The Future of Medical Education: Transforming the Health of Our Communities

AAMC Annual Meeting

November 5, 2012
Speakers
Fitzhugh Mullan, MD
Malika Fair, MD, MPH, FACEP
Gerald Clancy, MD
Karen DeSalvo, MD, MPH, MSc
Beyond Flexner: Social Mission in Medical Education

Fitzhugh Mullan, MD

November 5, 2012
Social Mission Defined

The social mission of medical education is the contribution of a medical school in its mission, programs, and the performance of its graduates to addressing the critical and unmet health problems of the society in which it exists.
MEDICAL EDUCATION
IN THE
UNITED STATES AND CANADA

A REPORT TO
THE CARNEGIE FOUNDATION
FOR THE ADVANCEMENT OF TEACHING

BY
ABRAHAM FLEXNER

WITH AN INTRODUCTION BY
HENRY S. PRITCHETT
PRESIDENT OF THE FOUNDATION
Flexnerian Challenges

• Science largely missing in medical practice
• Absence of standardization in medical education
• Competing sects of medical practice
• Rampant commercialism in medical education
• “Incredibly foul” medical schools
• Quality missing in medical education
Flexnerian Realization

- Closing of “foul” schools
- Medical education firmly implanted in research universities
- Quality assurance of medical education
- Standardization of medical education
- Medical education embedded in academic health center values
- Science and technology
- Orthodoxy
Flexner on University Medical Departments

“The basis for which we have urged for medical education gives undoubted advantage to university medical departments….for the moment, the difficulty of procuring anywhere else the necessary educational foundation is the most cogent (reason).”
Contemporary Challenges

• Access – 50 million Americans without insurance

• Distribution – Huge variation in availability of physicians from area to area

• Quality – Systemic problems with quality of care

• Cost – Expense of US system is now a drag on national economy
“Traditional” Social Mission Movements in Medical Education

- Diversity/minority admissions
- Community medicine
- Primary care
- Rural medicine
- Social medicine
- Medicine and public health
Emerging Social Mission Issues in Medical Education

- Health Disparities
- Social determinants in health
- Interprofessional education
- Cost management
- Generalism
- Geographic accountability
What can a school do?
Social Mission of Medical Education: Ranking the Schools

Background: The basic purpose of medical schools is to educate physicians to care for the national population. Fulfilling this goal requires an adequate number of primary care physicians, adequate distribution of physicians to underserved areas, and a sufficient number of minority physicians in the workforce.

Objective: To develop a metric called the social mission score to evaluate medical school output in these 3 dimensions.

Design: Secondary analysis of data from the American Medical Association (AMA) Physician Masterfile and data on race and ethnicity in medical schools from the Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine.

Setting: U.S. medical schools.


Measurements: The percentage of graduates who practice primary care, work in health professional shortage areas, and are underrepresented minorities, combined into a composite social mission score.

Results: The contribution of medical schools to the social mission of medical education varied substantially. Three historically black colleges had the highest social mission rankings. Public and community-based medical schools had higher social mission scores than private and non-community-based schools. National Institutes of Health funding was inversely associated with social mission scores. Medical schools in the northeastern United States and in more urban areas were less likely to produce primary care physicians and physicians who practice in underserved areas.

Limitations: The AMA Physician Masterfile has limitations, including specialty self-designation by physicians, inconsistencies in reporting work addresses, and delays in information updates. The public good provided by medical schools may include contributions not reflected in the social mission score. The study was not designed to evaluate quality of care provided by medical school graduates.

Conclusion: Medical schools vary substantially in their contribution to the social mission of medical education. School rankings based on the social mission score differ from those that use research funding and subjective assessments of school reputation. These findings suggest that initiatives at the medical school level could increase the proportion of physicians who practice primary care, work in underserved areas, and are underrepresented minorities.

Primary Funding Source: Josiah Macy, Jr. Foundation.

For author affiliations, see end of text.
# Medical Schools Social Mission Score, Primary Care, HPSA and Minorities

<table>
<thead>
<tr>
<th>Rank</th>
<th>School Name</th>
<th>State</th>
<th>Social Mission Score</th>
<th>% Primary Care [std score]</th>
<th>% HPSA [std score]</th>
<th>URM School State (Nation) Ratio [std score]</th>
<th>School URM %</th>
<th>State (Nation) URM %</th>
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<td>Rank</td>
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<td>State</td>
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<td>% Primary Care [std score]</td>
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<td>URM School:State (Nation) Ratio [std score]</td>
<td>School URM %</td>
<td>State (Nation) URM %</td>
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<td>3.6%</td>
<td>26.5%</td>
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</table>
Social Mission Modalities

- School mission statement
- Pipeline cultivation
- Student admissions
- Structure and content of curriculum
- Location of clinical experience
- Tuition management
- Mentoring and role modeling
- Preparation for residency
Beyond Flexner

- Study
- Conference
- Network
- Papers
- Website
- Fellowship
- School-by-school
Beyond Flexner Website

medicaleducationfutures.org/projects/beyond-flexner
Social Mission Defined

The social mission of medical education is the contribution of a medical school in its mission, programs, and the performance of its graduates to addressing the critical and unmet health problems of the society in which it exists.
Beyond Flexner: Models for the Future of Medical Education

Malika Fair, MD, MPH, FACEP

November 5, 2012
Beyond Flexner Study

AT STILL SCHOOL OF OSTEOPATHIC MEDICINE IN ARIZONA

MOREHOUSE SCHOOL OF MEDICINE

NORTHERN ONTARIO SCHOOL OF MEDICINE

OKLAHOMA UNIVERSITY SCHOOL OF COMMUNITY MEDICINE

SOUTHERN ILLINOIS UNIVERSITY SCHOOL OF MEDICINE

UNIVERSITY OF NEW MEXICO SCHOOL OF MEDICINE
AT STILL School of Osteopathic Medicine in Arizona

1. Community Campuses
2. Regional Directors of Medical Education
3. Apprenticeship Model
4. Unique Admissions Strategy
Morehouse School of Medicine

1. Primary Care and Underserved Emphasis
2. Number one in Ranking Study (Mullan, 2010)
3. Over 25 Pipeline Programs
4. Catch-up Excellence
Northern Ontario School of Medicine

1. Community Engagement
2. Integrated Curriculum
3. Cultural Immersion Experiences
4. Longitudinal Primary Care Experience
Southern Illinois University School of Medicine

1. URM Recruitment and Pipeline
2. Rural and First Generation Recruitment
3. Home Family Medicine Rotation
4. Institutionalized Community Service
University of New Mexico School of Medicine

1. Improve and Measure Health Outcomes
2. BA/MD Program
4. Community Immersion Experiences
University of Oklahoma School of Community of Medicine

1. Leader and Champion
2. Importance of Philanthropy
3. Next Generation Curriculum: Interdisciplinary and Medical Informatics
4. Financial Incentives for Service
AT STILL SCHOOL OF OSTEOPATHIC MEDICINE IN ARIZONA
MOREHOUSE SCHOOL OF MEDICINE
NORTHERN ONTARIO SCHOOL OF MEDICINE
OKLAHOMA UNIVERSITY SCHOOL OF COMMUNITY MEDICINE
SOUTHERN ILLINOIS UNIVERSITY SCHOOL OF MEDICINE
UNIVERSITY OF NEW MEXICO SCHOOL OF MEDICINE
Transforming the Health of Our Communities ...... During this Cycle of Health Reform

Reaching for Health Equity in the “Reddest of Red States”

Gerard P. Clancy, MD  President, University of Oklahoma, Tulsa
November, 2012
## Ranking of States by Primary Care Access Challenge Index

Leighton Ku et al, George Washington University, Feb 2011, NEJM

<table>
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<th>State</th>
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### Commonwealth Fund 2012, Overall Health System Performance - Top 10% and Bottom 10% Cities

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<th>Overall Rank</th>
<th>Local Area</th>
<th>Population Count</th>
<th>Access</th>
<th>Primary Care</th>
<th>Hospital Quality</th>
<th>Nursing Home</th>
<th>Other</th>
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### Top 10% of Local Areas

- Fargo/Moorhead, MN, ND
- Honolulu, HI
- Hartford, CT
- Portland, ME
- Iowa City, IA
- San Luis Obispo, CA
- Worcester, MA
- Madison, WI
- Springfield, MA
- Lebanon, NH
- San Jose, CA
- Des Moines, IA
- Providence, RI
- Rochester, NY
- Sioux Falls, SD

### Bottom 10% of Local Areas

- Metairie, LA
- New Orleans, LA
- Paducah, KY
- Lake Charles, LA
- Tyler, TX
- Memphis, TN
- Tulsa, OK
- Gulfport, MS
- Houston, TX
- Joplin, MO
- Commerce, TX
- Hattiesburg, MS
- Oxford, MS
- Monroe, LA

### Source

Source: Commonwealth Fund Scorecard on Local Health System Performance, 2012.
Legislative AND Market Driven Reform

Today Curve:
- Compete for insured
  - Volume
  - Procedures
  - Specialty Care
  - Hospital Care
  - FFS negotiations

“Rough Waters”

Tomorrow’s Curve:
- “Too many” insured
  - System Performance
  - Quality Payment
  - Transitions, Efficiency
  - Bundling of Payment
  - Shared Savings

Health Care Revenue


$ Fee For Service
$ Shared Savings
$ FFS, $ Capitation

“Rough Waters”

2012 AAMC Annual Meeting
Oklahoma: “The Reddest of Red States”

December 2010

- The Economist, NPR
  - Keith Gaddie, OU Professor, *Red State Rising*…”Oklahoma is the Reddest of the Red States”
- Rural Town Hall Meeting
  - Who do you really work for? Who sent you here? You are a fear monger. Poor people are just stupid.

April 2011

- Declined $54M health insurance exchange Early Innovator grant from HHS.

June 2012

- Delayed decision on Medicaid expansion.
The Decision to go “All In”

- Oklahoma’s condition demanded action.

- Health reform legislation offered new models for care and medical education and funding for start-up of these new models.

- Went “All In” for every HHS grant that would help transform the health of our community → Reaching for Health Equity.

Going “All In” in Poker:

- Bet all of your chips on one hand.
- Used when you have a great hand OR when you need to gamble to catch up.
School of Community Medicine: Expected Trends in Transformation

Rate of Transformation

Clinical Services

Education

Research


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Quietly implementing our “All In,” ACA assisted, 5 Piece Puzzle to transform the health of the community:

1. Assessment:
   - Community Needs Assessments → Honest about health disparities.

2. Primary Care:
   - More, Better Model and Better Payment

3. From Care Fragmentation to Care Coordination:
   - Greater Attention to Highest Cost Patients

4. Improve Safety and Efficiency and Reduce Duplication
   - Community-wide Health Information Exchange

5. New Medical Education Models for a New Era of Care
   - Beyond Flexner Movement
9 Major Infrastructure Grants as Levers of Change for a New Clinical and Therefore Teaching Environment

1. **Patient Centered Medical Homes**
   - Federal / State – Oklahoma Medicaid - Tier 3 status and Health Access Network designation (1 of 3 in OK, copied North Carolina)
   - Blue Cross Blue Shield of Oklahoma (only Oklahoma practice).
   - Federal - Comprehensive Primary Care Initiative national demonstration projects (1 of 7 nationally).

2. **Complex Patients:**
   - Federal - Planning grant for most complex patients (1 of 15 nationally).

3. **Health Information Exchange**
   - Federal - Implementation grant for regional health information exchange (1 of 17 nationally).

4. **Health Workforce**
   - Federal - Physician’s Assistant Program expansion.
   - Federal - Physician’s Assistant Program team care modeling.
   - Federal - Teaching Health Center program to expand Primary Care Residencies at FQHCs.
1. Community Needs Assessment: Health and Health Care Deserts

Clinical Services Distribution

40% of Population has access to 4% of Physicians

Age-Adjusted Death Rate in Tulsa

14 year difference in Life Expectancy
2. **Better Primary Care: Better Payment for Primary Care**

**Primary Care Initiative (CPCI):**

- Medicare, Medicaid, Blue Cross Blue Shield of Oklahoma and Community Care of Oklahoma all pay better for Patient Centered Medical Home Primary Care.

- Payors use same standards for Patient Centered Medical Home qualification, same rules for payment.

- Primary care physicians from across the community eligible.

- Tulsa - 1 of 7 national pilot sites.

- Medical School as the initiator and facilitator of the collaboration. Medical student and resident clinics as well.

*Source: Centers for Medicare & Medicaid Services*
3. Moving from Fragmentation to Coordinated Care

Partnership with Oklahoma Health Care Authority / Medicaid:

- Mature Patient Centered Medical Home practices can receive a bump in payments for care coordination duties of patients across the community.
- Medical school practice was first across the state to pilot model.
- Several physician groups have handed off care coordination duties to medical school program.
- Medical school patients with lower ER utilization, better medication adherence and higher use of generic medications.
3. Greater Attention to High Cost Patients

ACA driven Planning Grants for Dual Eligibles

- Nationally, 9M dually eligible (qualify for both Medicare and Medicaid), costing $319B per year.
- 1 of 15 planning grants across nation.
- Regional care coordination program with additional payments to care coordination specialists in complex patient populations.
- Medical School leads:
  - Outreach psychiatric and rehabilitation team care of those with most severe mental illnesses. Save $15,000 / patient / year in avoided hospitalizations.
  - Palliative Care teams – LOS reduced by 2 days.
4. Regional Health Information Exchange

Beacon Communities grant for Regional Health Information Exchange:

• 1 of 17 national pilots, $12M to Tulsa

• ~ 100 distinct health care organizations part of the MyHealth Health Information Exchange.

• Medical school wrote grant, staffs grant and is CEO of MyHealth - Health Information Exchange but not PI.

• Continuous Care Document – patient basics available to all providers across, adding detail.
  • Change treatment plan 3 out of every 5 patients seen

• 75,000 secure web-based primary care / specialist consults – reduced face to face evaluations by 35%.
5. Medical Education Models

- **Explicit Intentions** – Our commitment to improve the health of entire communities, with focus on underserved populations:
  - **Recruitment into Our Track** – past experience in service, future as change agents, excited about future.
  - **Loan Re-Payment Program** - $25K / year in exchange for care of the poor, no matter specialty, no matter location. Full scholarships for MPH.
  - **First Experiences in Medical School** – Summer Institute as an Intro to the “Anatomy of the Community” Community interviews, Poverty Simulations.
  - **Extensive Student Run Free Clinics (Bedlam):**
    - Interdisciplinary teams (PCMH) since 2003 – incorporated OU colleges of medicine, nursing, pharmacy, public health and social work
    - Acute care and longitudinal care.
  - **Extensive Use of Health Information Exchange for Patient Population Management** – (e.g. Pentaho).
  - **Pragmatic Care of the Poor within Curriculum:**
    - Poverty Simulations,
    - Prescribing, transportation, social determinants of health.
    - Well versed in health care systems (GQ).
Improving the Public's Health: Leveraging Medicine and Public Health

Karen DeSalvo, MD, MPH, MSc

November 5, 2012
Winning the Battle for the Public’s Health

Karen B. DeSalvo, MD, MPH, MSc
Health Commissioner, City of New Orleans

AAMC
November 5, 2012
Losing the battle for the public’s health

• In spite of daily devotion to the cause

• Statistics are grim
  • 38 in the world in life expectancy
  • Preterm birth increasing by a third in past few decades
  • By 2030 almost half of our population will be obese

• Spending more per capita than other industrialized nations
Louisiana at the Edge

• 49th in United Health Rankings
  • 47th in deaths from cancer

• County health rankings:
  • 60th of 64 Parishes in Louisiana

• Orleans
  • STD rates 10x national goal
  • Teen pregnancy nearly twice national average
  • 30% of population obese
  • Premature death nearly twice national rate

• Spending more per capita
Hurricane Katrina: August 29, 2005
Health System Decimated
Improve the Public’s Health
Each box contains a subgroup of the biggest box of 1000 persons. This figure includes children and reconfirms that most of the problems most people have most of the time would escape detection, analysis, and response by health care efforts restricted to hospitals and academic health centers.

Street Care to Primary Care

Grant support has enabled innovation.

Team care

Integration of social supports, mental health services

Street care to community care.

A “medical home” for the surrounding neighborhood.
Louisiana Blueprint for Health Care Reform

- Delivery Redesign to Focus on Primary Care
- Improve Quality
- Tools to Support Providers
  - Health Information Technology
- Expand Coverage
  - And realign incentives

• Very successful in many ways
• But can it improve the public’s health?

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Insufficiency of Medicine

• Interventions no longer extending lifespan

• For academic medicine, no rewards or penalties for improving the public’s health beyond the population they serve

• The incentive is for the public’s health to be poor.
  • Better bottom line, educational opportunity, research opportunity

• Wealth making, not health making
Public Health as Solution?

- Accountable to the entire public
- Assess, assure and policy make
- Can serve as neutral convener
  - Facilitate, link and leverage
- Business model not entirely predicated on sickness
Old Idea

Hippocrates, 4th century B.C.

• Urged physicians to pay attention to the environmental, social, and behavioral context in which illness occurs

1910, Flexner:

• Urged physicians “not to forget that directly or indirectly, disease has been found to depend largely on unpropitious environment.” These conditions—“a bad water supply, defective drainage, impure food, unfavorable occupational surroundings”

• “doctors have the duty “to promote social conditions that conduce to physical well-being.”
Premature Mortality (50% of outcomes)
- years of potential life lost - YPLL

General health status (50% of outcomes)
- self-reported fair or poor health

Health Outcomes

Health Determinants

Health care (10% of determinants)
- Access to care
- Quality of care

Health behaviors (40% of determinants)
- Tobacco
- Diet and exercise
- Alcohol use
- High risk sexual behavior
- Violence
- Education
- Income
- Social disruption

Socioeconomic factors (40% of determinants)
- Air quality
- Water quality
- Built environment

Physical environment (10% of determinants)

Source: University of Wisconsin Population Health Institute
Devolution of Public Health

• Public health extended life expectancy
  • Basic hygiene
  • Social determinants addressed (housing/TB)
• Medicine became the panacea
  • Drugs, devices, interventions extended life span
• Initially supportive relationship
• Functional separation in the post-World War II era
  • Advent of antibiotics, procedures
• Public health developed marginalized population focus
Insufficiency of Public Health

• Antiquated laws and structures better designed to tackle yellow fever than obesity or violence

• Still using public health nurse model
  • Individual v. systems and policy

• Dramatic variability in funding, form, function, reporting, and capability across the nation

• Using stale data

• Programmatically focused with limited innovation funds
Insufficiency of Public Health

• Lack of trust – Tuskegee Studies and regulation
• Dramatically underfunded.
• 4% goes to public health
  • In the US, $251 compared to the $8086
• And the funding continues to decline
• Locally seeing budget cuts
  • 8% in New Orleans again – 46% in past 2 budget cycles
  • $4.44/pp/py in general funds per person
  • $46/pp/py with program funds
Opportunity from Crisis

• Don’t despair
• Rising costs of health care prohibitive
• Affordable Care Act opportunities
• Population data available in real time
• Political will
• Robust prototypes
• Medicine and public health
• in major transformation again
• Let’s give the children their 5 years back
IOM Report

• Integrate Primary Care and Public Health
• Opportunity for data, population health planning, etc.
• Two weak sisters
• Needs to be more comprehensive and include all of medicine – especially academic health centers

IOM, Primary Care & Public Health Exploring Integration to Improve Population Health, March 2012
Winning the Battle
Integration of public health and medicine

- Agenda setting
- Data sharing
- Workforce training
- Reward and recognition
- Aligned financial risks and rewards

IOM, Integrating Primary Care and Public Health, March 2012; JF Williams, Acad Med. 1999; Academic health centers can bridge the gulf between medicine and public health.
Innovating in New Orleans

• Transform Public Health Department
  • Convene
  • Facilitate, link, leverage
  • Primary care
• Data sharing and acquisition
• Fitness/obesity and its consequences
Thank you.

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