A Year 3 Progress Report on Graduate Medical Education Expansion in the Veterans Access, Choice, and Accountability Act

Anthony P. Albanese, MD; Jemma Ayvazian, DNP; Edward Bope, MD; Amanda Van Gilder, MA; Christopher Pelic, MD; Karen Sanders, MD; Monica Lypson, MD; Christyann Clary, MSW; and Kathleen Klink, MD

The VA has made progress in implementing mandates to expand medical residency programs to more rural and underserved locations and to increase access to family care providers, but some specialties, like geriatrics, remain underrepresented.

Dr. Albanese is an Affiliations Officer, **Dr. Ayvazian** is the Clinical Director for Nursing Education, **Dr. Bope** is the Lead Graduate Medical Education Affiliations Officer, **Ms. Van Gilder** is a Management Analyst, **Dr. Pelic** is Clinical Director of Medical Dental Education, **Dr. Lypson** is Director of Medical Dental Education, **Dr. Sanders** is the Deputy Chief, **Ms. Clary** is a Health System Specialist, and **Dr. Klink** is the Acting Chief; all for the VA Office of Academic Affiliations.
Correspondence: Dr. Albanese (anthony.albanese@va.gov)

The VHA is the largest healthcare delivery system in the U.S. It includes 146 medical centers (VAMCs), 1,063 community-based outpatient centers (CBOCs) and various other sites of care. General Omar Bradley, the first VA Secretary, established education as one of VA's 4 statutory missions in Policy Memorandum No.2.[1] In addition to training physicians to care for active-duty service members and veterans, 38 USC §7302 directs the VA to assist in providing an adequate supply of health personnel. The 4 statutory missions of the VA are inclusive of not only developing, operating, and maintaining a health care system for veterans, but also including contingency support services as part of emergency preparedness, conducting research, and offering a program of education for health professions.

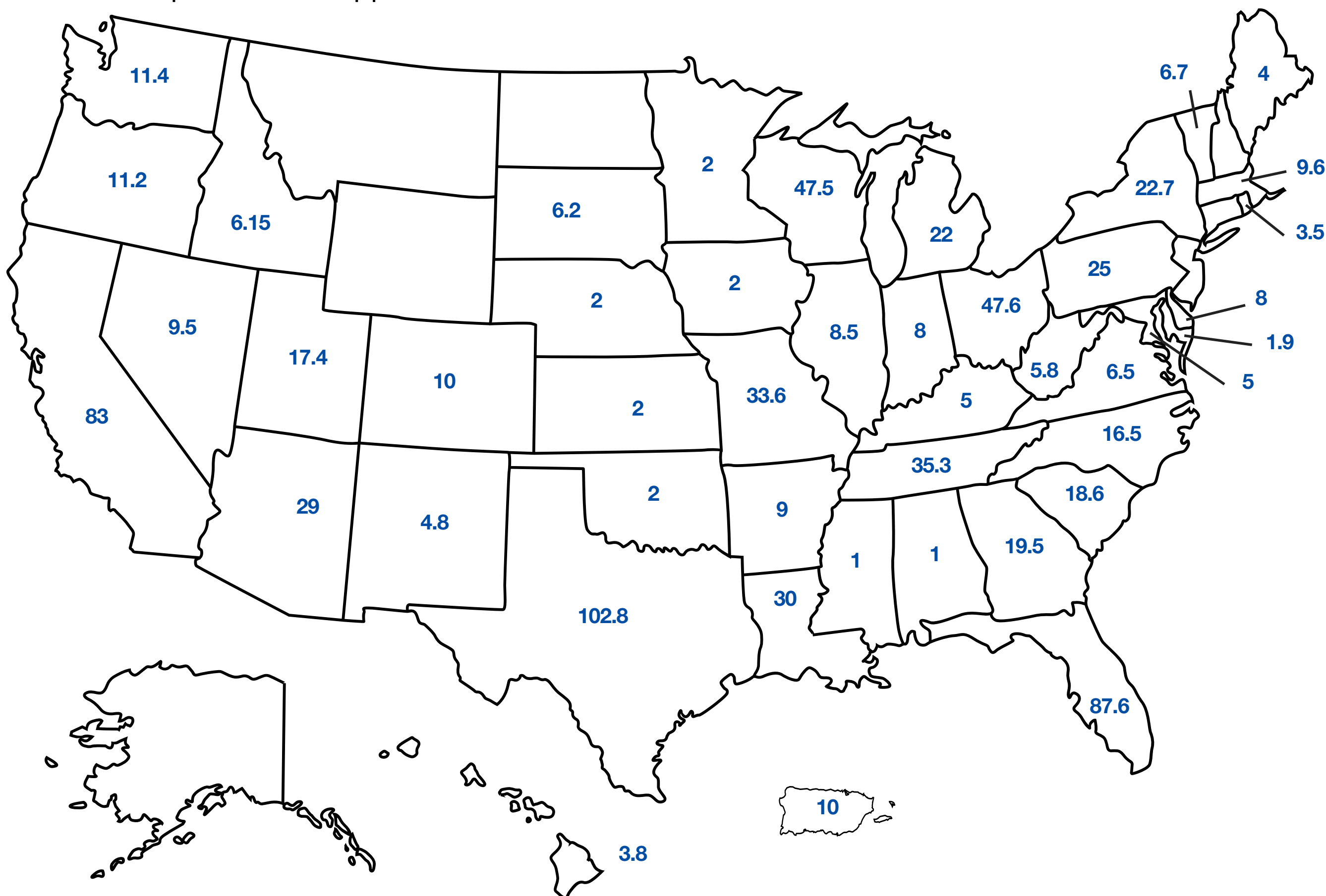
BACKGROUND

Today, with few exceptions, the VHA does not act as a graduate medical education (GME) sponsoring institution. Through its Office of Academic Affiliations (OAA), the VHA develops partnerships with Liaison Committee for Medical Education (LCME)/American Osteopathic Association (AOA)-approved medical colleges/universities and with institutions that sponsor Accreditation Council for Graduate Medical Education (ACGME)/AOA-accredited residency program-sponsoring institutions. These collaborations include 144 out of 149 allopathic medical schools and all 34 osteopathic medical schools. The VHA provided training to 43,565 medical residents and 24,683 medical students through these partnerships in 2017.[2] Since funding of the GME positions is not provided through the Centers for Medicare & Medicaid Services (CMS), program sponsors may use these partnerships to expand GME positions beyond their funding (but not ACGME) cap.

The gap between supply and demand of physicians continues to grow nationally.[3,4] This gap is particularly significant in rural and other underserved areas. U.S. Census Bureau data show that about 5 million veterans (24%) live in rural areas.[5] Compared with the urban veteran population, the rural veteran experiences higher disease prevalence and lower physical and mental quality-of-life scores.[6] Addressing the problem of physician shortages is a mission-critical priority for the VHA.[7]

With an eye toward enhancing 2 of the 4 statutory missions of the VA and to mitigate the shortage of physicians and improve the access of veterans to VHA medical services, on August 7, 2014, the Veterans Access, Choice, and Accountability Act of 2014 (Public

FIGURE 1 Map of VACAA-Approved Positions



Law [PL] 113-146), known as the Choice Act was enacted.[8] Title III, §301(b) of the Choice Act requires VHA to increase GME residency positions by:

> Establishing new medical residency programs, or ensuring that already established medical residency programs have a sufficient number of residency positions, at any VHA medical facility that is: (a) experiencing a shortage of physicians and (b) located in a community that is designated as a health professional shortage area.

The legislation specifies that priority must be placed on medical occupations that experience the largest staffing shortages throughout the VHA and "programs in primary care, mental health, and any other specialty that the Secretary of the VA determines appropriate." The Choice Act authorized the VHA to increase the number of GME residency positions by up to 1,500 over a 5-year period. In December 2016, as amended by PL 114–315, Title VI, §617(a), this authorization was extended by another 5 years for a total of 10 years and will run through 2024.[9]

GME DEVELOPMENT/DISTRIBUTION

To distribute these newly created GME positions as mandated by Congress, the OAA is using a system with 3 types of request for proposal (RFP) applications. These include planning, infrastructure, and position grants. This phased approach was taken with the understanding that the development of new training sites requires a properly staffed education office and dedicated faculty time. Planning and infrastructure grants provide start-up funds for smaller VAMCs, allowing them to keep facility resources focused on their clinical mission.

TABLE 1 The Choice Act–Approved GME Residency Positions by Specialty

Approved Medical Specialties	FTE Positions, No. (%)	Approved Medical Specialties	FTE Positions, No. (%)
Internal medicine	262.6 (34.0)	Hospice and palliative medicine, multidisciplinary	4.3 (.6)
Psychiatry, general	143.1 (18.5)	Pain medicine	4 (.5)
Family medicine	83.6 (10.8)	Nephrology	3.4 (.4)
Neurology	23 (3.0)	Vascular surgery	3.3 (.4)
Emergency medicine	21 (2.7)	Otolaryngology	3 (0.4)
Anesthesiology	19 (2.5)	Interventional cardiology	2.5 (.3)
Dermatology	18.1 (2.4)	Child and adolescent psychiatry	2 (.3)
Ophthalmology	16 (2.1)	Infectious disease	2 (.3)
Hematology and oncology	14.8 (1.9)	Clinical cardiac electrophysiology	2 (.3)
Cardiovascular disease	13.6 (1.8)	Sleep medicine	1.6 (.2)
Pulmonary disease and critical care medicine	13 (1.7)	Pathology, anatomic and clinical	1.5 (.2)
Gastroenterology	11.5 (1.4)	Advanced heart failure and transplant cardiology	1.5 (.2)
Addiction psychiatry	11.3 (1.5)	Forensic psychiatry	1.5 (.2)
Physical medicine and rehabilitation	10.8 (1.4)	Other	1 (.1)
Radiology, diagnostic	7 (.9)	Transplant hepatology	1 (.1)
Urology	7 (.9)	Critical care	1 (.1)
Orthopaedic surgery	7 (.9)	Vascular and interventional radiology	1 (.1)
Endocrinology, diabetes, and metabolism	6.8 (.9)	Chief resident, internal medicine	1 (.1)
Geriatric medicine, internal and family	6.3 (8)	Clinical neurophysiology	1 (.1)
Plastic surgery	6 (.8)	Neuromuscular medicine	1 (.1)
Surgery, general	5.5 (.7)	Neuroradiology	1 (.1)
Geriatric psychiatry	5.3 (.7)	Preventive medicine-occupational medicine	.8 (.1)
Rheumatology	5.2 (.7)	Neurologic surgery	.7 (.1)
Obstetrics and gynecology	4.7 (.6)	Female pelvic medicine/reconstructive surgery	.3 (< .1)
Preventive medicine	4.6 (.6)	Transitional year	.2 (< .1)
Psychosomatic medicine, psychiatry	4.5 (.6)	**Total**	**773.5 (100)**

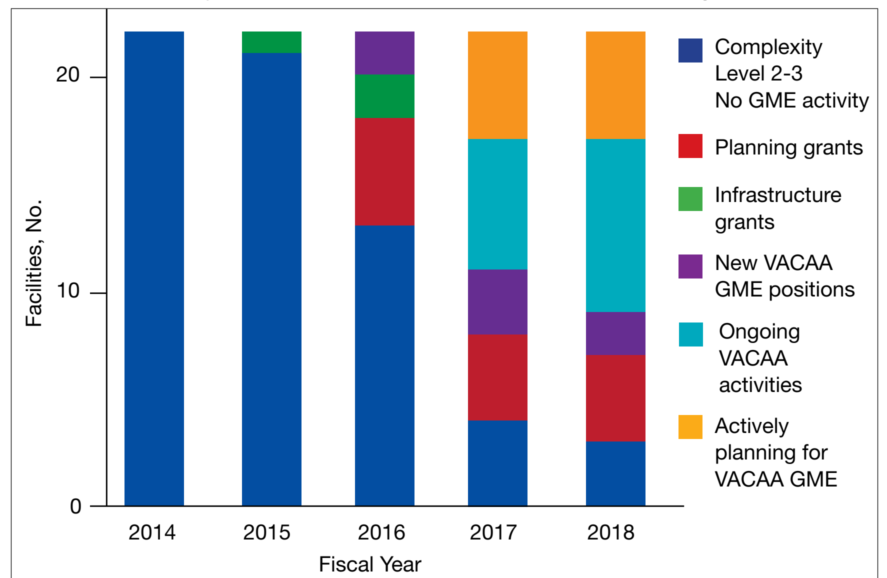
Abbreviations: FTE, full-time equivalent; GME, graduate medical education.

Planning grants (of up to $250,000 over 2 years) primarily were designed for VA facilities with no or low numbers of physician residents at the desired teaching location. Priority was given to facilities in rural and/or underserved areas as well as those developing new affiliations. Applications were reviewed by OAA staff along with peer-selected Designated Education Officers (DEOs) from VA facilities across the nation that were not applying for the grants. Awards were based on the priorities mentioned earlier, with additional credit for programs focused on 2 VHA fundamental services areas—primary care and/or mental

health training. Facilities receiving planning grants were mentored by an OAA physician staff member, anticipating a 2- to 3-year time line to request positions and begin GME training.

Infrastructure grants (of up to $520,000 used over 2-3 years) were designed as bridge funds after approval of Veterans Access, Choice, and Accountability Act (VACAA) GME positions. Infrastructure grants are appropriate to sustain a local education office, develop VA faculty, purchase equipment, and make minor modifications to the clinical space in the VAMCs or CBOCs to enhance the learning environment during the period before VA supportive funds from the Veterans Equitable Resource Allocation (VERA) (similar to indirect GME funds from CMS) become available. Applications were managed the same as planning grant submissions.

FIGURE 2 Facility-Level Graduate Medical Education Progress



Abbreviations: GME graduate medical education; VACAA, Veterans Access, Choice, and Accountability Act.

Position RFPs, unlike planning and infrastructure RFPs, are available to all VAMCs. The primary purpose of the VACAA Position RFP is to fund new positions in primary care and psychiatry. Graduate medical education positions in subspecialty programs also are considered when there is documentation of critical need to improve access to these services. Applications were reviewed by OAA staff along with selected DEOs from VA facilities around the U.S. Award criteria prioritized primary care (family medicine, internal medicine, geriatrics), and mental health (psychiatry and psychiatry subspecialties). Priority also was given to positions in areas with a documented shortage of physicians and areas with high concentrations of veterans.

CURRENT PROGRESS

To date the OAA has offered 3 RFP cycles consisting of planning/infrastructure grants, and 4 RFP cycles for salary/benefit support for additional resident full-time equivalent (FTE) positions. Resident positions were defined as residency or fellowship FTEs that were part of an ACGME or AOA-accredited training program. Figure 1 illustrates the geographic distribution of awarded GME positions. There are midwestern and northwestern states that still do not have GME training at local VAMCs or CBOCs. The use of planning and infrastructure grants by smaller VAMCs with lower complexity ratings (level 1 facilities are considered the most complex and level 3 are the least) to develop GME is illustrated in Figure 2.

In primary care specialties (family medicine, internal medicine, and geriatrics, a total of 349.4 FTE positions have been approved (Table 1). Due to a low number of applications, only 6.3 of these positions were awarded in geriatrics. In mental health, 167.6 FTE positions have been approved, whereas in critical needs specialties (needed to support rural/underserved healthcare and improve specialty access) 256.5 FTE positions have been added. Overall, 773.5 FTE positions have been approved as of September 30, 2017, with nearly half in primary care, and about one-third in other critical needs specialties (Figure 3). Notably, 8.5% (65.6 FTEs) of the positions were allotted to self-designated rural sites. Family medicine programs have been awarded 82.6 FTE positions and osteopathic programs 33.4 positions (Table 2). Rotations through VA training sites provide experience for an average of 4 residents per

TABLE 2 Graduate Medical Education Expansion by Target

VACAA Graduate Medical Education Initiatives	Approved Positions				Cumulative (4-year total)
	Round 1	Round 2	Round 3	Round 4	
Self-designated rural site	18.7	21.6	15.0	10.6	65.8
Family medicine	16.9	7.3	19.5	38.9	82.6
Osteopathic programs (AOA)	12.7	1.0	4.3	15.5	33.4

Abbreviations: AOA, American Osteopathic Association; VACAA, Veterans Access, Choice, and Accountability Act.

FTE, though this number varies greatly among different sites and specialties.

DISCUSSION

There are several important desired short-term outcomes from VACAA. The first is improved access to high-quality care for both rural and urban veterans. There is an emphasis on primary care and mental health because shortages in these areas across the U.S. are well established.[3,4,10] Likewise, rural areas have been prioritized because often there is a disparity of care. Urban areas and the wide variety of important subspecialties needed to support primary care and mental health were not neglected, with a significant portion of positions assigned to urban centers in a wide variety of specialty fields. Some question whether internal medicine should be considered a primary care specialty when only about 20% of internists graduating from residency plan to pursue primary care careers.[11,12] Although the percentage is small, a significant amount of primary care in the U.S. is provided by internists, and many that identify as subspecialists choose to practice in a primary care setting.[13,14]

One area of concern is the small number of applicants in geriatrics. Even with VACAA specifically targeting geriatrics as a primary care specialty, we have only received enough applications to approve 6.3 positions over the first 3 years of the program. As the veteran and overall population in the U.S. ages, it is important to develop a medical workforce that is willing and able to address their needs.

The VACAA statute is not intended to alter medical students' career choice but rather to provide funded positions for those choosing primary care, geriatrics, psychiatry (including psychiatric subspecialties), and experience in the VA clinical settings. The hope is that this experience will encourage practitioners to competently care for veterans after training in the VA and/or other civilian settings.

By enabling smaller VA facilities to become training sites through planning and infrastructure grants, residents have the opportunity to gain experience in more rural settings. Physicians who choose to train in rural areas are likely to spend time practicing in those areas after they complete training.[15] The process of developing facilities with no GME into training sites takes time and resources. Establishing an education office and choosing site directors and core faculty are all important steps that must be done before resident rotations begin. Resources provided through VACAA have enabled the VHA to reduce the number of VAMCs with no GME activity to just 3.

Another benefit of VACAA GME expansion is the opportunity to engage new LCME/AOA-accredited medical schools and ACGME/AOA-accredited residency-sponsoring institutions.[16,17] Representatives of these institutions may have perceived a reluctance of their local VAs to develop GME affiliations in the past. This statute has enabled many VAMCs to use nontraditional training sites and modalities to overcome barriers and create new academic affiliations.

However, VACAA only provides funds for training that occurs in established VA sites of care. This can hinder the development of

partnerships where other funding sources are required for non-VA rotations. Another VACAA limitation is that it does not fund undergraduate medical education as does the Armed Forces Health Professional Scholarship Program (HPSP). In addition, the primary financial relationship is between the VA and the sponsoring institution, thus VHA cannot send residents to underserved locations.

CONCLUSION

The VHA has a rich tradition of educating physician and other health care providers in the U.S. More than 60% of U.S. trained physicians received a portion of their training through VHA.[2] Through VACAA GME expansion initiative, the 113th Congress has asked VHA to continue its important training mission "to bind up the Nations wounds" and "to care for him who shall have borne the battle."[18]

Acknowledgments

In memoriam – Robert Louis Jesse MD, PhD. Dr. Jesse, the Chief of the Office of Academic Affiliations passed away on September 2, 2017, at age 64. He had an illustrious medical career as a cardiologist and served in many leadership roles including Principal Deputy Under Secretary for Health in the U.S. Department of Veterans Affairs. His expertise, visionary leadership, and friendship will be missed by all involved in the VA's academic training mission but particularly by those of us who worked for and with him at OAA.

Author disclosures

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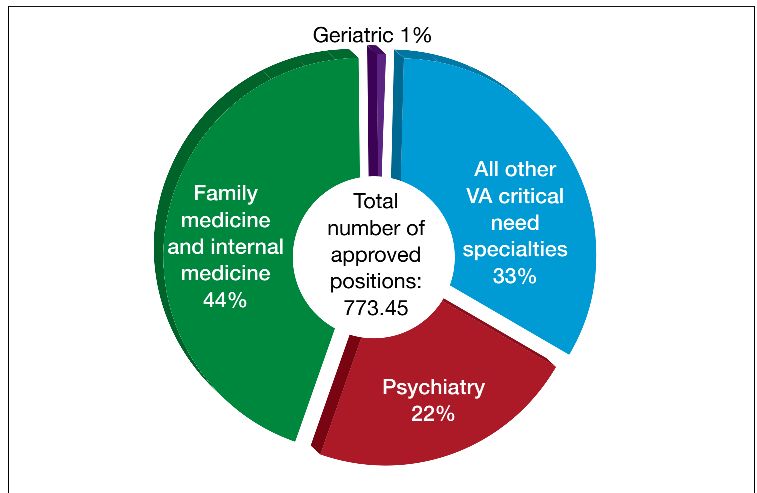
Disclaimer

The opinions expressed herein are those of the authors and do not necessarily reflect those of *Federal Practitioner,* Frontline Medical Communications Inc., the U.S. Government, or any of its agencies.

FIGURE 3 The Choice Act-Approved Positions by Specialty



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