Mark Masselli: This is Conversations on Healthcare I'm Mark Masselli.

Margaret Flinter: And I'm Margaret Flinter.

Mark Masselli: Well Margaret the countdown is on, the switch to ICD-10 coding in healthcare takes place October 1st and a lot of medical practices are scrambling right now.

Margaret Flinter: The much anticipated end line delays switch from ICD-9 to ICD-10 codes has generated a lot of anxiety for many practices as it significantly shifts how billions of dollars in medical claims are calculated and built every day. I think some people were still hoping for a last minute delay but that's not likely to happen and mostly I think people are prepared this time.

Mark Masselli: It's time to move on Margaret. And experts predicted most of the nation's large hospitals and medical groups whether the transition without too much difficulty but there could be some short term cash squeezes as the billing codes are switch to this new more complex coding system.

Margaret Flinter: They're much more precise and they give us a much better perspective on public health as well as individual health. The information's more details more nuance all good in a long run.

Mark Masselli: And the American Medical Association though long oppose to the switch but earlier this year they struck a deal with CMS and there will be a grace period before practices are penalize.

Margaret Flinter: And change does seem to be the operative word in healthcare, so many changes in the professional landscape that's beginning to have a real impact on medical education which is adapting to 21st century technologies and care models and thus education as well. And really causing the medical education industry if you will to reevaluate how that next generation of clinicians is being trained.

Mark Masselli: And that's something our guest today knows quite a bit about, Margaret Dr. Darrell Kirch is President and CEO of the Association of American Medical Colleges, we're looking forward to that conversation.

Margaret Flinter: And Lori Robertson will be stopping by, the managing editor of FactCheck.org she's always on the hunt for misstatements spoken about health policy in the public domain. But no matter what the topic you can hear all of our shows by going to chcradio.com.

Mark Masselli: And as always if you have comments please email us at chcradio@chc1.com or find us on Facebook or Twitter we love hearing from you.

Margaret Flinter: And we'll get to our interview with Dr. Darrell Kirch in just in moment.

Mark Masselli: But first here is our producer Marianne O'Hare with this week's headline news.

(Music)

Marianne O'Hare: I'm Marianne O'Hare with these healthcare headlines. Low does aspirin a long used preventive against heart attack and stroke has been upheld as a recommended strategy for folks at high risk of cardiovascular disease. Now it appears there's an added benefit, experts determine taking low does aspirin regularly can help prevent heart attack stroke and colorectal cancer and the benefits outweigh the risks in adults ages 50 to 60.

Exposure to air pollution however has an opposite effect, folks expose to fine particulate and aerosol pollutants have an increase risk for early death. According to a study done by NYU Langone the largest study that's come into date, it showed between 3% and 10% increase in development of cardiovascular disease and premature death through to exposure to find unseen particles and air pollution. According to the study exposure to this type of pollution is particularly lethal because it can easily slip through the lungs into the blood stream.

We're heading into flu season and according to a recent study three out of four older Americans over 60 fail to get their single shot only 65% of adults get the flu shot and 60% receive a pneumonia vaccine. Upwards of 49,000 Americans can die from flu complications in any given year according to most recent statistics. Study shows that money is a hurdle for both patients and providers that needs to be addressed.

And pot use and teens, the recent Johns Hopkins study shows pot use is actually down among American teens. 15 years ago close to 50% of American teens have reported at least some marijuana smoking, the study showed a dropped of 40% in 2013. Drug such as methamphetamine has dropped down to 3% of the population from 9% in 1999. An observers fear there will be an uptick in marijuana abuse in states like Colorado and Oregon where it's now much more readily available. I'm Marianne O'Hare with these healthcare headlines.

(Music)

Mark Masselli: We're speaking today with Dr. Darrell Kirch President and CEO of the Association of American Medical Colleges which represents all accredited US Medical Schools. Dr. Kirch served as the Dean of the Medical School and CEO of Hershey Medical Center and Penn State. A psychiatrist in neuroscientist, he served as acting Scientific Director at the National Institute of Mental Health, he's a member of the

American Psychiatric Association, American College of Psychiatrist. He has earned numerous awards for his work including the outstanding service medal of the United States Public Health Service and he earned his BA and MD at the University of Colorado. Dr. Kirch welcome to Conversations on Healthcare.

Dr. Darrell G. Kirch: Thank you so much it's a pleasure.

Mark Masselli: We happen to have both the blessings and the curse of all of the transformations that are going on in the healthcare spectrum. And, you know, in a recent speech to your colleagues you suggested that the world of medical education must be focused in on resilience during this critical juncture in healthcare. I wonder if you could share with our listeners why the other focus in on resilience?

Dr. Darrell G. Kirch: I feel and many of my colleagues feel that the rapidity of advancing science together with all the demands to develop new models for delivering care and financing healthcare together with a need to prepare workforce that's ready to work in that new environment is an unprecedented amount of change. And the reality is unfortunately the data show that a lot of physicians are experiencing what we would could burnout in the face of that. In fact there was a study published I think it was 2012 over 45% were experiencing symptoms of burnout. And then what concern me than more deeply when I read the study was they also have screening questions for depression and over 40% screened positive for depression.

So there is an inescapable conclusion here that the amount of change the rapidity of change is creating tremendous feelings of burnout depression and worse for our colleagues. I think that physicians come to medicine and prove that they are resilient people. So what I emphasized in the talking reference is the importance of cultivating their own inherent resilience remembering why they came to medicine in the first place. Developing stronger networks of support, we're putting a lot of our energy into working on that topic.

Margaret Flinter: I'm not sure I have heard a more clearing call also for the development of a teen culture in healthcare as we look at the demands on time on data all of the new technologies. And when you now think about taking all of the thing that you've learned in those very sobering statistics and applying it to the training of the healthcare professions and in your case specifically of medical students. How do you look at modifying the training to a new reality so that people are prepared for this very different healthcare system than the one that existed even ten years ago?

Dr. Darrell G. Kirch: Decades ago when I was a medical student, the emphasis was on me as an individual and on my accumulation of fact based knowledge. But now what we're realizing in medical education and training is that there are competencies beyond your sheer medical knowledge that are equally important. And so when you visit

medical schools as I do you see a lot of emphasis on patient care in skills like communication. You see a lot of attention to working within complex systems and also one of the key competencies we feel is the ability to work in interprofessional teams. Physicians of my generation were taught how to be independent practitioners. Now, we're all interdependent. The interdependences with our nursing colleagues, our pharmacy colleagues and others that's a huge culture shift. For today's student they haven't known that old culture. So I find a lot of energy and excitement among people in medical school and residency training today when they see the kind of mutual support that they can give each other and how much these teams can accomplish compared to what a single individual can accomplish for our patients.

Mark Masselli: Well we seem to have a physician shortage looming on the horizon some 50,000 to 90,000 physicians by 2025. And you noted in a recent talk that you gave at the Aspen Institute that the solution is simply not going to be found with more nurse practitioners but there's seems to be a lack of funding support for residencies and wonder if you could sort of elaborate for our listeners some of the strategies that you're working on and associations working on to create more sustainable funding residencies to meet some of the pent-up demand that's out there.

Dr. Darrell G. Kirch: Right the American population is not only growing but it is ageing. 10,000 baby boomers turn 65 every day, that is automatically guaranteeing that we face a need for increased healthcare. We feel that this is an all hands on deck problem, we definitely need to use other practitioners more carefully, we need to adopt new care models, we need to drive unnecessary testing and treatment out of the system. But even if we do those things we are concern that we will face shortages. The major funding source for residency training in this country comes from funds drawn from Medicare. And unfortunately those funds have been frozen at the same level since 1997.

We have been advocating very strongly for increasing the amount of those funds, we also advocate for programs like the National Health Service Corps that offer scholarship support in return for service in underserved areas. We feel that there need to be solutions coming from multiple fronts, we don't have doctors freeze dried on a shelf that's a long pipeline to create doctors and we need to be building that pipeline now.

Margaret Flinter: I know a number of medical schools are looking innovative ways to attract more minority group members into medicine. And there are other medical schools seeking to attract students from non-traditional pre-med majors the so called HUMEDS the humanity students who are able to transition to medical school without destroying background and the sciences and the MCATs have undergone some major revisions to ensure a more robust set of competencies for incoming medical students.

How do you see them facilitating different crop of medical students and physicians who can really meet these evolving health challenges we've been talking about?

Dr. Darrell G. Kirch: We know the evidence is clear that minority populations in our country experience worse health status on multiple indicators and we also know that people from those own minority communities who become physicians are more likely to return to those communities work with those patients and address themselves disparities. So from our perspective this isn't a political issue it's diversity and the workforce becomes very much a healthcare outcomes issue. Traditionally medicine and especially our own AMC MCAT test focused on the physical sciences exam has undergone a major revision this year to include the social and the behavioral sciences.

This has been very well received especially my patient groups that I speak with. They want physicians who have a broad perspective on their context more than just their biochemical and genetic makeup. And so we're trying to broadened the perspective at the very beginning of the pipeline with the test that students take as they apply to medical school. When I went to medical school actually I came from the humanities background I was a philosophy major, but I was a rarity now we're already seeing more and more students come from those kinds of background feeling that medicine is more than just the equations and chemical formulas and that the human side of medicine is equally important.

Mark Masselli: We're speaking today with Dr. Darrell Kirch President and CEO of the Association of American Medical Colleges which represents all accredit US Medical Schools and various other teaching institutions. And Dr. Kirch really talked about being a vehicle for transforming healthcare and the transformation of medical education and I think along with that is the rule that the academic medical centers play. And we've been blessed on our show to have a number of a very interesting guest talking about the transformations going on at their medical schools. If you could synthesize for our listeners about how we can take all this interesting transformation that's going on in a way that might help the rest of our systems benefit from the innovation.

Dr. Darrell G. Kirch: The experiences I have when I visit medical schools are very gratifying. Every campus I visit has some innovation in medical education going on, so the role we're trying to play as an association is to help all these literally thousands of medical educators who are deeply passionate people. Our goal is to help all of them create a national and even international learning community where they share this innovations with one another where technological application or a new technique in designing the classroom so called flipped classrooms where the students take a much more active role and leading their learning. We try to disseminate this through learning communities.

The combination of this really is coming up for us in a few weeks in Baltimore where we will have an annual medical education meeting that at this point looks like it will have over 2000 medical educators from North America and beyond. We've left the world where curriculum is a very static thing that was redesigned only once a decade to now there are innovations that are breaking through in a curriculum literally on a daily basis. One of the specially gratifying things is how many of them are led by our own students and residence, they're so technologically savvy, they're so creative and they're so passionate they're doing incredible things that are becoming adopted by their colleagues around the country. It's a very exciting time.

Margaret Flinter: Well we couldn't agree with you more -- we take a lot of satisfaction from seeing just how excited our students and trainees of all the health professions are and how committed they are to really creating that healthcare system of the future. But, you know, in all the visionary work we're talking about I like to get your perspective on one piece little more mundane and that's what are we doing into teach a health profession students or medical students in particular about cost, that suddenly is a area where we've been confronted with the need for so much greater transparency for the sake of patients. What's the thinking within the medical education community about really preparing the providers of the future to be able to understand cost talk about cost communicate cost with their patients?

Dr. Darrell G. Kirch: Historically we believed that considering cost in healthcare for physician was somehow even an ethical violation. But the reality is resources are finite and we need to make sure that when we are applying resources we are doing it to the right person in the right way at the right time. Now the stage has totally shifted the vast majority of our schools when surveyed in one way or another are including education teaching telling their students about tools to help them assess the cost benefit different kinds of treatments.

I would underscore that some people politically push back on this describing it as a sort of rationing. The reality is we have a huge amount of resources in the United States that we apply to healthcare 3 trillion dollars a year. The problem they aren't always well allocated, we can do a much better job without but we can't do it if we're flying blind. So this shift now is I think deeply embedded in a medical education at both the student level and the resident level. And we have an ethical obligation to do the best we can as far as many patients as possible and that means paying careful attention to our resources.

Mark Masselli: Dr. Kirch we're not the only country facing challenges and training clinicians and emerging technologies like Telehealth and online education and showing some great potential around the world. I'd be interested in your long term of vision of

where you see medical education headed not just here in America but in the global community.

Dr. Darrell G. Kirch: I've been privileged in this position to visit with associations and medical educators visit medical schools and teaching hospitals in Europe, Africa, Central America, Asia. Not too many years ago the challenge for the medical schools in Sub-Saharan Africa was obtaining text books, today now the efforts have (inaudible 18:47) to give them broad hand access they can tap into curricular materials that the AMC put online.

So as there's more and more sharing of information of curricular tools, I think it's good for the global as a whole, I think it raises the quality of medical education everywhere. I think my observation is in America just as we are leaders in science we are leaders in medical education and it's still true that people from all over the globe will come here to seek all a part of their training. Our goal as an association and the goals of our members is to be more generative and help disseminate that knowledge to the people who aren't able to come here. And I think we're in a real breakthrough period in this regard.

Margaret Flinter: We've been speaking today with Dr. Darrell Kirch President and CEO of the Association of American Medical Colleges for more information you can go to AAMC.org. Dr. Kirch thank you so much for joining us on Conversations on Healthcare today.

Mark Masselli: At Conversations on Healthcare we want our audience to be truly in the know when it comes to the facts about healthcare reform and policy. Lori Robertson is an award-winning journalist and managing editor of FactCheck.org a nonpartisan, nonprofit consumer advocate for voters that aim to reduce the level of deception in US politics. Lori what have you got for us this week?

Lori Robertson: Well we've seen republicans misrepresenting Planned Parenthood services but democrats do it too. Senath minority leader Harry Reid claims that 30% of US women get their healthcare from Planned Parenthood, not true. By one measure the number is less than 3%. More than 106 million adult women visited a healthcare professional in 2012 according to the CDC. That same year Planned Parenthood says its health centers saw approximately 3 million patients which would be 2.8% of all women who visited a healthcare professionals in 2012 not 30% as Reid said. Reid's spokesman has (inaudible 21:01) misspoke and meant to say that one in five or 20% of -- have visited a Planned Parenthood clinic at least once in their lifetime. Reid in fact have used that statistic before but that’s (inaudible 21:14) is questionable. Planned Parenthood itself said the statistic on its website but doesn’t identified the source however a Huffington Post Yougov online survey from 2013 reported that 20% of

respondent said they had personally visited a Planned Parenthood. That's not a scientific survey instead respondents are recruited through online advertising and they agree to participate in surveys. The American association for public opinion research has said that Yougov's polling method has "little grounding in theory" and that's my fact check for this week I'm Lori Robertson Managing Editor of FactCheck.org.

Margaret Flinter: FactCheck.org is committed to factual accuracy from the country's major political players and is a project of the Annenberg Public Policy Center at the University of Pennsylvania. If you have a fact, that you would like checked, email us at www.chcradio.com. We will have FactCheck.org's Lori Robertson check it out for you here on Conversations on Healthcare.

(Music)

Margaret Flinter: Each week Conversations highlights a bright idea about how to make wellness a part of our communities and to everyday lives. As the saying goes music soothes the savage beast. And according to a recent study conducted by Queen's University in Belfast, Ireland there is some empirical data to back that up. In a first of kind longitudinal study children suffering from a variety of behavioral and emotional conditions who are expose to music therapy and addition to traditional therapies have far better outcomes than those children in a control group that offer traditional therapy without music therapy.

Dr. Sam Porter: It's not a matter of them been given music or choosing music they actually make music along with music therapist assisting them. So the idea is for them to express themselves through music.

Margaret Flinter: Lead researcher Dr. Sam Porter said there's been anecdotal evidence that music improves mood in children and adolescence as well as adults. But his study reveal just how effective the music therapy was.

Dr. Sam Porter: Our primary item was an improvement in communication now there were two very interesting secondary outcomes levels of depression and levels of self esteem. And in the secondary outcomes we find a statistically significant difference between the control group and the intervention group.

Margaret Flinter: Dr. Porter says when the group gave a musical therapy it showed overtime more interaction with their surroundings and a better response to the traditional therapies as well. And he says the effects were sustained overtime.

Dr. Sam Porter: I mean that's one of the marvelous things about music therapy. It's the things that (inaudible 23:55) there are no side effects it is not a dangerous therapy to get kids involved and it is a productive way of getting kids to improve their health. That is just such a good way and a harmless way of doing things.

Margaret Flinter: The study was conducted in conjunction with the Northern Ireland Music Therapy Trust (inaudible 24:13) the promising findings as an incentive to incorporate this relatively low cost non invasive therapy into standard protocols as an additional tool to enhance outcomes for the youth population which often suffers negative side effects from a powerful medications. A simple targeted music therapy approach age appropriate and showing great advocacy and improving outcomes for young patients with lasting benefits now that's a bright idea.

(Music)

Margaret Flinter: This is Conversations on Healthcare, I'm Margaret Flinter.

Mark Masselli: And I'm Mark Masselli, peace and health.

Conversations on Healthcare, broadcast from the campus of WESU at Wesleyan University, streaming live at www.wesufm.org and brought to you by the Community Health Center.