Advisory Committee on Veterans Health Administration (VHA) Resident Education
Report to the Secretary of Veterans Affairs

PREAMBLE

The Department of Veterans Affairs (VA) has had a long and productive partnership with America's schools of medicine. Initiated in 1946 by General Omar Bradley and authorized by Policy Memorandum Number 2, VA's academic affiliations have proven to be of great value to VA by contributing to the high quality of health care for our nation's veterans. Through academic affiliations, VA participates in the training of young physicians while providing care to veterans with well-trained academic faculty shared with medical schools. The healthcare environment created through continuous teaching and learning provides immeasurable benefit to veteran health care. Although VA's relationships with its academic partners have changed over time, the education of healthcare professionals continues to be a vital statutory mission that enhances VA's other missions of providing comprehensive health care for veterans, conducting research, and engaging in contingency support of the Departments of Defense (DoD) and Homeland Security.

In 1945, VA awaited the expected arrival of 100,000 injured troops from World War II. At the time, there were 98 VA hospitals, many in scenic but remote locations. For a total of 84,000 hospital beds, fewer than 1,000 physicians were available to provide care. As Paul B. Magnuson (VA's second chief medical director) has written, "the outside of the hospital was beautiful with well-maintained shrubs and flower beds, but what went on inside was beyond description." In 1946, Policy Memorandum Number 2 authorized the creation of relationships between VA and the nation's medical schools. These relationships, supporting the shared missions of education, research, and high quality patient care, were highly successful and mutually beneficial. Over the next 35 years, many new VA hospitals were deliberately located in proximity to medical schools and academic health centers in order to enhance the mutual benefit of these relationships.

VA has become an important and irreplaceable component of the nation's undergraduate and graduate medical education enterprise. VA is affiliated with 107 of the country's 126 allopathic medical schools and participates in post-graduate medical education (GME) through integrated residency programs administered through medical schools and academic health centers. VA funds almost 9% of all U.S. post-graduate resident physician positions, and about 30% (31,000) of all U.S. residents receive training in VA healthcare facilities each year. Nearly 17,000 medical students are also trained yearly in VA facilities.

VA's involvement in medical education has grown in scope and complexity over the last 60 years. However, balancing the education mission and the increasing demand for clinical services has proved challenging for both VA and its academic partners. Eligibility reform, corporate reorganizations, and resource constraints in VA have applied additional stress to this delicate balance. Yet VA provides a unique training environment for the nation's physicians that cannot be duplicated elsewhere. Military injuries and illnesses, computerized medical records, patient safety, evidence-based medicine and quality improvement are but a few of VA's areas of

expertise. VA's innovative Special Fellowship programs have resulted in the national recognition of a number of emerging specialties – e.g., geriatrics, spinal cord injury, and addiction psychiatry – in areas of particular relevance to the veteran population.

Moving into the 21st Century, VA and its academic partners have been challenged to maintain high quality educational environments with stable or restricted budgets, changing systems of healthcare delivery, increasing patient loads, an expanding body of knowledge to impart to residents, and accreditation rules that limit the number of hours residents may be on duty. A national shortage of physicians is also predicted for the near future.

In light of the changing healthcare and educational environments, the Advisory Committee on Veterans Health Administration (VHA) Resident Education was established by the Secretary of Veterans Affairs to provide advice and consultation on VA's resident physician education program. [See **Attachment 1** for membership.]

OVERVIEW & PROCESS

The last major review of VA's graduate medical education programs was performed by the Residency Realignment Review Committee (*a.k.a.* 'Petersdorf' Commission) in 1995-96. Working at a time when forecasts suggested that there would be diminishing demand for VA health care services and a radical restructuring of American health care, the committee recommended a reduction in the total number of VA resident physicians and a shift of certain specialist positions to generalist or primary care positions. As a result of these recommendations, VA increased its proportion of generalist resident positions from 38% to 48%. However, by the year 2000, the assumptions that guided these recommendations proved to be invalid and VA was forced to re-evaluate its resident specialty mix. An important lesson was learned regarding the inflexibility of a top-down allocation process (which ultimately conflicted with accreditation requirements, a changing healthcare delivery environment, and the healthcare needs of veterans), even in the face of good faith efforts.

Early in fiscal year 2004, the Secretary of Veterans Affairs initiated the current review of the philosophy and deployment of VA's residency training positions (including the total number of positions, the specialty mix of resident physician training positions, and the geographic distribution of positions). In anticipation of and to assist the deliberations of the federally-chartered advisory committee, an internal Veterans Health Administration (VHA) Graduate Medical Education (GME) Advisory Committee was convened and met in March, July, and August 2004. The GME Advisory Committee was composed of VA education, facility, and VISN leaders. The review process was conceived as a two-step sequential review. First, the internal GME Advisory Committee provided a VA perspective, a more detailed programmatic review, and preliminary recommendations. Then, the external, federally chartered committee, representing the broader domains of resident education, was to provide the final recommendations to the Secretary of Veterans Affairs. The results, conclusions, and recommendations of the GME Advisory Committee are contained in the document, *Report of the VHA Graduate Medical Education Advisory Committee* (November 2004). The approach and proceedings of the GME Advisory Committee may be summarized as follows:

1. A systematic review of the past and present status of VA resident physician education and projected veterans' healthcare utilization was conducted.
    a. The number and geographic distribution of resident positions relative to total U.S. positions by specialty and by groupings of specialty types over the last 10 years was analyzed. The historic location of VA facilities near medical school partners was considered in the review.
    b. Changes in residency training were reviewed in the context of recent VA developments, including the shift from inpatient to outpatient care, the focus on quality and performance measures, patient safety, medical informatics, and the Capital Assets Realignment for Enhanced Services (CARES) initiative.
    c. The GME Advisory Committee also reviewed the projected changes in the physician workforce and the anticipated shortage of healthcare practitioners in the future.
    d. The Institute of Medicine's report "*Health Professions Education: a Bridge to Quality"* (2003) was considered in the committee's review.
2. The GME Advisory Committee requested the VHA Office of Academic Affiliations (OAA) to conduct three custom-designed studies to assist its deliberations:
    a. Projected facility needs ('Crystal ball' survey to assess the field's opinion regarding the desirability of changing local resident allocations, done in May 2004. A similar survey was done in March 2001).
    b. Projected VISN/Regional utilization (CARES) vs. current resident positions by region/VISN and by specialty grouping (corresponding to CARES categories of clinical utilization for inpatient medicine, surgery, and psychiatry, and for outpatient primary care, specialty care, and mental health, as well as ancillary-diagnostic services).
    c. An economic analysis [Resident Education Index] was used to assess the capacity of a residency training program to train medical residents by clinical specialty (medicine, surgery, and psychiatry) based upon the value of the healthcare services generated by residents in the three major specialty categories.
3. The GME Advisory Committee developed its conclusions and preliminary recommendations, which were reported to the Advisory Committee on VHA Resident Education. The recommendations focused on the role and scope of graduate medical education in the VA, the total number of positions, the geographic distribution and the specialty mix of resident physician positions in the VA.

The external, federally-chartered Advisory Committee on VHA Resident Education (hereafter referred to as "the Advisory Committee") held its first meeting on December 9, 2004, and was given the following charter:

"*The Advisory Committee on VHA Resident Education provides advice and consultation on matters relating to a broad assessment of resident physician positions in relationship to future veterans' healthcare needs. The Committee will engage in the following activities:*

- *Provide external perspective and national guidance on VHA's resident physician education program.*
- *Affirm the philosophical principles governing VHA's resident physician education program.*
- *Review the recommendations of VHA's internal Graduate Medical Education Advisory Committee."*

The external Advisory Committee reviewed the material considered by the GME Advisory Committee and held additional deliberations to address the Secretary's charge. While fundamentally endorsing the GME Advisory Committee's conclusions and recommendations, the Advisory Committee members formulated new recommendations and adopted a global framework for presenting their input to the Secretary of Veterans Affairs.

PHILOSOPHICAL PRINCIPLES GOVERNING VHA'S GRADUATE MEDICAL EDUCATION PROGRAM

The Advisory Committee affirmed the critical role VA plays in providing the underpinnings of high quality graduate medical education (GME) *from the general perspective* of competency development in preparation for independent practice to serve national health care needs and *from the specific perspective* of meeting VA healthcare delivery needs.

The committee compellingly emphasized that the trainee's educational needs, rather than institutional service needs, should take priority in educational experiences of residents in VA or any other clinical setting. Residency training must remain focused on the needs of the learner. The committee reasserted that the fundamental purpose of graduate medical education is the *education of the resident*, while recognizing that involvement in patient care is essential to the educational process. The committee acknowledged that tension will always exist between education and service, but that "managing the tension" is at the heart of successful clinical education, since residents, under supervision, must be involved in patient care in order to acquire the knowledge, skills, and attitudes necessary for independent practice. Thus, the Advisory Committee endorsed the concept proposed by the GME Advisory Committee of assuring exposure to "sufficient" clinical workload to meet training objectives as being a primary driver of clinical education. Provided *sufficient* workload is available, any workload beyond that level should not be a decisive factor in considering where to locate training programs. The Advisory Committee also acknowledged that VA graduate medical education training promotes an environment and spirit of inquiry among trainees, supervising practitioners, and associated staff. The resulting emphasis on 'cutting edge' healthcare directly and immediately benefits patients by enhancing the quality of care delivered and by promoting recruitment and retention of high quality VA clinical staff.

The Advisory Committee affirmed the value and quality of VA educational experiences as noted in the Preamble. They also acknowledged and concurred with the findings of the Office of Academic Affiliations studies done for the GME Advisory Committee relative to future veterans' healthcare needs and the value added to the system as a result of resident participation in patient care (as detailed in the *Report of the VHA Graduate Medical Education Advisory Committee*). Further, the committee felt that the economic analysis, while useful, did not validate an *economic* justification of residency training programs.

As charged, the Advisory Committee summarized the following additional principles pertaining to VHA residency education programs:

Additional Principles:

a. The VA graduate medical education experience has a high value for VA, veterans, and the nation. VA should continue as a major, active participant in graduate medical

education, which can be viewed as a long-term investment for VA. This educational investment creates a pool of appropriately trained physicians to meet both VA and societal needs.

b. Graduate medical education provides an immediate and direct benefit to veterans through enhanced quality of care and the recruitment and retention of highly trained academic physicians.
c. An appropriate balance between education and service must be upheld (sufficient but not excessive workload). [As one member of the Advisory Committee said, "*Residents should follow patient care, but not necessarily go to areas with the greatest patient care demand*."]
d. VA's policy on resident supervision sets a high standard for attending presence both in clinic and procedural sites and in attending involvement and responsibility in managing patient care. Previous models of resident care that did not explicitly describe and require the supervision of residents are no longer supported in VA, in other teaching hospitals, or by accrediting agencies.
e. Residency training takes 3-8 years to complete. Sudden changes in the distribution, numbers, and types of positions cannot be readily accommodated.
f. With respect to overall numbers of physicians, available analyses predict a future shortage of physicians. An increase in the number of residents (as contributing to the pool of qualified physicians – not for their contribution to meeting service needs) would better equip VA to deal with future medical workforce shortages.
g. VA has had a leadership role in graduate medical education, but could play an even greater role by maximizing certain opportunities (e.g., by increasing emphasis on educational infrastructure, by expanding use of simulators in training, and by expanding sites of ambulatory care; see also "Suggestions" below).
h. Residency training programs should only be established where there is an adequate educational infrastructure to support a suitable teaching environment. Infrastructure considerations must, at a minimum, take Accreditation Council for Graduate Medical Education (ACGME) accreditation requirements into account, including recommended ratios of residents to supervising attending physicians.
i. The importance of VA's role in the training of the next generation of physicians in the electronic medical record cannot be over-emphasized. [VA has clearly played a leadership role, as evidenced by the fact that 30% of all US residents rotating through the VA are trained to use CPRS (computerized patient record system) – VA's electronic medical record.]

ASSESSMENT OF VHA GRADUATE MEDICAL EDUCATION PROGRAMS

In fulfillment of its mandate to provide "*a broad assessment of resident physician positions in relationship to future veterans' health care needs*," the Advisory Committee delineated the following challenges and suggestions to assist VA in planning for its graduate medical education programs:

Challenges & concerns/issues relevant to VA graduate medical education programs:

a. Infrastructure considerations should receive more attention. Educational programs necessitate an infrastructure that is supportive of education, including space, adequate

numbers of qualified supervisory physicians, sophisticated medical equipment, and state-of-the-art care facilities.

b. Proposed use of community-based outpatient clinics as training sites for graduate medical education will require infrastructure support in order to assure that both an appropriate teaching environment and logistic support for implementation are available. The Advisory Committee supported the concept of increasing resident experiences in community-based outpatient clinics. If the VA were to expand these rotations, resident physicians would be exposed to outpatient clinical training in community sites in addition to the traditional inpatient training experiences.
c. Models of care used in teaching programs should increase emphases on disease prevention and on chronic disease management. Currently, many residency programs emphasize the treatment of acute illnesses.
d. Accreditation standards concerning resident duty hours by the Accreditation Council for Graduate Medical Education will continue to significantly impact facilities participating in physician resident training programs. The limitation of the resident duty week to 80 hours has created the need for more ancillary and attending staff to support patient care services.
e. Resident training in virtually every field requires that learners have in-depth experiences with both male and female patients in hospital and ambulatory settings. At present, only 6% of VA patients are women. Accordingly, adequate gender diversity to meet training requirements must be achieved through arrangements with educational affiliates. The development of new proposals to meet this challenge should be encouraged.
f. Over the past 16 years, while the total number of residents supported by VA has remained stable (8,700 to 8,900), the proportion of U.S. residents funded by VA has fallen from about 11% to 9%, because of an increase in the total number of residents trained in this country. New, additional resident physician positions are necessary if VA is to have the ability to:
    i Expand training to new facilities or to community-based outpatient clinics,
    ii Utilize increased educational opportunities at existing facilities,
    iii Support resident training in emerging disciplines important to the care of veterans,
    iv Respond to changes in the length of training imposed by certifying bodies, and
    v Develop new affiliations (e.g., to respond to shifting veteran demographics).
g. Geographic distribution of residents is closely linked to the location of schools of medicine and the location of VA medical centers near schools of medicine. Expansion of current training programs should be accomplished only in concert with affiliated programs and academic partners. Conversely, all new VA facilities (e.g., those developed as part of the CARES process) should seek affiliations with academic partners.

Suggestions to facilitate maintenance and expansion of opportunities to enhance VA's graduate medical education programs to benefit VA and the nation:

a. Create career tracks for resident physicians, who could engage in specific educational experiences that prepare them for subsequent VA employment. Such an approach would create an effective recruitment mechanism.
b. Career Development Awards in Education for VA staff physicians (similar to those sponsored by VA Research, but with protected time and resources to develop

educational initiatives and educational research) would promote innovation in VA graduate medical education and would increase the value of the clinical education of residents rotating to VA facilities.

c. VA should continue to use requests for proposals as a mechanism for funding new resident training programs in emerging disciplines (e.g., the important role of VA's Special Fellowship Program in fostering disciplines related to veterans' healthcare needs).
d. The key role of the Office of Academic Affiliations in VHA's central management and oversight of graduate medical education programs should continue. Central management and policy oversight is essential due to the size and scope of the programs, the budget, and the necessity of maintaining and improving policy standards.
e. Leadership at the highest levels of the Department of Veterans Affairs is needed to strengthen the emphasis on productive academic affiliations. This will enhance VHA's educational mission while creating additional benefits to VA, particularly for veterans receiving care at VA facilities.
f. VA could lead a fundamental change in medical education by exposing residents to less typical sites of care (e.g., community-based outpatient clinics) and expanding the opportunities for resident training in clinical settings similar to subsequent practice situations. A special emphasis on training in geriatric medicine could be part of this expansion.
g. The use of community-based outpatient clinics as an education resource is supported, provided that appropriate infrastructure and logistic concerns are addressed. However, it is recognized that the distance of some community-based outpatient clinics from their parent VA facilities will remain a significant barrier to implementation of resident training.
h. VA has used patient simulators in some locations but could expand their use, which in turn would benefit medical education and patient safety in VA facilities.
i. VA/DoD joint venture and sharing capabilities should be leveraged to improve educational opportunities with active duty personnel.

CONCLUSIONS & RECOMMENDATIONS

Conclusion 1: VA-medical school partnerships for graduate medical education are integral to the provision of high quality health care for the nation's veterans. VA's educational programs provide excellent training in areas that are directly relevant to veteran patient care.

Recommendation 1:

VA should continue and strengthen its partnerships with the nation's medical schools in the provision of graduate medical education. VA should strive to become a leader in physician education as it has become a leader in patient safety and medical informatics.

Conclusion 2: VA's proportionate role in graduate medical education has diminished nationally.

Recommendation 2:

VA should restore and maintain its historic support for 11% of total U.S. resident physician positions as soon as feasible in order to maintain a leadership role in graduate medical education and to maintain training of a significant proportion of U.S. residents in areas of importance to the VA and to the nation.

Strategy 1: Newly created residency positions should be allocated to new specialty and sub-specialty disciplines, new VA sites of care, and new affiliations based on evaluation of education objectives, infrastructure, and veterans' healthcare needs.

Strategy 2: Recruitment of resident physicians into the VA workforce is appropriate and should be encouraged in light of predicted physician shortages.

Conclusion 3: Oversight mechanisms currently in place are adequate and need not be altered.

Recommendation 3:

The current collaborative process between facilities and VISNs addresses local and regional resident physician needs, and VHA's Office of Academic Affiliations provides oversight concerning the funding, allocation, and distribution of all positions. National initiatives (via requests for proposals) should continue to be used to stimulate interest in and support emerging disciplines that are relevant to the healthcare needs of veterans. The oversight process for changing the specialty mix of trainees should remain flexible and responsive to VA's needs.

Conclusion 4: The current geographic distribution of residents reflects the historic location of VA facilities in proximity to medical schools. Existing physician residency training programs have sufficient clinical workload to support training objectives, and provide necessary patient care services.

Recommendation 4:

Geographic redistribution should be undertaken by increasing VA resident positions in new facilities or in areas with increased educational opportunities. Expansion of programs should occur only when an appropriate training environment and infrastructure are in place. Changes to the geographic distribution of residents by other mechanisms would likely be extremely disruptive to veterans' health care.

Attachment 1.

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