AMA Innovations in Medical Education Webinar Series
Health systems science: The third pillar of medical education

Richard Hawkins, MD
Stephanie R. Starr, MD
Jed D. Gonzalo, MD
Joy H. Lewis, DO, PhD
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Your MISSION is Our MISSION
Today’s Host

• Richard Hawkins, MD, Vice-President, Medical Education Outcomes, American Medical Association
Objectives

• Discuss the emergence of health systems science as the third pillar of medical education

• Learn about the integration of medical education and health care systems through health systems science curricula

• Discuss the systems navigation curriculum as an authentic example of health systems science curriculum

• Discuss how to integrate students in the community to be trained in identifying social and economic factors which affect health and wellness
Health Affairs

Gaps In Residency Training Should Be Addressed To Better Prepare Doctors For A Twenty-First-Century Delivery System

Francis J. Crosson1,*, Jean Leu2, Beth M. Roemer3 and Murray N. Ross4

1American Hospital Association, Chicago, Illinois
2American Hospital Association, Washington, DC
3American Hospital Association, Washington, DC
4American Hospital Association, Washington, DC

The American Hospital Association (AHA) has identified several gaps in residency training that need to be addressed to better prepare doctors for a twenty-first-century delivery system. These gaps include:-

1. **Workforce:** There is a need for a more diverse and flexible workforce that can adapt to the changing healthcare landscape.
2. **Financing:** New methods of financing are required to support the delivery of high-quality care.
3. **Leadership:** There is a need for more effective leadership at all levels of the healthcare system.
4. **Social Accountability:** The emphasis on social accountability has led to changes in the way healthcare is delivered.
5. **Alignment:** Alignment between medical education and medical practice is crucial to ensure that the healthcare system is delivering the best possible care.

In conclusion, it is time to address these gaps and implement the necessary changes to ensure that doctors are well-prepared to meet the challenges of the twenty-first century.
AMA Accelerating Change in Medical Education
Goals:

• Create competency based assessment & **flexible individualized learning plans**

• Develop exemplary methods to achieve **patient safety, performance improvement and patient centered team care**

• Understand the **health care system and health care financing**

• Optimize the **learning environment**
Accelerating Change in Medical Education Initiative

- $13.5 million in grants to medical schools
  - 11 schools in 2013
  - 21 schools in 2016
  - 19,000 students ~ 33 million patient visits each year

- Consortium formed to jumpstart and speed dissemination of ideas
  - Venue for collaboration, innovation and scholarship
AMA Accelerating Change in Medical Education Consortium Innovation Themes

• Integration of medical education and health care systems
  • Emergence of Health Systems Science
• Technology in support of learning and assessment
• Competency-based programming
• Workforce solutions to improve population-based care
• Metrics to support CQI of educational programs
• Faculty development: Coaching and quality improvement
• Envisioning the learner of the future
Integration of Medical Education and Health Care Systems

- Engagement of health systems leaders in developing curricula
- Early integration of students
  - Emergence of “Health Systems Science” (HSS)
  - Value-added roles for medical students (and faculty)

Health Systems Science – “the principles, methods, and practice of improving quality, outcomes, and costs of health care delivery for patients and populations within systems of medical care”
- Patient population management
- Health care disparities
- Informatics
- Healthcare financing structures
- Epidemiology of errors
- Quality improvement science

↓

- Leadership / change management
- Root cause analysis
- Working in teams
- Care coordination
- Care transitions
- Error disclosure
- Using HIT, EHR....
Integration of Medical Education and Health Care Systems

AMA Innovations in Medical Education Webinar Series
Presenter

• Stephanie R. Starr, MD
  Director, science of healthcare delivery education, Mayo Clinic School of Medicine
Presenter

• Jed D. Gonzalo, MD
Associate professor, medicine and public health sciences; Associate dean, health systems education, Penn State College of Medicine
Joy H. Lewis, DO, PhD
Professor, chair of department of public health; Director of public health programs & practice-based research, A.T. Still University School of Osteopathic Medicine in Arizona
Health Systems Science Education at Mayo Clinic School of Medicine

Stephanie R. Starr, MD
Associate Professor of Pediatrics
Director for Science of Health Care Delivery Education
Mayo Clinic School of Medicine

Your MISSION is Our MISSION
Science of Health Care Delivery ≈ HSS
Four-year SHCD curriculum required for MD

- Class of 2019+ (MN)
- Class of 2021+ (AZ)
- Blended learning (74 online modules) + classroom, simulation, clinical experiences
- Yr 1 (4 wks), Yrs 2 – 4 (1+ wk each)
- High-Value, Cost-Conscious Care and Shared Decision-Making ‘threads’ into Yr 3
- Standardized pt scenarios (OSCE), SHCD milestones
- Option for + 12 credits to = ASU Masters in SHCD

Value = quality of care ______ cost of care over time
HVCC Care curriculum

Step 1: Understand risks, benefits, and costs of interventions
Step 2: Decrease interventions of minimal/no value
Step 3: Choose interventions that maximize value
Step 4: Create plan incorporating patient’s values & concerns
Step 5: Identify systems-level opportunities to improve value

EBM = evidence-based medicine
SDM = shared decision-making

ABIM-ACP model
Smith Annals Int Med 2012;157:284-6
SHCD Milestones: For UME

- Adapted from 2013 GME milestones
- Mapped to AAMC EPAs
- Intentional ‘hand-off’ UME to GME

Committee views each student’s progression over time

Havyer  *BMC Med Ed* 2017;17:145
Student Assessment

- Workplace assessments
  - OSCE, QI project design, systems error analysis
  - Projects, case-based responses, reflections
  - MCQ questions in modules; NBME HSS exam
Curriculum evaluation

- Student-of-course feedback
- NBME HSS exam (starting 2017)
- Year 4 AAMC graduation questionnaire
- *In progress*
  - Annual curriculum evaluation
  - Graduate survey
  - Program director survey
- SHCD-related scholarship by students (*future*)
Reflections on 4-year HSS curriculum

HSS is broad; students need to see connections

- across HSS topics
- within HSS topics at different levels (individual provider, microsystem, macrosystem)
- across basic, clinical and HSS (*in vivo* to *in vitro*)

You may have more existing HSS at your school than you know (‘orphan’ preclinical topics); work is to

- intentionally choose HSS scope and outcomes for your school
- label existing HSS content
- close HSS curricular gaps
Health Systems Science and Value-Added Medical Education

Jed Gonzalo MD MSc
Associate Professor of Medicine and Public Health Sciences
Associate Dean for Health Systems Education
Penn State College of Medicine
### Health Systems Science Competencies

**Systems-Based Practice:**
Demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.

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<tr>
<th>Functional Competencies</th>
<th>Foundational Competencies</th>
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<td>Patient-Centered Care</td>
<td>Systems Thinking</td>
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<td>Processes and Collaboration</td>
<td>Change Agency and Management</td>
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<td>Clinical informatics, data, tools</td>
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<td>Population and public health</td>
<td>Leadership</td>
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<td>Policy and payment</td>
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<td>Value-based care</td>
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<td>Health system improvement</td>
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Are Medical Students an Asset or Liability?

“Value-Added Medical Education:” Experiential roles for students in practice environments that have the potential to positively impact individual patient and population health outcomes, costs of care, or other processes within the health system, while also enhancing student knowledge, attitudes, and skills in Clinical or Health Systems Science.
How Can Medical Students Add Value?

<table>
<thead>
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<tbody>
<tr>
<td>History-taking</td>
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<td>Evidence-based medicine</td>
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<tr>
<td>Patient education</td>
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<td>Patient advocates</td>
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<td>“Care Extenders”</td>
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<tr>
<td>Clinical process extenders</td>
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<td>Safety Analysts</td>
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<td>QI Team Extenders</td>
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<td>Population Health Managers</td>
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<tr>
<td>Research and systems projects</td>
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<td>“Systems” Projects</td>
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HSS Curricular Continuum

Year 1
- SHS711 - Science of Health Systems; Patient Navigator Roles (n=150 students)

Year 2
- SHS721 - Science of Health Systems Course (n=150 students)

Year 3
- Integrated Clerkship HSS Exercises (several pilots)

Year 4
- SHS743 - Translating Health Systems (n=150 students)
- HSS Electives (Interprofessional Academy Elective, Population Health Elective)

GME
- Core HSS Curriculum (4 hours across all GME programs)
- HSS Resident Course (1-week immersive course, n=40)

Faculty
- Health Systems Science Academy (Year 1 - n=14, Year 2 - n=29)
- Health Systems Science Seminar Series
Systems Navigation Curriculum

- Patient Navigation
  - Experiential component
  - Prepares students for practice
  - Fosters relevance and motivation

- Health Systems Course
  - Conceptual component
  - 41 clinical sites/5 systems
  - "New bench" of mentors
  - 100+ contact hrs
  - "New bench" of educators

Prepares students for practice
An Example – Internal Medicine Clinic

**Team:** 2, 1st-year students, care manager, social worker, physician mentor

**Case:** 84F with multiple comorbidities with “no show” rate. Through in-clinic discussions, calls, and home visits, students learned the patient’s ex-husband, was an alcoholic, and her primary means for transportation. In her cluttered apartment, she had fallen 3x during the past year, each resulting in a fracture. Students helped facilitate:

1. A motorized wheelchair,
2. In-home ramp,
3. Walk-in shower, and,
4. Dependable source for transportation.

Students helped the patient apply for public assistance, and advocated for her while she was in clinic. Following visits, students educated the patient about her treatment plan, and confusing areas. Students determined moving to a nursing home was financially unfeasible. Although she qualified for assistance, the process of approval would be lengthy. Students reached out to local churches to help identify in-home needs. They identified an organization willing to volunteer weekly and help her with activities of daily living, and providing an expanded social network.
Implications

1. The Expanding Educator “Bench”
   • Curriculum developers
   • Small-group facilitators
   • Large-group instructors
   • Research mentors
   • Evaluators
   • Clinical preceptors (not just physicians)

2. “New” culture required in medical education and health care
Citations

5. Gonzalo et al. Concerns and Recommendations for Integrating Health Systems Science into Medical Education. Acad Medicine 2017
17. Shea et al. Compensation to a dept. of medicine for the teaching of medical students. NEJM 96
Integrating students in the community to be trained in identifying social and economic factors which affect health and wellness.

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Thank You to the AMA and

Kate Whelihan, MPH, CPH
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Deborah M. Heath, DO

Lisa Watts, DO
Faith Polkey, MD, MPH
ATSU-SOMA Students
NACCH and our partner Health Centers
SOMA Regional Directors of Medical Education
ALL of the ATSU-SOMA Administration, Faculty and Staff
...to prepare community- and research-minded osteopathic physicians who serve the unmet healthcare needs of society through innovative, learner-centered undergraduate and graduate medical education programs. The curriculum and selection of students, faculty, and staff, are geared toward our mission of service to the underserved.
The New Physician will be able to...

- work with inter-professional teams
- use technology and data
- communicate effectively
- focus on patient-centered, preventive, primary care
- work with community members & institutions
- integrate primary care and public health
- adapt, show resilience
Unique Foundation

• ATSU SOMA is partnered with the National Association of Community Health Centers (NACHC).

• Years 2-4 students are embedded in contextual learning environments at 12 community health center (CHC) campuses.
  
  • Health Systems Science education is emphasized in authentic settings
  
  • Students are paired with role model CHC physician preceptors
Introduction to and Incorporation of the SDH OMS-I
Social Determinants of Health

- The social determinants of health are the conditions (the physical environment) in which people are born, develop, learn, work, age, receive health care, and are represented politically.

  - These circumstances are shaped by the distribution of money, power and resources at local, national, and global levels.

  - The social determinants of health largely determine health inequities - the unfair and avoidable differences in health status seen within and between different cultures.
Community Oriented Primary Care Projects

OMS-II ALONG WITH EPIDEMIOLOGY & BIOSTATISTICS
AND PGYI-III
Student-Led Community Oriented Primary Care (COPC) Projects

• One way we can **give back** to our community health center (CHC) campuses.

• Must be related to **CHC priorities**.

• Important to our shared mission with **the National Association of Community Health Centers (NACHC)**.
Community Oriented Primary Care (COPC) is an approach that integrates public health and primary care to address the health needs of a specific community. The diagram illustrates the relationship between public health, primary care, and the community.
Population Health

The health outcomes of a group of individuals, including the distribution of such outcomes within the group.

- Kindig and Stoddart (2003)

Develop and Evaluate projects directed towards the social determinants of health.
The Social Determinants of Health and the Social Determinants of Health Equity.
Why is this important?

- Improve the health of the **community**
- Impact **patients in the room** and people who do not seek care
- Chance to **engage** positively with the community
- Opportunity to engage practicing providers, faculty, students and residents in **scholarly work** aligned with their passions and ideals
4 COPC Steps

1. Define the community of interest
2. Identify the problem
3. Develop and implement interventions
4. Conduct ongoing evaluation (of process and outcome)
COPC Toolkit

TABLE OF CONTENTS

HOW TO PREPARE FOR YOUR PROJECT

The community project will follow the elements of COPC. As a team, you will identify a need, develop an intervention and plan methods for evaluating the process and the outcomes.

Each community project must focus on the social determinants of health relevant to your community and be aligned with the priorities of your CHO.

To develop your project and ensure you are meeting these standards, please start by reviewing the list of needs assessment resources. You should utilize these resources to describe the makeup of the community, identify areas of need and develop the barriers and resources to addressing the need.

You will also need to talk with CHO stakeholders. Each group is required to perform 2 interviews with each CHO, AMH, MHA, AEP, or community members.

Needs Assessment Resources

A list of needs assessment resources can be found on the following pages. Each resource is provided with a description and the website to access. Review the resources to identify what best suits your needs. You should be looking for data on the demographics of your community, the existing social determinants of health, public health measures from your CHO, and other data relevant to your interests and the needs of the community. These resources can help you identify challenges to address and populations to target in order to achieve the most successful results.

CHO Interview Form Instructions

Each project team is required to perform a minimum of 2 oral interviews with CHO stakeholders. The first interview should be with your ROSE faculty advisor who should help you identify topics off each and CHO milestones to interview. The second interview should be conducted in CHO with either a CHO, CHO, or Quality Improvement Director. The interview should be conducted in the community and CHO community. The interview must be completed by the end of the CHO interview.

After completing your 2 required interviews, draft at least 2-3 topics of interest and any potential programs or individuals you might work with. The second interview will review your topics and provide recommendations. You will then be required to bring your ideas back to the CHO interview before deciding on a topic. This step is important because it's essential to have CHO endorsement of your project. When CHO endorsement is engaged, they can provide resources and assistance.

Click the link here to access the interview form to complete. Once completed, submit your form to the assignment drop box on Blackboard. This form will be due on

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Group Expectations

- Assign roles to each team member – use your skills!
- Important to continually collaborate and communicate so all parts of the project match
Mini-Doc Program: Waianae, HI
Community Impact

Dear Big Doc's,
Thank you for teaching me things about my body and I am learning about the lungs it was cool. I hope you are getting this and I hope everyone have a good day.

Dear Doctors,
Thank you for coming to Karane Academy and teaching our 3rd grade class. My favorite activity was asthma and that thing that can infect asthma like dust.

What is a Mini Doc? A Mini Doc is a young student that is learning how to be a health expert. Don’t let their size fool you! They care about their families, friends and their community. They want to see everyone living a healthy and happy life. We hope you will let them be their “first patients” and let them leave a healthy impact.

What did I learn from my Mini Doc?
I learned to control my anger to not have a heart attack.

How do you know student:
He is my grandpa.

Student Name:

Protected
Don’t forget to bring this form back to school!!
Rotation Experiences

OMS-III AND OMS-IV
Circle the City Medical Respite Center

- **Overview**
  - 50 bed, free-standing medical respite center in Central Phoenix, AZ
  - Staffed 24/7 by nurses (RN’s/LPN’s), respite assistants, and security
  - Providers on-site 7 days/wk.
Helen Hill, DO, MPH (SOMA 2016)
PGY2 University of Missouri Kansas City,
Family and Community Medicine

In 2015

"Today I had the privilege of being able to talk to a gentleman (my patient) for almost twenty minutes. I was collecting more of his history because he was so obtunded when he presented but really I was reminded how good it was to just talk with another person on this journey we call life, and why I am becoming a physician."
When I log him into e*value, the school's logging program for patients, he will be reduced to "hypertensive crisis, sleep apnea, pacemaker, obesity, and substance abuse". I wish we could log "insufficient resources" or "experiencing homelessness" or any of a number of social challenges he faces that compromise his health. He isn't able to hold a job because he falls asleep when he sits. Why? Because his sleep apnea is so bad he doesn't sleep, he chronically desaturates and then wakes up when his brain realizes it is not getting enough oxygen. If he had stable housing he would be on CPAP at night. But to have stable housing you have to have income.
<table>
<thead>
<tr>
<th>DIAGNOSIS CODE</th>
<th>DEFINITION</th>
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<tbody>
<tr>
<td>SDH – Poverty</td>
<td>Income below poverty line; lack of basic needs such as nutrition, clothing, shelter.</td>
</tr>
<tr>
<td>SDH - Near Poverty</td>
<td>Just enough money to meet basic needs but not enough for extras. Qualifies for sliding fee discounts at FQHC.</td>
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<tr>
<td>SDH - Food Insecure</td>
<td>Does not have reliable access to sufficient quantity of affordable, nutritious food. Does not know where next meal is coming from. Might live in food desert.</td>
</tr>
<tr>
<td>SDH - Unstable Housing or Homelessness</td>
<td>Does not have permanent housing, may live on the streets, in a shelter, mission, abandoned building, vehicle or any unstable non-permanent situation.</td>
</tr>
<tr>
<td>SDH - Poor Quality Housing</td>
<td>Living in housing unit that has physical problems (deficiencies in plumbing, heating, electricity, hallways, and upkeep) or the presence of negative characteristics including evidence of rodents, water leaks, peeling paint, and absence of a working smoke detector.</td>
</tr>
<tr>
<td>SDH - Lack of or No Insurance</td>
<td>Either no health insurance or has insurance which is not sufficient to cover medical expenses or doesn’t cover medications. Prohibits seeking care or follow through.</td>
</tr>
<tr>
<td>SDH - Lack of Access to Healthcare</td>
<td>Living in a medically underserved area where access to primary care and other services is limited.</td>
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<tr>
<td>SDH - Health Literacy Limitations</td>
<td>Not having the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions</td>
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<tr>
<td>SDH - Unemployed or Underemployed</td>
<td>Being unemployed or having employment which is insufficient in some way including low pay or unavailability of hours to work.</td>
</tr>
<tr>
<td>SDH - Unstable Work Schedule</td>
<td>Difficulty scheduling or keeping appointments due to variable work schedule; multiple jobs, varying start/stop times, long shifts or unsure when will work. Person may be a migrant worker who relocates frequently due to work availability.</td>
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<tr>
<td>DIAGNOSIS CODE</td>
<td>DEFINITION</td>
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<tr>
<td>SDH - Family Care Demands</td>
<td>Responsibilities at home caring for others (children, partner, parents, family) which prevent person from caring for themselves.</td>
</tr>
<tr>
<td>SDH - Transportation Issues</td>
<td>Hard to get to appointments due to lack of transportation. Does not own vehicle, can't afford public transportation, lives far from public transportation or services unreliable.</td>
</tr>
<tr>
<td>SDH - Educational Limitations</td>
<td>Observed difficulty processing and understanding medical information. Can include difficulty reading, listening, asking questions or applying information.</td>
</tr>
<tr>
<td>SDH - Language Barrier</td>
<td>Primary language not English; inability to communicate freely and openly with provider.</td>
</tr>
<tr>
<td>SDH - Cultural Barrier</td>
<td>Cultural background is not in concordance with Western Medicine. May believe Western Medicine can be detrimental or is the place of last resort. Beliefs may conflict with medical care - prohibit patient from seeking care or adhering to treatment plan.</td>
</tr>
<tr>
<td>SDH - Immigrant Status</td>
<td>Not born in US, now living here legally or illegally. Can have difficulty obtaining public assistance if 'illegal'. May be child with legal status whose parents do not have legal status.</td>
</tr>
<tr>
<td>SDH - Poor Neighborhood Composition</td>
<td>Not feeling safe going outside in neighborhood, threat of crime/violence. Under stress from environment. Environmental pollution, lack of green space. Children can't play outside, can't exercise, hard to get to appointments.</td>
</tr>
<tr>
<td>SDH - Social Isolation</td>
<td>Lacking a sense of belonging socially, lacking engagement with others, has a minimal number of social contacts and are deficient in fulfilling and quality relationships</td>
</tr>
<tr>
<td>SDH - Other</td>
<td>Any other social determinant observed but not included here.</td>
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<tr>
<td>PROCEDURE CODE</td>
<td>DEFINITION</td>
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<tr>
<td>Crisis Intervention</td>
<td>Immediate, short-term help to resolve emotional, mental, physical, and behavioral distress or problems.</td>
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<tr>
<td>Educational Materials Provided</td>
<td>Provision of materials to help educate patients on conditions, medications, treatments, services, etc.</td>
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<tr>
<td>Extended Appointment Time</td>
<td>visiting with a patient beyond the regularly scheduled appointment time</td>
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<tr>
<td>Family Counseling</td>
<td>working with a whole family unit to improve communication, resolve conflicts and encourage changes for a healthier lifestyle</td>
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<tr>
<td>Lifestyle Counseling</td>
<td>working with a patient to improve healthy choices and discontinue habits which may be impeding health</td>
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<tr>
<td>Referral to CHC Services</td>
<td>Referral to a service offered within the CHC</td>
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<tr>
<td>Referral to External Services</td>
<td>Referral to services provided by external institutions</td>
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Only when the SDH are incorporated into the EHR can they be quantified, reviewed and fully addressed by health care providers and health systems.

Including the SDH in the EHR can enable more effective treatment of patients at the point of care and more effective population management.

Knowledge is power, and in the EHR world, the knowledge must be available in a systematic and searchable mechanism. With the ability to directly tie observed SDH factors to health outcomes for individuals and populations, future funds and programs can more efficiently and more effectively promote true health.

Education is more than assessments based on performance on an exam. It is more about what you light within the student.
How can community projects influence medical students’ education and professional lives?

Provides us with context into the current health, social/cultural and economic environment that will help us add depth to the type of health care we provide.

It is no more a figure in a book but a person we see.

It also raises more awareness and reality into what the current atmosphere of healthcare management, care and governmental involvement really is like as we prepare to jump into the fight to help improve public health policy and overall patient and community health outcomes.

- Megan Aspelund, ATSU-SOMA class of 2018
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Questions

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# Future Events

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<td><strong>Please join us</strong> to ask questions of our panelists at:</td>
<td><strong>January 2018</strong></td>
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- Integration of health systems science into medical school curricula
- Implementing systems navigation curriculum for medical students
- Integrating students in the community