

# Reporter

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News About the Nation's  
Medical Schools and Teaching Hospitals

## Academic Medicine Responds to the Opioid Epidemic



AAMC Executive Vice President Atul Grover, MD, PhD, (left), moderated a congressional briefing on Jan. 28 featuring experts on opioid abuse from medical schools and teaching hospitals around the country.

—By Rebecca Greenberg

The AAMC and the Congressional Academic Medicine Caucus held a Capitol Hill briefing in January to highlight efforts at medical schools and teaching hospitals to respond to the opioid epidemic that has been gripping communities from small towns to large urban centers. In 2014 alone, the Centers for Disease Control and Prevention (CDC) attributed more than 47,000 deaths to prescription drug abuse.

"This has been an alarming problem. It's absolutely tearing many of our communities apart as it has affected predominantly young people," said briefing panelist Terence Flotte, MD, dean of University of Massachusetts (UMass) Medical School to an audience of more than 100 congressional staff and other attendees. Fatal opioid overdoses have more than doubled in the commonwealth since 2000, and the majority of opioid-related deaths have been people younger than 44.

In response, all four medical schools in Massachusetts have introduced new educational content for a total of 3,000 medical students. With support from Gov. Charlie Baker, medical schools at UMass, Boston University, Harvard, and Tufts have implemented 10 core competencies related to the prevention and treatment of opioid addiction.

Policymakers have made addressing the epidemic a high priority. The president's fiscal 2017 budget, released in February, proposed \$1 billion in mandatory funding to expand access to treatment for opioid and heroin abuse. There is strong bipartisan support in the Senate for wide-ranging legislation that would authorize programs to address the epidemic, though funding for the programs has not yet been approved.

Bradley Allen, MD, senior associate dean for medical education at Indiana University (IU) School of Medicine described at the briefing how the medical school has

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## Improving Communication Between Primary and Specialty Care Physicians

—By Alicia Gallegos, special to the Reporter

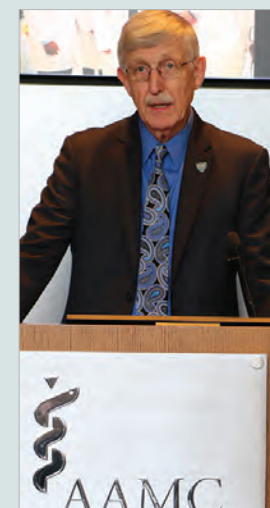
As it becomes more difficult to coordinate patient care in an increasingly complex health care system, several teaching hospitals are leading the way to improve communication between primary and specialty care physicians. These gaps in communication and coordination were the catalyst for a new AAMC profile series, "Innovations at the Interface of Primary and Specialty Care," which provides an in-depth look at three programs designed to help health care providers work together more effectively to improve patient care.

"Traditionally, primary care providers and specialists communicated with each other, punctuated by regular

interactions, while caring for patients in the hospital," said Scott Shipman, MD, MPH, AAMC director of primary care initiatives and workforce analysis. He said that in today's health care system, "physicians rarely see one another in day-to-day practice, have limited meaningful dialogue of any kind, and in some cases even see one another in an adversarial way." The result, Shipman continued, is "a significant risk of fragmented care, with well-documented negative effects on quality and costs of care."

To address this problem, the AAMC Center for Workforce Studies sought to find and document compelling programs that demonstrated effective

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### AAMC Hosts Budget Briefing with NIH Director Francis Collins

Francis Collins, MD, PhD, director of the National Institutes of Health (NIH), held a budget briefing at the AAMC following the release of President Obama's final budget for the nation on Feb. 9. Collins discussed how the NIH plans to use the \$2 billion increase that Congress provided in December and outlined the president's FY 2017 proposals. Funding increases will support a variety of NIH projects, including the National Cancer Moonshot,

Precision Medicine Initiative®, antimicrobial research, and the BRAIN Initiative®. Close to 200 members of the academic medicine and research communities attended the briefing that was cohosted by the Ad Hoc Group for Medical Research.

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Learn about the "Take the Volume Pledge," a campaign to limit certain surgical procedures to hospitals and surgeons that perform a minimum number of them.



# What Does the Public See When They Look at Us?

Darrell G. Kirch, MD, AAMC President and CEO

Given the fast pace of daily life at our medical schools and teaching hospitals, every so often we need to pause to reflect upon how our work and our missions are viewed by those outside the walls of our institutions. Academic medicine is a complex and multifaceted field, but we depend on public awareness of our work and support for our missions to succeed in educating the next generation of physicians, discovering medical innovations, and providing critical patient care for all in the communities we serve.

To shed light on how the public views academic medicine, the AAMC has conducted public opinion research at regular intervals since 1996 using one of the nation's leading research firms, Public Opinion Strategies. Our most recent study consisted of four focus groups in two major U.S. markets; a national telephone survey of 800 registered voters; a national Internet survey of 1,500 adults; and interviews with Washington, DC, health care policy leaders. The goals of the project were to assess how the public perceives medical schools and teaching hospitals and determine whether the messages we use to communicate our value resonate broadly.

Here's the good news: The research found that the public recognizes the added value offered by our institutions. When it comes to teaching hospitals, 7 out of 10 people agree these institutions provide added benefit for patients compared with other hospitals. They believe that our institutions have the best doctors and deliver better quality and more in-depth care. As patients, they value access to medical innovation, cutting-edge technology and equipment, and the latest treatments. When asked about academic medicine more broadly, a majority recognize the unique value we bring through medical innovation and in responding to health crises.

One of the things that struck me most was the high value that respondents placed on academic medicine's responsibility to serve our communities. The intersection of our three mission areas makes our institutions uniquely positioned to respond in moments of crisis, such as developing vaccines for life-threatening diseases like Ebola. A current example of caring for our communities during an emergency is the water crisis in Flint, Mich. The situation was first brought to light by Mona Hanna-Attisha, MD, MPH, a pediatrician at Hurley Medical Center in Flint and an assistant professor at Michigan State University College of Human Medicine, after she detected an alarming rise in lead levels in her patients' blood. In January, Michigan State

and Hurley Children's Hospital announced a new pediatric public health initiative, led by Dr. Hanna-Attisha, to address widespread lead exposure among the children of Flint.

But the physicians and scientists at our schools and teaching hospitals address the quieter challenges that our communities face, too—the ones that do not always make the headlines. Day in and day out, our physicians are improving access to care through free clinics, telehealth, and health screenings in community spaces. Our institutions are partnering with state and local leaders to address systemic health disparities and take decisive action to improve health outcomes for entire communities. And our researchers are searching for practical solutions to our most pressing public health concerns, from emerging diseases, to substance abuse, to the effects of race and ethnicity on the patient-physician relationship.

I am gratified that the public and our elected officials recognize and value this work. However, we must pay close attention to what more they want us to do. They want us to lead care delivery system reform—to find new ways to deliver better care at lower costs. They want us to think about physician distribution, both geographically and across specialties. They want us to improve how we educate and practice in interprofessional teams. And they want us to train physicians who not only provide excellent care, but who also understand the implications of public policy on the health of their communities.

So I ask that all of us in academic medicine think about what we can do to meet these goals. I encourage leaders at each of our institutions to strengthen your relationships within your communities and with your state and local officials. I ask our physicians and administrators to evaluate whether you can improve transparency, efficiency, and cost in care delivery. I encourage our scientists to publish your results and successes broadly, to show how the research you do contributes to the health of our nation. I ask our

educators to train future physicians not only to practice humanistic care for individual patients, but also to improve the health of entire communities. And I urge our students and residents to take advantage of the opportunities you have to get hands-on experience working with diverse groups in your communities through free clinics, screenings, and other outreach programs. We have broad public support for our missions. We can build on that foundation by work that brings together education, research, and care to improve population health across our entire nation.

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**“One of the things that struck me most was the high value that respondents placed on academic medicine's responsibility to serve our communities.”**

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## The Road to Biosocial Medicine

By Donald A. Barr, MD, PhD, is a professor of pediatrics and education at Stanford University and the author of *Introduction to Biosocial Medicine: The Social, Psychological, and Biological Determinants of Human Behavior and Well-Being* (Johns Hopkins University Press, 2015).

*Editor's Note: The opinions expressed by the author do not necessarily reflect the opinions of the AAMC or its members.*

*Two roads diverged in a Brooklyn school...*

The person at the point of divergence on this road was not poet Robert Frost. Rather, she was a 6-year-old girl in kindergarten at a charter school serving mostly black and Hispanic students. As reported in an October 2015 front-page story in the *New York Times* by Kate Taylor, this girl was having trouble. "She racked up demerits for not following directions or not keeping her hands folded in her lap. Sometimes, after being chastised, she threw tantrums." In response, the administration placed her on its "Got to Go" list, which meant those in charge intended to have her mother withdraw the girl and move her to another school.

It seems likely that this girl was exhibiting impaired development of the executive function necessary to control her emotional impulses—probably a consequence of growing up in a highly stressful home environment. Recent research suggests she may have had a combination of amygdalar hyperactivity and impaired hippocampal development as the neural basis for these behaviors.

If we were to have this 6-year-old as our patient, how could this knowledge help us guide her to a healthier road? Any child given the "Got to Go" label is at risk of developing a low sense of self-efficacy and a present-fatalistic perspective on time. Combined with this girl's cognitive delay, the negative psychological impact may drag her further and further behind as she goes through school. Population data suggest she will be at risk for dropping out of high school, perhaps becoming a teen parent, and adopting health behaviors that may contribute to a lifetime of reduced well-being.

In a policy statement published in 2012, the American Academy of Pediatrics recommended that pediatricians "be armed with new information about the adverse effects of toxic stress on brain development, as well as a deeper understanding of the early life origins of many adult diseases." This approach to care would enable pediatricians to develop "innovative strategies to reduce the precipitants of toxic stress in young children and to mitigate their negative effects on the course of development and health across the life span."

This is what biosocial medicine is all about. In this model, the care provider would follow the levels of stress and adversity the Brooklyn girl was experiencing and how it affected her neural development, in particular the interaction of her amygdalar and hippocampal control systems. Her physician would consider the factors that contribute to her personality characteristics—in particular time, preference, and perceptions of self-efficacy. How are these characteristics affecting the girl's motivation, especially her motivation to succeed in school and move on to higher education?

The physician would also need to determine how the girl's social and cultural environment might influence these

factors as she moves into adolescence. Perhaps most important, what types of interventions have demonstrated the potential to redirect her trajectory of well-being?

In their 2015 commentary in *Academic Medicine*, Arthur Kleinman, Paul Farmer, and their colleagues argue that as physicians, we must come to appreciate that "the determinants of health are best conceptualized as biosocial phenomena, in which health and disease emerge through the interaction between biology and the social environment." To provide physicians with this perspective, there must be a fundamental transformation in medical education. The authors therefore advocate for the "institutionalization of biosocial curricula" into medical and premedical education.

For decades, medical education has been based on a biomedical model of illness. Smoking causes respiratory and cardiovascular diseases as well as cancer. We know that. But why do people smoke in the first place? What can we do to get them to stop? As John Lumpkin emphasizes in his December Viewpoint contribution, "It's more effective to keep bad dietary and lifestyle habits from forming than to reverse unhealthy behaviors once they have taken hold."

In designing the new Foundations of Behavior section for the revised Medical College Admission Test (MCAT®), the AAMC's MR5 Committee addressed the question of what a biosocial curriculum might look like. The committee identified what pre-med students should learn, including "the ways in which psychological, social, and biological factors influence perceptions and reactions to the world; behavior and behavior change; what people think about themselves and others; the cultural and social differences that influence well-being; and the relationships between social stratification, access to resources, and well-being."

As described in the MCAT preview guide, the new test section assesses students' knowledge and use of the concepts in psychology, sociology, and biology—the solid foundation needed in medical school to learn about the behavioral and sociocultural determinants of health.

My training is both as a physician and a sociologist, so my teaching and scholarship fall within the intersection of these fields of knowledge. This approach can be problematic as those of us who have pursued interdisciplinary education and professional work can attest. My work is not simply the summation of sociology, psychology, and biology. It involves integrating these disciplines.

To prepare students for the study of medicine, I believe that colleges and universities must develop new approaches to teaching the foundations of biosocial medicine that integrate historically separate disciplines. Given the traditional separation of higher education into distinct academic disciplines, one might suggest that, in addition to biology, students take introductory courses in psychology and sociology.

Now, back to our 6-year-old from Brooklyn. What if she had health providers versed in biosocial medicine? What if they worked closely with an educational system that offered alternative approaches to learning for at-risk children? In a supportive environment like that, this child might be able to find a more desirable path through school and into adulthood than the troubled road on which her teacher had placed her. And as a poet from New England once pointed out, *that could have made all the difference.*

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# Front Page Stories continued

## Opioid epidemic, continued

guided physicians and health care workers in the small town of Austin, Ind., in dealing with secondary effects of opioid abuse—HIV and hepatitis C outbreaks—caused by needle sharing. IU faculty and trainees worked with local health care providers to apply preventive measures, such as needle exchanges and prophylaxis medications, and to instruct local providers how to better recognize the underlying drug abuse in rural communities. More broadly, the medical school has enhanced its education and residency training on pain management and substance abuse, with a special emphasis on an interprofessional approach.

Briefing attendees also learned how medical students and faculty at Dartmouth's Geisel School of Medicine are working side-by-side to advance the treatment of Neonatal Abstinence Syndrome—another secondary consequence of the epidemic. Alison Holmes MD, MPH, associate professor of pediatrics at the school, discussed the treatment protocol that improved the outcomes of opioid-exposed newborns who have withdrawal symptoms, and led to shorter hospital stays and reduced costs of care. Holmes received the 2014-15 AAMC Challenge Award for her work on this.

### An urgency to refine the curriculum

Content on pain management and substance abuse is included in almost all medical schools already, but the opioid crisis has created urgency to refine the curriculum, said Tannaz Rasouli, AAMC senior director of public policy

and strategic outreach. "Academic medical centers are designed to take the pulse of the community and respond to its needs, whether it's through medical discovery, innovative care delivery, or preparing the next generation of health professionals for existing and potential threats."

The CDC estimates that 44 people die each day from prescription pain medication overdoses, with nearly 7,000 people treated in emergency rooms for misusing these medications. "A number of institutions are revamping, revising, and enhancing their curricula to reflect the changing situation and context to meet health care needs. Students are learning beyond the classroom in an environment that is constantly evolving in real time. As new knowledge or new challenges emerge, medical education adapts," Rasouli said.

In addition to new educational models, Karen Miotto, MD, clinical professor in the Department of Psychiatry and Biobehavioral Sciences at the David Geffen School of Medicine at the University of California, Los Angeles, suggested the need for more reimbursement for comprehensive pain programs. "We often don't have access to the things we know really work for a chronic condition like pain, which is a multidisciplinary treatment approach," she said.

Miotto also pointed to resources that support practicing physicians and trainees in safe and effective use of opioid medications and in treatment of opioid use disorder. Both the Providers' Clinical Support System for Opioid Therapies

(PCSS-O) and the Physicians' Clinical Support System—Buprenorphine (PCSS-B) offer support to health care providers dealing with challenging cases and situations. Mentors from these support services can provide guidance on taper levels or coping with an intoxicated patient.

"The worst feeling for a medical trainee is that they are all alone and don't know what to do," Miotto said. Patients showing signs of opioid addiction at UCLA are referred to clinics that specialize in dual diagnosis or addiction medicine. "What we can do is provide a consultation to discuss opiate safety and overdose risks," she said.

At the briefing, AAMC Executive Vice President Atul Grover, MD, PhD, drew connections between the opioid crisis today and the AIDS outbreak he witnessed as a resident in San Francisco in the 1990s.

"When I started my residency, we were dealing with an inner-city population that was dying of HIV. By the time I left, the hospices were being emptied. It was the most amazing thing to have experienced, and academic medicine played an important role in that. We are trying to play an important role here as well," he said.

In October, the AAMC joined a White House initiative to combat prescription drug abuse through professional guidance and best practices. "As the medical schools and all the practicing physicians, we were saying that we own this problem. We need to have people better trained to try to address it," Flotte said.

## Physician communication, continued

teamwork between primary care and specialist physicians and led to improved quality and/or efficiency of care. They found examples at Mayo Clinic in Rochester, Minn.; the University of New Mexico Health Sciences Center in Albuquerque; and Kaiser Permanente Colorado in Denver, where improving communication and coordination between primary care and specialty care physicians was a priority. "These programs consistently demonstrated improved access, better quality, and greater provider satisfaction, often with lower costs. We hope they serve as models for other institutions," said Shipman.

### Three institutions, three approaches

Reducing fragmentation and enhancing physician teamwork were key goals behind recent initiatives at Mayo Clinic. Mayo's efforts include the launch of electronic consultations (eConsults) and the development of care process models that define roles and relationships between primary and specialty care in the management of certain conditions.

Another Mayo initiative centers on embedding specialists in primary care clinics. Placing specialists in the same physical space as primary care doctors helps them become more familiar with the culture of primary care and reduces barriers to physicians having real conversations, said Sarah J. Crane, MD, an assistant professor of primary care internal medicine and geriatrics at Mayo Clinic.

"What we found was that we didn't know the [specialists], and they didn't know us," Crane said. "There were real trust factors. We wanted to bring everyone closer together so they would have more real-time conversations about patients because that's how we felt we would get the best information."

Since its embedding projects started, Mayo has decreased specialty visits by 20 percent and reduced testing rates,

Crane said. "We're more efficient. We're saving money on testing, but we're also getting sick patients where they need to go faster."

At Kaiser Permanente Colorado (KPCO), initiatives to integrate primary and specialty care physicians include electronic advice referrals, real-time virtual consults through secure electronic communication, and the institution of primary care liaisons.

The liaisons work with specialty practices to strengthen relationships and interactions, said Ann Wells, MD, KPCO's director of chronic care solutions. "Most specialty departments have a primary care provider liaison," Wells said. "The liaison works with the department to improve communication, review evidence-based guidelines, and problem solve issues that may come up. For example, decreasing inappropriate referrals or reviewing access issues."

KPCO also has an integrated delivery system with a common electronic medical record, Wells said. Physicians can ask for advice or referrals from most specialty providers and see all notes generated or labs ordered from all providers through this system.

Meanwhile, a serious shortage of health providers with expertise to treat complex chronic conditions in New Mexico led to a unique program at the University of New Mexico Health Sciences Center (UNMHSC). Project ECHO, which stands for Extension for Community Healthcare Outcomes, expands the capacity of primary care clinicians in rural and underserved areas to treat complex conditions, such as hepatitis C.

Before the project launched, hepatitis C patients across the state were not getting timely care, said Sanjeev Arora, MD, director of Project ECHO and a founder of the university's Hepatitis C Disease Management Program.

No primary care physicians in the state were treating hepatitis C, and patients waiting to see Arora had an eight-month wait, he said.

"The people were coming to see me very late with liver cancers and liver failure," he said. "I knew if I had seen them earlier, we could have cured them. This was leading to a lot of unnecessary deaths."

Through Project ECHO, specialists at UNMHSC are put in contact with primary care clinicians through regular teleECHO clinics to discuss patient cases and receive didactic training. The goal is for primary care clinicians to become comfortable delivering complex, specialty-level care directly to patients.

Since the project began, the self-efficacy of primary care physicians in the program has gone through the roof, as shown in a 2010 study in *Hepatology*, Arora said. In addition, doctors' professional satisfaction rates have gone up, while professional isolation rates have been reduced. Patient outcomes have also improved.

Project ECHO has now been replicated at 70 major universities and in 12 countries. The goal is to touch the lives of 1 billion people by 2025.

"We're trying to start a movement to show that knowledge is not the property of just a few experts," Arora said. "Academic medical centers have a unique opportunity to democratize their knowledge and share it freely and to take responsibility to change the workforce. That would really improve the health care system in a major way."

To read more: [www.aamc.org/primaryspecialtycare](http://www.aamc.org/primaryspecialtycare)

# Push to Provide High-Value Care Takes Root in Medical Training

—By Kim Krisberg, special to the Reporter

*Editor's Note: Throughout 2016, the Reporter will explore how medical schools and teaching hospitals are educating the next generation of physicians in an environment of discovery and innovation.*

A man in his 50s is scheduled for a medical procedure for a painful umbilical hernia. Even though he is otherwise healthy, he has a distant history of asthma, so his physicians order a chest X-ray.

That X-ray suggests a lung abnormality so the hernia operation is cancelled. During follow up with a CT scan, the lung abnormality turns out to be a false alarm, but the scan finds a spot on the adrenal gland. To sort that out, the patient receives another CT scan, which shows the spot is benign. Months later and with his medical costs mounting, the patient finally gets the hernia operation.

According to Brandon Combs, MD, an assistant professor in the Division of General Internal Medicine at the University of Colorado School of Medicine, this true-life story is emblematic of the challenges of delivering high-value, cost-conscious health care. "This whole course of events is not uncommon," he said.

In response, Combs, along with Tanner Caverly, MD, MPH, now a fellow and clinical lecturer at the University of Michigan Medical School, decided to turn such cases into teaching tools. In 2012, they officially launched the Do No Harm Project, which uses clinical vignettes to raise awareness about medical tests and procedures that may not be necessary and spark conversations about high-value care.

The Do No Harm Project began at the Denver Veteran Affairs Medical Center, a teaching site affiliated with the University of Colorado. Once a month, all trainees there have an opportunity to submit medical overuse stories to the Do No Harm story repository, now nearing 100 submissions. Trainees who participate receive a day free from clinical duty to write their stories. Today, Do No Harm is integrated into two longitudinal clerkships at the University of Colorado. The program also inspired the Teachable Moments series in *JAMA Internal Medicine* and, with the support of the Lown Institute, is encouraging medical schools across the country to launch similar efforts.

"We think this whole process of talking and writing about medical overuse can change behavior and lead to higher-value, higher-quality care," Combs said. "This is where the narrative meets the science."

The Do No Harm Project is part of a growing movement to educate medical students and residents better about high-value care and cost-conscious care. While growth in per capita health care spending slowed in recent years, U.S. health care spending still increased 5.3 percent in 2014 to \$3 trillion, according to new data published in January in *Health Affairs*. And because physicians have a singular role in ensuring such costs align with high-value care—care that balances benefits, costs, and harms—innovative curricula and efforts are popping up across the country.

At Mayo Medical School, education in delivering high-value care is part of the new Science of Health Care Delivery curriculum. Stephanie Starr, MD, co-director of the new curriculum, described this education as the "third science" after basic and clinical sciences.



**"We think this whole process of talking and writing about medical overuse can change behavior and lead to higher-value, higher-quality care."**

— Brandon Combs, MD  
University of Colorado School of  
Medicine

"There's a gap between what health care professionals need to understand beyond basic and clinical science," Starr said. "Without that third science, the other two won't be as impactful as they could be."

The required curriculum, which began this year for first-year students at the college's Rochester, Minn., campus, is spread over four years and also covers health care policy, economics, and technology; leadership; person-centered care; team-based care; and population-centered care. Starr said students are especially eager to hear from practicing clinicians on how they balance the complexities of delivering higher-quality, lower-cost care, when the definition of value can differ wildly depending on the stakeholder.

"There's nothing black and white about medicine," Starr said. "But it's clear that folks need to understand this challenge early in their training."

At Vanderbilt University Medical Center, residents are taking the lead in dismantling the myth that more care is better. Meghan Kapp, MD, MS, resident physician in the Department of Pathology, and Wade Iams, MD, chief medical resident, are co-chairs of a resident-led Choosing Wisely initiative. Launched in 2012 by the American Board of Internal Medicine Foundation and *Consumer Reports*, Choosing Wisely aims to reduce unnecessary medical tests and procedures. At Vanderbilt, Kapp, Iams, and

their fellow residents decided to zero in on one particular Choosing Wisely recommendation: decreasing daily laboratory tests.

Iams said that in addition to institutional data showing that daily blood draws could be safely reduced by up to 40 percent, house staff could easily rally around this goal—it saves time and prevents unnecessary pain and cost for the patient. However, instead of taking a top-down approach, the residents used education and data feedback to spur culture change. They refrained from identifying what constitutes a "necessary" lab and instead encouraged staff to think more critically about a test's necessity within the unique context of each patient, Kapp said.

Under the initiative, which began at Vanderbilt in 2014, patients receiving daily labs decreased from upward of 95 percent to about 60 percent. "It definitely makes me think more upstream—about why I'm doing what I'm doing," Iams said. "Ultimately, it comes down to the individual patient and what matters most to him or her."

For Nilay Patel, MD, a cardiology fellow at Massachusetts General Hospital (MGH), it was clear during his early training that cost was a mounting concern, and yet he wasn't receiving any specific education on how to be a "better steward of our resources," he said. In response, during his internal medicine residency at MGH in 2013, he sent out a short survey to fellow residents. He discovered that while many thought about cost and value on a daily basis, few felt knowledgeable on the topic.

In 2014, Patel received an AAMC Clinical Care Innovation Challenge Pilot Award to develop a high-value care curriculum for internal medicine residents that included lectures, small-group conferences, and one-on-one teaching with faculty advisers, as well as an awareness campaign promoting five Choosing Wisely recommendations. Patel said early data show that participating residents are more comfortable thinking about cost of care and feel better equipped to deliver high-value care. "By being critical, you can really optimize value," he said.

*MedEdPORTAL® provides free access to educational tools and resources about high-value care in medical training. Visit [www.mededportal.org](http://www.mededportal.org) to learn more.*



# Teaching Medical Students to Integrate Electronic Medical Records into Patient-Centered Care

—By Stephen G. Pelletier, special to the *Reporter*

Technology like the electronic medical record (EMR) has transformed health care delivery with about 83 percent of office-based physicians using some form of an EMR at the end of 2014, according to the Office of the National Coordinator for Health Information Technology. But bringing a computer into the exam room is an adjustment for both doctors and patients. A recent study in *JAMA Internal Medicine* suggests that when clinicians consult their computers too often during patient exams, patient satisfaction declines.

Teaching medical students how to use EMRs and other technology now common in patient interactions has become a new necessity in medical education. According

to Richard Frankel, PhD, a professor of medicine at the Indiana University School of Medicine, having a computer in the exam room is akin to introducing a third party to the doctor-patient relationship, so training needs to take that into account.

“I think everybody would agree that there are some great benefits to having an electronic health record, but what hasn’t been taken into account are the social and emotional costs of having the computer in the exam room,” Frankel said. His research found that physicians can sometimes interact with the computer rather than the patient as much as 80 percent of the time during the exam. “And patients, of course, notice that,” he added.



With a grant from the Arnold P. Gold Foundation, Alkureishi's team conducted a literature search and talked with experts to pinpoint how technology affects physician-patient communications, patient satisfaction, and the overall doctor-patient relationship. According to a resource on the AAMC's MedEdPORTAL® site, researchers suggest teaching students how to start a patient visit without technology and how to educate patients about the value of having a computer in the exam room. Their findings inform a one-hour lecture for second-year medical students at Pritzker on how to use EMRs in a manner that keeps the focus on the patient, not the computer.

In an observed structured clinical encounter (OSCE) one week after the lecture, students work in a practice area of the school's EMR system. They assess a virtual patient's medical history and practice a clinic visit while using the EMR. Students end their second year with a refresher lesson, at which time, Alkureishi said, "we really advocate

curriculum," said Margaret S. Chisolm, MD, an associate professor of psychiatry and behavioral sciences at Johns Hopkins Medicine. But she noted that if this training is introduced early, it needs to be reinforced later.

Early in medical school, Chisolm said, "students are more likely to focus on the mechanics of the technology, because that is so daunting, and less on how to integrate it." The most appropriate point of contact for "just-in-time learning," she believes, is after students start their clerkships. Students can then apply the training to "the real-life barriers that they are encountering." Chisolm believes that training also should be a high priority and part of the orientation curriculum for medical residents, as well as for faculty.

Faculty members from Pritzker were, in fact, part of a team that recently offered a four-hour continuing medical education session at the Cleveland Clinic on

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**“Having a computer in the exam room is akin to introducing a third party to the doctor-patient relationship, so training needs to take that into account.”**

— Richard Frankel, PhD  
Indiana University School of Medicine

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that students build what we call their tech toolkit and seek ways that they can use this technology with patients in a very mindful, collaborative, and educational way.”

Alkureishi said this curriculum has been effective for improving EMR use. "Learners agree it's important and should be required. Their self-perceived levels of knowledge and confidence [in using EMR effectively] increased as a result." Alkureishi is quick to add, though, that "the real measure we want to look at is whether, in the eyes of patients, clinicians' ability to use the EMR in a patient-centered manner improves." Pritzker offers similar training to interns in internal medicine and pediatrics and to faculty.

Indiana's Frankel would like to see physicians and medical schools adopt a protocol he developed to help manage how physicians use computers in the exam room. He calls the method POISED: prepare, orient, information gathering, share, educate, and debrief. Within this model, doctors first prepare by reviewing an EMR before seeing a patient, then orient the patient by explaining how the computer will be used during the appointment. After information gathering, the physician should share the data that appears on the screen with the patient. Doctors can use that computer data to educate the patient, which often leads to discussions that reinforce good health habits and positive behaviors. Finally, doctors should debrief by finding out how much and how well the patient understood the information. This often prompts doctors to reflect by asking, for example, "Did I get this right?"

#### **Different teaching approaches**

"Medical schools absolutely need to make patient-centered use of the electronic medical record part of the

patient-centered EMR use. Pritzker has partnered with Epic, the maker of the software used, so trainees can access information easily about the mechanics of the EMR and how to optimize the functionality to have the most positive impact on patient care and the patient experience.

Medical educators at Hopkins have developed checklists to help trainees remember best practices for EMR use. Tips include letting patients view their EMRs on the screen and explaining the value and benefits of the technology. Trainees are also taught to turn away from the computer completely when sharing sensitive or difficult information with the patient.

One of the challenges in teaching medical students how to use EMRs in a patient-centered way is the lack of evidence-based standards for such curricula. The Alliance for Clinical Education recommends that medical schools develop a clear set of EMR competencies. Medical educators would like to see more definitive and explicit guidelines related to expectations for teaching students to use the EMR effectively. Alkureishi added that mandatory training on how to use EMRs appropriately when interacting with patients is rare in medical schools, but she noted that many medical educators believe such training should be a requirement.

"When you ask physicians what is most satisfying about being a physician, it's never ever about the technology," Frankel said. "They always say it is the relationship that they have with their patients. We don't want to lose that kernel of what makes the profession worthwhile. To do that, we need to give the technology its due but also to balance that against the relationships that physicians develop with their patients."

One of the institutions that has introduced EMR training and is teaching best practices is the University of Chicago Pritzker School of Medicine. Students there watch a video that illustrates the wrong way to use EMR technology—the doctor faces a computer, with his back to the patient, throughout an office exam.

"We have a responsibility to teach trainees patient-centered technology use, but there is little in the way of curricula and training on this," said Maria Alkureishi, MD, assistant professor of pediatrics and director of pediatric clerkship at Pritzker. Alkureishi and her colleagues are pioneering curricular material to help train medical students to avoid communication barriers technology can introduce during a patient's exam.

# Convenience Revolution Transforms Care, Poses Questions for Academic Medicine

—By Alicia Gallegos, special to the *Reporter*



At the ClickWell Care clinic run by Stanford Health Care Alliance, patients need only a mobile device or phone to visit a primary care doctor.

The virtual clinic is “open” throughout the day, on weekends, and during evening hours to allow for flexible appointments. Patients can e-meet with wellness coaches to discuss health goals or request an online review of home health data.

The clinic was developed to meet the needs of patients who find it difficult to attend in-person appointments, said Sumbul Ahmad Desai, MD, vice chair of strategy

and innovation and a clinical assistant professor at Stanford School of Medicine. The clinic coordinates with Stanford specialists and includes the option of in-person appointments with ClickWell doctors.

“It’s been pretty successful,” said Desai, who helped launch the clinic in early 2015. “Because we offer in-person visits...we’ve had better uptake. We started off with 1,000 patients, and now we’re up to about 2,500.”

The Stanford clinic is part of a growing trend toward health care that is easier to navigate and more convenient for patients. Retail clinics, direct-to-consumer care, telehealth, and virtual visits are some of the ways that providers are meeting patients’ on-demand expectations. According to a 2015 article in the *New England Journal of Medicine*, there are 1,900 retail clinics nationwide. The movement—dubbed the convenience revolution—is



transforming the way health care is delivered, financed, and researched, according to medical experts.

Various drivers are fueling the new surge of alternative delivery models, said Ateev Mehrotra, MD, a health care policy professor at Harvard Medical School who researches delivery innovations.

“Patients are struggling to get into primary care offices” he said. “At the same time, societally, what we expect as a reasonable wait has changed in an era of 24-hour banking and grocery stores that never close. What might have been a reasonable wait time 20 years ago now doesn’t seem so reasonable.”

But the boom of new health care delivery models could have significant implications for academic medicine—both positive and negative—experts say. The movement is raising important questions about quality, education, and the standard of care.

“Academic medical centers [are] trying to figure out what the right protocols are,” Desai said. “How do we train the next generation of physicians to be able to interact with these various new modalities to be able to offer convenient care? It is a different way of practicing.”

For academic medicine, a primary challenge of the convenience movement is accepting the culture change that follows, according to Ronald Dixon, MD, who directs the Virtual Practice Project at Massachusetts General Hospital (MGH). The Virtual Practice is a combination of tools aimed at improving patient-physician communication, including a patient portal.

“A lot of this requires more team-based care,” he said. “You have to trust nurse practitioners and retail practitioners, and you have to trust online systems. More people may be looking at your data and looking at your flags as opposed to you seeing all the data yourself. That’s a big change in culture and perspective.”

### Rise of the retail clinic

Over the last two decades, retail clinics have popped up in stores and pharmacies across the country. According to a 2015 Robert Wood Johnson Foundation (RWJF) report, nearly 11 million patient visits occur annually at retail clinics nationwide, making such clinics a common staple in the health care landscape.

CVS MinuteClinic has led the way. Since its inception as QuickMedx in 2000, the MinuteClinic now has more than 1,000 locations, which have registered more than 28 million patient visits. Open seven days a week, the clinics offer evening, weekend, and holiday hours and accept most health insurance plans.

But like other alternative delivery models, retail clinics are raising concerns among the academic medicine community about the potential for fragmented care.

“From the academic community, we hear the concern that this is going to disrupt primary care relationships in an era when people are really emphasizing better coordination of care,” Mehrotra said. “These [clinics] are judged to be going in the opposite direction and leading to more fragmentation of care.”

Research shows patients who visit retail clinics are more likely to go back and less likely to visit their primary care physician, he added. The argument is that primary care

homes are more focused on preventive care and disease management, Mehrotra said.

But Andrew Sussman, MD, president of CVS MinuteClinic and executive vice president and associate chief medical officer for CVS Health, stressed that CVS MinuteClinics are not just brief stops for acute illnesses.

“In term of services, we have expanded our acute illness services, but the real growth is in our prevention and wellness portfolio,” he said. “We believe MinuteClinic can play a vital role in helping patients monitor their numbers for chronic diseases like diabetes, hypertension, and hyperlipidemia, while working closely with their primary care provider to report their results.”

CVS MinuteClinic is also broadening its affiliations with hospital systems and academic medical centers, Sussman said. It now has more than 60 such collaborations, including partnerships with Cleveland Clinic, UCLA Health, and Emory Healthcare.

“In every case, we are working to integrate our [electronic health record] systems to facilitate the exchange of patient records and improve continuity of care,” Sussman said.

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## The convenience revolution is transforming the way health care is delivered, financed, and researched.

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Affiliations between retail clinics and health care systems are growing as more academic medical centers look for ways to join the convenience revolution, Mehrotra said. To date, more than 100 such partnerships have been formed, according to a RWJF report.

The mentality has shifted from distancing teaching hospitals from alternative providers to that of, “If you can’t beat them, join them,” he said.

Other health centers are creating contractual relationships with telehealth companies or developing their own patient tools and clinics.

“We see a huge variety of different options,” Mehrotra said. “The perspective of many larger academic health systems is that these convenience options are a way to get new patients in their system.”

### A changing financial paradigm

Along with changing delivery, the convenience revolution is likely to affect how health care is financed, noted Dixon. In the future, Dixon envisions less participation by insurers and more engagement with patients at MGH.

“I think there will be more transactional and consumer involvement in routine convenient care and less third-party payer involvement,” said Dixon. “Price point will become a key issue and therefore more transparent.”

To remain competitive, more health plans will probably engage with service models that offer convenient care, Desai added.

Health plans already are incorporating convenience structures within their offerings. BlueCross BlueShield

of Minnesota, for example, has created an accountable care-like product with Allina Health Network (AHN) that combines AHN’s network with other providers, including retail clinics. AHN is accountable for the total cost of care for members attributed to its network, including costs incurred at retail clinics.

Meanwhile, telehealth service LiveHealth Online offers patients live video visits that are covered in-network by health insurer Anthem, although patients do not need to be Anthem members to use the service.

The health plan also was the first to include live video visits as a standard benefit for Medicare Advantage members, said John Jessor, vice president of provider engagement strategy for WellPoint and general manager of LiveHealth Online.

“Anthem health plans specifically look to LiveHealth Online as one of the many ways to respond to individual consumer needs for convenience, access, and affordability,” Jessor said.

He noted that with LiveHealth Online, the net reimbursement to doctors is similar to that of net

reimbursement for office visits. The cost of these visits is lower for consumers because there is less office overhead, he said.

### The revolution and research

There are mixed opinions about how the rise of alternative delivery systems will affect health care research. Mehrotra believes the new models will expand research possibilities and allow for evaluation of diverse data.

“We have started to see some of the retail clinic data being used for research as [retail clinics] have a unique database across hundreds of sites around the country,” he said. “But I don’t see this as a notable change from the type of research others are doing.”

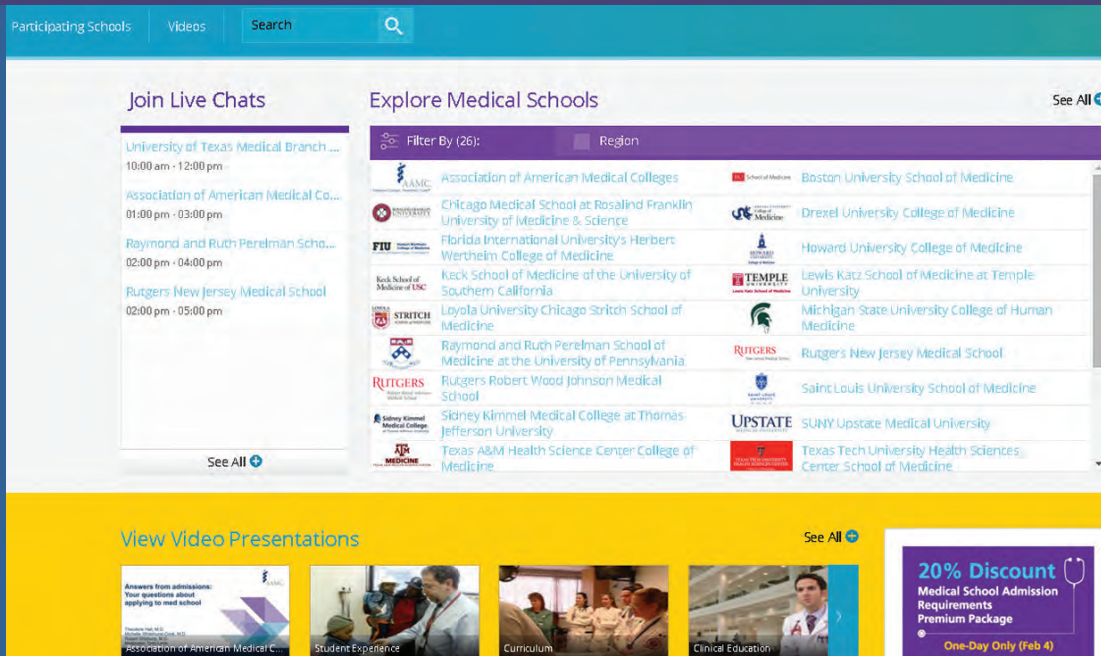
However, Dixon anticipates clinical research will begin to incorporate more consumer experience and satisfaction-based research methodologies.

Researchers will now spend time validating new methodologies of care, Desai noted. Stanford Health Care Alliance recently launched a digital health center focused on the validation, implementation, and outcomes of convenience programs. “It’s an exciting time for research in this domain,” she said.

The convenience revolution is not slowing down anytime soon, Dixon said. “We now have to be comfortable with knowledge sharing, informing patients, continuous access, and education. That’s a change that’s going to come slowly to academic medicine,” he said.

## AAMC Medical School Virtual Fair Attracts Thousands to Pilot Event

—By Robin Warshaw, special to the Reporter



There were no free pens in school colors or glossy brochures to take home, but thousands of prospective medical students eagerly logged on to participate in the AAMC’s first Medical School Virtual Fair on Feb. 4. After three years of planning and with 25 medical schools participating, the pilot event drew 6,195 attendees.

The new recruitment approach is a natural extension of other efforts, including traditional in-person fairs. “Students are in the online environment, and it’s where they’re comfortable. It’s meeting them on their platform,” said Rebecca Rice, AAMC director of service outreach.

A virtual fair helps students and schools connect by mobile phone, laptop, or desktop, so that no travel expenses are incurred and no time is taken away from classes or work. It also allows both sides a broader range of discovery. Through an online event, students can easily explore schools in any geographic location and medical colleges may gain a more diverse applicant pool.

“This could be one of the more effective ways of reaching a large number of individuals at any one time—much larger than when we are stationed at a particular location,” said Theodore Hall, MD, associate dean for admissions at the David Geffen School of Medicine at the University of California, Los Angeles. He wanted his institution to participate because “visibility was my number-one goal.”

Pilot schools represented different regions and both public and private institutions. Each school at the virtual fair had a “booth,” or webpage, for posting downloadable information, along with videos about such topics as its programs, mission, and student life. A live chat between attendees and admissions representatives appeared on each school’s page, with questions and answers visible to everyone. Schools staffed the live chat for part or all of the fair’s eight hours.

The AAMC booth had 10 staffers who answered thousands of questions from 2,077 visitors about applying to medical school. “We were able to guide people, correct misinformation, and keep them from taking missteps,” said Tami Levin, AAMC director of premedical and applicant resources. The online format made it easy to share direct links, she added. “Today’s applicant wants information immediately.”

The fair attracted attendees from all 50 U.S. states, as well as from around the world. “It certainly was a chance to talk to a lot more applicants than we do at an in-person

fair,” said Emily Hines, admissions director at Saint Louis University School of Medicine. “At regular fairs, you have lulls. In this [virtual] one, people were chatting all the time. We hope to see some of those applicants in this cycle or the next few cycles.”

### The student takeaway

At times, it was hard to keep up with the live queries. Of the prospective students who attended the virtual fair, 15 percent asked five or more questions. Hall said he was “initially overwhelmed” by the volume of attendees and chat interactions. “We had 3,114 exchanges between our staff and students, and we had 1,869 participants come to our webpage and talk to us,” he said.

The virtual venue offered unique benefits. Students could request private chats with admissions staff, for example. Such a conversation often dealt with academic or personal challenges or postgraduate work. “It gave [potential applicants] the opportunity to share specific information they might not be comfortable discussing face-to-face,” said Mercedes Rivero, MS, assistant dean for admissions at Rutgers New Jersey Medical School. After the virtual fair, booths remained open for a month, with some offering more chances for live chatting.

Some students at the fair were current applicants who had not yet heard from participating schools and used the opportunity to make contact. “It was impressive to see them leverage this to provide new information in support of their candidacies,” Rivero said. That initiative earned three waiting applicants an interview invitation at Rutgers.

The virtual fair made it easier for New Jersey resident Vanessa Pizutelli to consider West Coast schools and learn about scholarships and ways to handle costs. Pizutelli, who has a master’s degree in biomedical sciences and attended in-person fairs as an undergraduate, saved information from about 20 schools in an electronic file, which she found more efficient than organizing print material from traditional fairs. In the virtual format, she said, “you can focus on the schools.”

Stephanie Radu, a University of South Florida junior, prepared for the event by looking at the colleges’ videos and AAMC webinars about the application process. The *AAMC Pre-Med Navigator* newsletter also published virtual fair tips for students. During the fair, Radu learned how school cultures fit with her research interest and the volunteer work she wants to continue in the homeless community. She used contact information to follow up with questions.

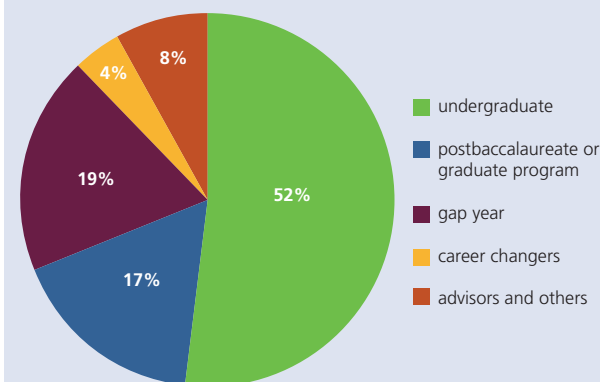
“For a pre-med student, one of the most common misconceptions is that you’re applying to every school and just trying to get into one,” she said. “[The virtual fair] justified my interest in some programs and also justified my disinterest in others.”

Sarah Zinamon, a graduate of the University of Pennsylvania and gap-year attendee, had applications at a few of the schools. She learned from others’ live-chat questions and asked her own about research mentorships and decision-making schedules. “[The fair] was good and useful in giving you access to representatives,” she said.

The pilot provided important lessons that will be incorporated into the planning of any future fairs. Organizers are reviewing feedback from participating medical schools about their experiences and looking at ways to improve and expand the event. After pilot results have been analyzed, plans for a possible 2017 virtual fair will be considered.

### AAMC Virtual Fair At a Glance

6,195 attended the virtual fair



22% of attendees visited 10 or more schools

Average school pages visited:

6.8

# Practice Makes Perfect: Health Systems Take Pledge to Implement Volume Restrictions

—By Rebecca Greenberg

Peter Pronovost, MD, made an unsettling discovery while caring for one of his patients at Johns Hopkins Hospital in Baltimore. Upon reviewing her history, he learned she had undergone an esophageal cancer resection at a nearby hospital that had performed only one such procedure in the past two years. She was now in critical condition and being treated for numerous surgical complications.

“Were you told about the risks?” Pronovost asked his patient, an elderly African-American from a low-income background. “Did you know that [the hospital] had only done one? Were you told that you might have a better outcome if you had gone across town?” Her answer to all of these queries was “no.”

Because the damage to her trachea was irreparable, the woman soon died. The case left a lasting impression on Pronovost, who as a quality and safety expert understood the dangers associated with low surgical volumes.

“There was no excuse. We’ve known for many years that both surgeon and hospital volumes are related to outcomes,” he said. “The evidence is quite clear that people would have better care if we addressed it.”

More than three decades of peer-reviewed research supports the connection between patient outcomes and how frequently a procedure is performed. An analysis last May in *U.S. News & World Report* included calculations by John Birkmeyer, MD, a leading quality and safety researcher and executive vice president of Integrated Delivery System at Dartmouth-Hitchcock Medical Center. His data suggest that as many as 11,000 deaths between 2010 and 2012 could have been prevented if the patients had gone to hospitals performing a higher number of procedures, including cardiac bypass surgery and elective hip and knee replacements.

“Whether you are a golfer or musician or purveyor of any complicated task, there certainly is proficiency with repetition and practice. There is also scientific evidence that shows that surgeons who do a procedure more often have better dexterity and technical skill,” Birkmeyer said. Apart from the operating surgeon, he added, the anesthesiologist, the nurses, and other members of the operating room team work in a more coordinated fashion if they do the same procedure over and over again.

## The volume pledge

After being consulted for the *U.S. News* analysis, Birkmeyer and Pronovost, who directs the Armstrong Institute for Patient Safety and Quality at Johns Hopkins Medicine, decided to work together to support the use of volume restrictions. In May they launched “Take the Volume Pledge,” a campaign to limit certain surgical procedures to hospitals and surgeons that perform a minimum number of them.

Dartmouth-Hitchcock, Johns Hopkins, and the University of Michigan Health System are part of this effort, pledging to restrict 10 surgical procedures—including gastrointestinal, cardiovascular, and joint replacement surgeries—to hospitals and surgeons that meet set



volume thresholds. Thresholds range from 10 per hospital and 5 per surgeon for carotid stenting to 50 per hospital and 25 per surgeon for hip and knee replacements.

“Most of our attention now is focused on local implementation and establishing policies and procedures, but at the same time there has been a considerable amount of interest in this area from other hospitals and other health systems that recognize that this is just a common sense idea and one with obvious benefits for patients,” Birkmeyer said.

Despite growing interest in the quality implications of applying volume standards, the initiative is not without controversy. Some assert that surgeons and surgery departmental leaders are better able to determine who is qualified to perform procedures than a rigid volume standard and view this initiative warily as a threat to autonomy. Others express concerns that it could create a barrier in access to surgical care for some populations. This is especially true at rural hospitals where the requirements might not be realistic or practical.

“Rural areas have unique issues and people from those areas are the best ones to figure them out,” Pronovost acknowledged. Still, he believes those who have access to large urban health centers should be directed to a high-volume hospital for certain procedures.

Pronovost recalled that while his patient with the unsuccessful resection surgery was in intensive care, rounds were stalled as medical students, residents, and fellows discussed how the tragedy could have been avoided. “It became an hour-long moral discussion about whose responsibility it was to address this,” he said.

During rounds, the group considered if individual surgeons should disclose the number of procedures they have performed on patients directly, if it should be up to

the credentialing hospitals to vet surgeons based on the number of surgeries they have performed, or if regulators such as Centers for Medicare and Medicaid Services should set guidelines.

“The reality is you probably need leadership accountability where all three of those levels work in concert,” Pronovost said. “The point is you should have a threshold—you shouldn’t be able to do just one or two [of certain procedures]. There is a lot of preventable harm that we could do something about.”

Most would agree that the burden should not be on patients to probe for this information. “The poor and disenfranchised, and those with low health literacy generally, are unlikely to know to ask these questions and may have little sense of choice in surgeons and hospitals,” said Scott Shipman, MD, MPH, director of primary care initiatives and workforce analysis at the AAMC. “This initiative aims to ensure that everyone receiving surgical care within these health systems will receive care by a physician and a hospital with adequate and ongoing experience.”

Quality and safety advocates at the three “pledge” hospital systems are working with numerous organizations to change the procedures regarding volume standards “to make it simpler for other hospitals to follow suit,” said Birkmeyer.

He noted that higher-volume hospitals have the infrastructure in place to manage patients in the event that they develop surgical complications. “[High-volume hospitals] have better staffed intensive care units, more advanced imaging capabilities, and readier access to different types of specialists who can manage patients who get sick with complications after surgery. So there are a variety of complementary reasons why higher volume is associated with better outcomes,” he said.

# In Brief

## NIH Finalizes Strategic Plan for Fiscal Years 2016-2020

The National Institutes of Health (NIH) recently released *NIH-Wide Strategic Plan, Fiscal Years 2016–2020: Turning Discovery Into Health*. The plan focuses on four objectives: advancing opportunities in biomedical research, fostering innovation through NIH priority setting, enhancing scientific stewardship, and developing the “science of science” to excel as a federal science agency. The last time the agency went through a strategic planning process was in 1991. According to the NIH, this plan is designed to highlight the “crosscutting nature of the NIH institutes, centers, and offices” and help optimize processes, enhance stewardship, and identify major trans-NIH themes as the agency “strives to turn scientific discoveries into better health.” For information: [www.nih.gov/sites/default/files/about-nih/strategic-plan-fy2016-2020-508.pdf](http://www.nih.gov/sites/default/files/about-nih/strategic-plan-fy2016-2020-508.pdf)

## Journal Article Examines Challenges of U.S. Physician Workforce

A recent article published in the *American Journal of the Medical Sciences* examines the size, distribution, and composition of the physician workforce in the United States and its future challenges. The article provides an overview of the current state of the workforce and graduate medical education (GME), a brief history of calls for GME reform since 1910, and the recent discussions about the workforce projections. The authors are AAMC Executive Vice President Atul Grover, MD, PhD; AAMC Chief Health Care Officer Janis Orłowski, MD; and former senior director of the AAMC Center for Workforce Studies Clese Erikson, MPAff.

## New Resource Offers Best Practices to Increase Transparency

Teaching hospitals have a new online resource that highlights best practices for delivering clear information on pricing and data to patients so they can make informed decisions about the health care services they receive. Under the direction of the 2014–2015 Advisory Panel on Health Care, the AAMC developed the resource to help educate staff and residents on how to communicate this information so that patients can better identify out-of-pocket costs and determine the value of services. To learn more, visit [www.aamc.org/pricetransparency](http://www.aamc.org/pricetransparency).

## New Report Examines Social Risk Factors in Medicare Payment Programs

The National Academies of Sciences, Engineering, and Medicine has released the first of five reports from a committee convened to identify the social risk factors affecting health outcomes of Medicare beneficiaries and how to account for these factors in Medicare payment programs. In the report, *Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors*, the committee describes the results of a literature search linking social risk factors to health-related measures of importance to Medicare payment and quality programs. The committee considered certain factors, such as socioeconomic position, race, ethnicity, cultural context, and social relationships, and concluded these factors do have an influence on health use, cost, and outcomes. For information: <https://www.aamc.org/MedicareSocialRisk>

## Academic Medicine: Article Examines Innovative Course Integrating Social Medicine and Global Health

A recent article published in *Academic Medicine* examines an innovative course for first-year students at Harvard Medical School that integrates social medicine and global health. Covering these two disciplines in one course helps students learn how social factors such as education and income affect health outcomes within the context of the challenges facing health care in the United States and abroad. The course allows students to observe the effects of health inequalities by exploring Boston neighborhoods on foot and learning how to advocate for patients to shape local, national, and global health policy. According to the article, 64 percent of students who completed a post-course survey reported a deeper understanding of social medicine concepts and their relevance for clinical practice in the United States and abroad. For information: <https://www.aamc.org/globalhealthcourse>

## Register Now for the AAMC Health Workforce Research Conference

Registration opens in early March for the AAMC’s 12th Annual Health Workforce Research Conference. Scheduled for May 5–6 in Chicago, the conference is the premier opportunity for researchers, educators, and policymakers to meet and discuss state and federal workforce issues. This year’s theme is “Getting to the Workforce We Need.” The conference will feature a keynote speech from Vivian Lee, MD, PhD, MBA, University of Utah senior vice president for health sciences, dean of the School of Medicine, and CEO at University of Utah Health Care. The meeting also will include plenary panels on health workforce issues such as telehealth, emerging health professions, and state and specialty workforce issues. For information: [www.aamc.org/data/workforce/meetings](http://www.aamc.org/data/workforce/meetings)

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## AAMC Calendar: March and April 2016

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|---|---|--|--|
| <b>29–31</b><br><b>Group on Regional Medical Campuses Spring Meeting</b><br>Washington, D.C.<br>Information: Melanie Fronhofer<br>mfronhofer@aamc.org<br>202-741-5502 | <b>6–8</b><br><b>FOCI Academe (Forum on Conflict of Interest in Academe) Meeting</b><br>Fairmont Olympic, Seattle, Wash.<br>Information: Ronalyn Teodoro<br>rteodoro@aamc.org<br>202-909-2002                         | <b>13–16</b><br><b>2016 AAMC National Professional Development Conference for Institutional Advancement</b><br>Arizona Grand Resort & Spa<br>Phoenix, Ariz.<br>Information: Shana Brand<br>sbrand@aamc.org<br>202-828-0417 | <b>8–9</b><br><b>2016 Northeast Group on Educational Affairs (NEGEA) Retreat Brown University</b><br>Providence, R.I.<br>Information: Alexandra Chirico<br>achirico@aamc.org<br>202-741-6456 |
| <b>April 1–2</b><br><b>2016 Being a Resilient Leader</b><br>AAMC Learning Center<br>Washington, D.C.<br>Information: Alexa Peal<br>apeal@aamc.org<br>202-828-0467     | <b>28–30</b><br><b>2016 Leadership and Management Foundations in Academic Medicine and Science</b><br>AAMC Learning Center<br>Washington, D.C.<br>Information: Alexandra Chirico<br>achirico@aamc.org<br>202-741-6456 |  |  |