroit VAMC and Detroit Wayne County Health Authority
- ✓ AOA Accredited
- ✓ Geriatrics rotation at Community Living Center (CLC) with exposure to hospice and palliative outpatient and consultative care
- ✓ Supervision by VA geriatricians
- ✓ County is MUA with anticipated PC shortage

Successful Round Two Case Studies

- ✓ Bedford VAMC/ Boston Medical Center – Family Medicine
- ✓ 2 positions first year, then ramp up by 2 additional/year x 3 years
- ✓ Access not as much of a problem in this VISN as recruitment/retention
- ✓ Primary care residents exposed to intellectual challenges with VA patient populations

Successful Round Two Case Studies

- ✓ Columbia VAMC and Greenville Health System, U of SC
- ✓ New Affiliate is a new med school located near the CBOC—both HPSA & rural setting
- ✓ Currently FM program has no experience with Veterans or with PACT model
- ✓ Residents will learn benefits of integrated care model, unique female veterans issues and benefit from a mini-clinic in musculo-skeletal care

Successful Round Two Case Studies

- ✓ Loma Linda VAMC & Inland Empire Consortium for Healthcare Education
- ✓ Located in a primary care HPSA, rapidly growing population, 50% p.c. shortage
- ✓ VA primary care wait times >30 days due to 5% increase in demand/year and no staff increase over 4 years
- ✓ High poverty, ethnic & minority diversity, low high school education level

Primary Care and Mental Health Residency Infrastructure Grant Support **Available for VACAA Position Recipients**—January 2016

Medical Support and Compliance: Funds support overhead costs associated with maintaining GME programs, as exemplified in the OAA Handbook 1400.10.

Medical Services: Funds support salaries of VA staff who instruct or supervise residents and trainees. They may also be used to supplement staff salaries within an education office.

Facility funds: Support costs of minor construction projects, or augment major construction projects that allow necessary space expansion to accommodate increased VACAA GME positions training capacity.

Funding for 2016 and Projected Future Fiscal Years

- **Medical Support and Compliance**
 - 3 years: \$1,277,688
 - 2016: \$567,742
- **Medical Services**
 - 3 years: \$7,117,811
 - 2016: \$1,396,955
- **Facility Funds**
 - 3 years: \$1,222,389
 - 2016: \$520,651
- **Total 2016 :** \$2,485,336
- **Projected 3 year total:** \$9,496,161

Eligible VA Sites for Planning Grants

Released February 19, 2016

Find the VA Closest to Your Residency Training Program

Alexandria VAMC	Erie VAMC	Poplar Bluff, MO VAMC
Altoona, PA VAMC	Fort Wayne VAMC	Prescott VAMC
Anchorage VAMC	Ft. Harrison, MT	Roseburg VAMC
Asheville VAMC	Harlingen VAMC	Sheridan, WY VAMC
Bath, NY VAMC	Iron Mountain, MI	Spokane VAMC
Bedford VAMC	Lyons VAMC	St. Cloud, MN VAMC
Black Hills HCS, SD	Manchester, NH VAMC	Tomah, WI VAMC
Butler, PA VAMC	Marion VAMC (IL)	Topeka VAMC
Cheyenne VAMC	Martinsburg VAMC	Tuscaloosa VAMC
Clarksburg VAMC	Montgomery VAMC	Walla Walla VAMC
Coatesville, PA VAMC	Muskogee VAMC	White City, OR VAMC
Danville VAMC	Newington VAMC	
Des Moines VAMC	Northampton VAMC	

Into the Weeds for RTT!

- **Two Models for Expanding RTT**
- Scenario #1:
- One new VA-VACAA FTE each year for two years = TWO FTEs
 - 2 FTE = 24 VA months = 6 resident each doing 4 months at the VA annually
- Scenario #2
- One-half new VA-VACAA FTE each year for two years = One FTE
- One FTE = 12 VA months: six residents each do 2 months of VA EACH year

Models for Types of Rotations

- **Longitudinal**
 - Continuity clinical experience at the VA
 - Nursing home assigned patients and follow ups
 - Any specialty rotations with longitudinal format, e.g. psychiatry, rehab, home based care

- **Rotations**
 - Dermatology
 - Surgery (in-pt and out-pt)
 - Urology
 - Radiology
 - Urgent or Emergency Care
 - ICU: Med, cardiac
 - Neurology
 - Psychiatry
 - Oncology
 - Community Medicine

Concept of Shared Faculty Between VA and Family Medicine Training Programs

- Focus clinical experiences on family medicine led clinical care
- Family medicine faculty have appointments at VA **and** at Family Medicine sponsoring program affiliate, such as the teaching hospital, medical school
- Topical areas where family medicine can provide clinical teaching and VA needs clinical skills family medicine can provide that will improve access for vets:
 - Women's health
 - Biopsies generated through derm telehealth consultation services
 - Geriatrics
 - Palliative care
 - Other, additional as identified through discussion with local VA facility leadership

Questions? / Contact Info

Contact: GMEHelp@va.gov

Kathleen Klink, MD, FAAFP

Director of Medical & Dental Education, Office of Academic Affiliations

Kathleen.Klink@VA.GOV

Edward Bope, MD, FAAFP

GME Affiliations Officer, Office of Academic Affiliations

Edward.Bope@VA.GOV

For reference only:
**Veterans Access, Choice & Accountability Act of 2014,
Sec. 301 [PL 113-146]**

TITLE III—HEALTH CARE STAFFING, RECRUITMENT, AND TRAINING MATTERS

SEC. 301. TREATMENT OF STAFFING SHORTAGE AND BIENNIAL REPORT ON STAFFING OF MEDICAL FACILITIES OF THE DEPARTMENT OF VETERANS AFFAIRS.

(b) INCREASE OF GRADUATE MEDICAL EDUCATION RESIDENCY POSITIONS.—

(1) IN GENERAL.—Section 7302 of title 38, United States Code, is amended by adding at the end the following new subsection:

“(e)(1) In carrying out this section, the Secretary shall establish medical residency programs, or ensure that already established medical residency programs have a sufficient number of residency positions, at any medical facility of the Department that the Secretary determines—

“(A) is experiencing a shortage of physicians; and

“(B) is located in a community that is designated as a health professional shortage area (as defined in section 332 of the Public Health Service Act (42 U.S.C. 254e)).

“(2) In carrying out paragraph (1), the Secretary shall—

“(A) allocate the residency positions under such paragraph among occupations included in the most current determination published in the Federal Register pursuant to section 7412(a) of this title; and

“(B) give priority to residency positions and programs in primary care, mental health, and any other specialty the Secretary determines appropriate.”.

(2) FIVE-YEAR INCREASE.—

(A) IN GENERAL.—In carrying out section 7302(e) of title 38, United States Code, as added by paragraph (1), during the 5-year period beginning on the day that is 1 year after the date of the enactment of this Act, the Secretary of Veterans Affairs shall increase the number of graduate medical education residency positions at medical facilities of the Department by up to 1,500 positions.

(B) PRIORITY.—In increasing the number of graduate medical education residency positions at medical facilities of the Department under subparagraph (A), the Secretary shall give priority to medical facilities that—

(i) as of the date of the enactment of this Act, do not have a medical residency program; and

(ii) are located in a community that has a high concentration of veterans.