also used as a framework for advising the Office of the National Coordinator for Health Information Technology about meaningful use of electronic health records in primary care.

Those who want to add material or references or to discuss or dispute any of its contents in a constructive way, please contact james-mold@ouhsc.edu.

The manuscript can be found at: https://www.napcrg.org/AboutUs/Committees/CommitteeonAdvancingtheScienceofFamilyMedicine(CASFM).

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From the Agency for Healthcare Research and Quality

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AHRQ UPDATES ON PRIMARY CARE RESEARCH: CARE COORDINATION MEASURES ATLAS AND DATABASE

The Institute of Medicine has identified care coordination as a key component of strategies to improve the effectiveness, safety, and efficiency of the American health care system.[1] Care coordination involves deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care. Achieving coordinated care typically involves specific care coordination activities, such as creating a proactive plan of care and sharing information across providers and sites of care, and using broad approaches that are commonly used to improve health care delivery (for example, team work and health information technology). Well-designed, targeted care coordination can improve outcomes for everyone: patients, providers, and payers. Care coordination is particularly critical for people living with multiple chronic conditions.

While the need for care coordination is clear, it can be challenging for primary care practices to assess the quality of their existing care coordination activities, identify gaps, and determine where improvements are needed. One aspect of the challenges facing practices is that there are many definitions of care coordination and few agreed-upon measures to guide implementation and evaluation of effective care coordination efforts. The Agency for Healthcare Research and Quality (AHRQ) has developed 2 resources to fill this gap:

• The **Care Coordination Measures Atlas** presents a framework that identifies key domains for measuring care coordination and their relationship to potentially measurable effects. The Atlas also measures care coordination from the perspectives of patients and caregivers, as well as from the perspectives of health care professionals and health system managers. The Atlas is available at http://www.ahrq.gov/professionals/systems/long-term-care/index.html.

• Building on the Atlas, AHRQ has created **the Care Coordination Measures Database** to further assist evaluators and researchers interested in care coordination measurement. Users can compare more than 80 validated tools and search by coordination activities, approaches, or individual perspective, eg, patient/family, health care professional, or health system representative. The database may be accessed on the AHRQ website.

For additional information about AHRQ's efforts in this area, **visit AHRQ's Care Coordination page**: http://www.ahrq.gov/professionals/prevention-chronic-care/index.html, and **AHRQ's Innovations Exchange**: http://www.innovations.ahrq.gov/. The Innovations Exchange is a one-stop resource that offers health professionals and researchers opportunities to share, learn about, and adopt a diverse array of evidence-based innovations and tools that can speed the implementation of new and better ways to deliver health care.

References

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AAFP **From the American Academy of Family Physicians**

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JUST-RELEASED CLERKSHIP STUDY: GROWING SHORTAGE OF CLINICAL TRAINING SITES CHALLENGES MEDICAL SCHOOLS

What has appeared to be solid progress toward growing an adequate US health care workforce could be derailed by an escalating shortage of clinical training sites to accommodate many of those learners.

That's the crux of the message delivered in a recently released report titled *Recruiting and Maintaining U.S. Clinical Training Sites: Joint Report of the 2013 Multi-Discipline Clerkship/Clinical Training Site Survey.* The

report is available at http://members.aamc.org/eweb/upload/13-225%20WC%20Report%20FINAL.pdf.

The report, which was jointly developed by the American Association of Colleges of Nursing, the American Association of Colleges of Osteopathic Medicine, the Association of American Medical Colleges, and the Physician Assistant Education Association, chalks up the shortage, in part, to the opening of new allopathic and osteopathic medical schools, the expansion of existing schools, and larger class sizes. (Total US medical school enrollment increased by 23% between 2000 and 2010.)

The report's authors also pointed to an explosion in the number of training programs for nurse practitioners (NPs) and physician assistants (PAs), as well as a growing number of Caribbean-based medical schools seeking US training experiences for their students.

"It's a tsunami. And this crisis is really going to hit fever pitch in a few years," said family physician Gary LeRoy, MD, associate dean for student affairs and admissions at Wright State University Boonshoft School of Medicine in Dayton, Ohio.

The survey on which the report was based explored the concerns of medical schools and NP and PA programs, all of which have students competing for invaluable hands-on clinical training.

The resulting report found that:

- Across all 4 disciplines, most respondents said finding clinical training sites for their students had become more difficult
- Most respondents said finding primary care training sites presented the greatest challenges
- More than one-half of respondents felt pressured to pay for training sites
- Many respondents had implemented nonmonetary incentives and alternative solutions to address training site shortages

Addressing the Problem in Ohio

According to LeRoy, Boonshoft could see its growth stunted as the shortage of clinical training sites limits the school's enrollment capacity. And 57% of MD-granting schools that responded to the survey face the same dilemma.

LeRoy said his medical school had methodically increased its class size every few years since 2000 to a record 110 students in 2014 in an attempt to prepare for the predicted US physician shortage. The school has made other adjustments, as well.

Still, LeRoy said he draws the line at simulation-based training sessions reportedly used by some 58% of MD schools. He said the strategy "short-changes" students.

"Medicine is a people-driven profession; our patients are at the center of it all," said LeRoy. "Even though simulators (purportedly) can teach students how to deliver a baby, put in an IV line, or how to run a code, it's a whole different dynamic when you have a living, breathing person there in front of you. Students have to be put in those real-time, real-life environments," said LeRoy.

Easing the Bureaucracy in Nevada

Family physician Thomas Schwenk, MD, dean of the University of Nevada School of Medicine in Reno, said the growth and expansion of medical schools is only part of the story.

"This goes beyond capacity issues. I actually think there's something else happening, and that is a greater appreciation for the value of community-based teaching and the engagement of community-based physicians—as well as the need to diversify the experience of students," he said.

Schwenk said he believes community physicians are looking for more than traditional perks such as parking passes or football tickets or a minimal stipend that can never really make up for the lost productivity that occurs when a physician precepts a student in his or her office.

His medical school is in the midst of creating what he called an "office of community physician faculty engagement" that will assist preceptors with all the messy issues that come with the job—from scheduling training slots to completing evaluation forms to dealing with performance issues involving student-learners.

The idea, said Schwenk, is to engage physicians through logistics and infrastructure and support. "All the physicians will have to do is what they really want to do, and that is to teach," he noted.

Getting Back to Basics in Florida

Florida State University (FSU) College of Medicine in Tallahassee is one of the nearly 20% of medical schools cited in the report that indicated they had experienced no shortage of clinical training sites.

Dean John Fogarty, MD, credited his school's unique model—with its 6 regional campuses and more than 2,800 community-based physicians—for ensuring that students have notable clinical experiences.

"Our students are in an office-based setting with a board-certified doc caring for 200 patients, and it's a 1-on-1 relationship for 6 or 8 weeks," said Fogarty. "Compare that to the typical medical student training on a hospital ward with a team where the student is the low man on the totem pole, doing the scut work, taking care of 1 to 3 patients at any given time," he added.

FSU preceptors are paid a stipend of $500 a week