# A.T. Still University School of Osteopathic Medicine in Arizona

## Beyond Flexner Site Visit Report
## Site Visit: November 7-9, 2011

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# Introduction

Beyond Flexner, a W.K Kellogg Foundation-funded study at the Department of Health Policy of the George Washington University School of Public Health and Health Services, explored unintended consequences of the Flexner Report with a focus on innovative models of medical education that address social mission. The Beyond Flexner Study began with the development of an Advisory Committee consisting of sixteen leaders in medical education and health policy. The research team and Advisory Committee identified eight core modalities that stand out as essential elements in the social mission of education, and selected six medical schools which have demonstrated a commitment to strengthen their contribution to health equity.

A.T. Still School of Osteopathic Medicine in Arizona was chosen to participate in this study because of their unique partnership with community health centers across the United States, curricular emphasis on primary care, and the successful recruitment of many students into needed specialties. A team of four individuals, Drs. Candice Chen, Arthur Kaufman, Malika Fair, and Leana Wen traveled to Phoenix for a three day visit in November 2011. This visit consisted of multiple group and individual interviews based on a standard Beyond Flexner site visit template including a site visit to El Rio Community Health Center, based in Tucson, AZ.

We would like to express our appreciation to the A.T. Still School of Osteopathic Medicine in Arizona leadership, faculty and students for their cooperation and help towards achieving the goals of the site visit. Special thanks to Dr. Thomas McWilliams for arranging a highly successful visit and for his support of the Beyond Flexner Study.

# Key Findings

### 1. Community Campuses

ATSU-SOMA students spend the second through fourth year in one of eleven community campuses nationwide based in community health centers (CHC). This is a departure from traditional Flexnerian medical education and capitalizes on the apprenticeship model. Students obtain both significant primary care exposure and specialty rotations linked with their assigned community.

### 2. Admissions

ATSU-SOMA has a unique admissions process which encourages the recruitment of students who have shown dedication to their local community health center. These are often students that have worked in the health center and when trained would be the community minded physicians they would like to employ. These applicants receive an endorsement from the health center director which fast tracks them to the interview process but does not guarantee admission. Approximately 10% of the class has received this endorsement and it is called the "Hometown program." Hometown students receive priority for their choice of community campus.

### 3. Emphasis on Community Service

ATSU-SOMA admissions process has a unique approach to weighing a student's background, altruism, and community involvement with scholastic achievement. Competitive students have a minimum of 100 community service hours (average is over 500), come from a rural or underserved background, and express values consistent with the mission of the school. They do not have a minimum MCAT score for acceptance.

### 4. Regional Directors of Medical Education

Each community campus has one or two Regional Directors of Medical Education (RDME) who serve as the primary contact person and mentor for the students during the second through fourth year. These are employed clinicians of the CHC and faculty of ATSU-SOMA that serve as mentors and facilitators for the students. Students are within these communities and their cohort of students which creates a miniature medical school of unique faculty and a peer mentoring environment.

### 5. Needed Specialties

For the first graduating class over 80% chose a career identified by CHC's as a "needed specialty" which includes all primary care fields, OB-GYN, psychiatry, general surgery, and emergency medicine.

# Background

The history of A.T. Still University is rooted in the world's first school of osteopathic medicine: the American School of Osteopathy, founded in October 1892 by Andrew Taylor Still. [1] Dr. Still

opened the school in response to growing interest in his ground-breaking osteopathic practices. The first class of 5 women and 16 men graduated in 1894, and included three of Still's children and one of his brothers.[2] In 1971, the school changed its name to Kirksville College of Osteopathic Medicine, and in 2002, it became part of the new A.T. Still University. [1] A.T. Still University is home to five schools, including the Kirksville College of Osteopathic Medicine, Arizona School of Health Sciences, School of Health Management, Arizona School of Dentistry and Oral Health, and School of Osteopathic Medicine in Arizona. [1]

The ATSU School of Osteopathic Medicine in Arizona was established in 2006, and graduated its first class in 2011.[1] When establishing ATSU-SOMA, the leadership sought to immerse their students in a learning environment that would cultivate a desire to practice in underserved areas for the duration of their career. They sought community sites that would represent all of the different community health centers nationally: urban, rural, and community migrant from all regions of the US that had large community health centers. The school partners with the following Community Health Centers and safety-net providers, which serve as Community Campuses: [3]

Sunset Park Family Health Center is based in Brooklyn, New York, and serves urban, émigré, ethnic, HIV, older adult and homeless populations in Brooklyn.

Beaufort-Jasper-Hampton Comprehensive Health Services, is located in Beaufort, South Carolina and serves rural, suburban and ethnic populations in the low-country region of South Carolina.

Alabama Medical Education Consortium is based in Troy, Alabama and represents Alabama's Community Health Centers. The consortium serves rural, suburban and ethnic populations across Alabama.

HealthSource of Ohio, is located in Milford, Ohio, and serves rural, farming, ethnic, religious and Appalachian communities across southern Ohio.

North Country/Canyonlands Community Health Center of Flagstaff, Arizona serves isolated and ethnic populations in rural northern and eastern Arizona.

Adelante HealthCare is located in Phoenix Arizona, and serves communities in central Arizona and the Southwest.

El Rio Community Health Center is based in Tucson, Arizona, and serves urban, suburban, ethnic, HIV, and homeless populations in and around Tucson.

Family HealthCare Network of Porterville, California serves suburban and farm-worker populations in the valley at the base of Yosemite National Park.

Northwest Regional Primary Care Association Campus is a regional model based in Portland, Oregon, but serving rural and urban community health centers throughout Alaska, Idaho, Oregon and Washington.

HealthPoint serves urban, suburban, émigré and ethnic populations in the east and south of Seattle, Washington.

Waianae Coast Comprehensive Health Center is based in Waianae, Hawaii, and serves Native Hawaiian, Asian and suburban populations in the northwest coastal section of the island.

## Social Mission Modalities

The remainder of this site visit report will focus primarily on the education of medical students at ATSU-SOMA and the ability of the institution to meet its stated social mission. The information gleaned from this visit provides perspective for new and expanding medical schools and suggests ways in which traditional medical schools can improve their contribution to health equity. ATSU-SOMA's strategy for meeting its social mission is described using the following modalities:

**Mission**

The mission statement reads, "A.T. Still University of Health Sciences serves as a learning-centered university dedicated to preparing highly competent professionals through innovative academic programs with a commitment to continue its osteopathic heritage and focus on whole person healthcare, scholarship, community health, interprofessional education, diversity, and underserved populations." The abbreviated Mission, related by students and faculty, was "to promote primary care service to underserved populations," and was known by virtually every group with whom the site visitors met.

The mission expresses itself in each component of the medical education program, from the selection process which favors in applicants' community service or what they call, 'heart'; to the location of learning in varied underserved settings in states across the country; to the equal and mutually-beneficial learning partnership established between the medical school and the National Association of Community Health Centers' eleven, decentralized training sites for students in years two through four.

Despite the high cost of education at this private, non-profit institution, the leadership of the institution reiterates to applicants and students that the school should be judged by its hoped-for outcomes: at least 50% of its graduates serving in an underserved community for at least part of their professional career and at least 70%-80% entering a primary care or special need career. Further, the eleven community campuses are offered a role in recommending applicants for admission. And the three year immersion of students helps students with a social commitment self-select into ATSU-SOMA.

Finally, the mission is manifest in the small group, non-competitive learning environment in the first year which is amplified in years two through four. There, students are sent to underserved urban and rural areas of the country in groups of ten which fosters a hospitable, mutually supportive milieu favorable to the learning needs and academic success of a student body of

diverse ethnic and socioeconomic makeup (particularly for Hispanic and Native American students).

**Pipeline**

With its thorough integration into CHCs, ATSU-SOMA is well-positioned to create the true 'circular pipeline', where students are recruited from underserved communities to train in the community and then return there to practice. There are a few programs in place to promote the front end of this pipeline. The Hometown program, for example, allows for CHCs themselves to nominate applicants to the school. These applicants have virtually guaranteed interviews and a much higher rate of acceptance. The school is to be commended for the thoughtful vision of this program, including keeping the criteria of Hometown nominations purposefully gray to dissuade enterprising premedical students. At the moment, less than 10% of each incoming class is estimated to be Hometown-endorsed candidates, a number that can be increased through more aggressive community outreach efforts.

A related effort to expand pipeline at the front end is the '10% advantage' program. ATSU-SOMA is now offering to each of its eleven sites the opportunity to select one of its ten students every year. In theory, this sounds like a fantastic opportunity for both the school and the site: the school can further incentivize CHCs to reach out to local undergraduate institutions, and the site can select for its own applicant who has a higher chance to return to practice around that community. In practice, though, few sites have opted for the 10% advantage thus far, and it remains to be seen what barriers may be in the way to the program's implementation.

The remainder of the pipeline initiatives appear to be less structured in nature. Students cited examples of second year community service projects that have included outreach to local high schools and colleges, as well as an initiative to allow college students to shadow them in the classroom and in the clinics. Regional Directors of Medical Education (RDME's) at each of the eleven sites have been charged with building an articulation agreement with at least one major regional institution in each site to develop pipeline programs.

The administration at both the central campus and at the CHC sites appears to be well-aware that there is much room for improvement in expanding the pipeline. Given the unique curriculum and three years of integration into diverse sites across the nation, ATSU-SOMA has the potential to implement some of the strongest pipeline programs in the nation, including mandatory engagement with undergraduate campuses and junior high/high schools around each CHC site, further encouragement of the Hometown program and the 10% advantage, and targeted programs for underrepresented minority students.

**Admissions**

ATSU-SOMA is very clear in their approach to admissions and they recruit to match their mission. Their recruitment presentation states unambiguously that their school aims to serve the underserved and promote primary care, and that the three-year integration with the CHC is a critical component to achieve these goals.

To that effect, the admission criteria are such that the "heart to serve" is a primary determinant. As one faculty member said, "we can teach them medicine, but we can't give them the heart to serve." As a result, service orientation is prioritized over MCAT scores and GPA. In fact, there is no minimum MCAT score (the admissions dean stated that he has accepted those with MCATs below 20 before), and the minimum GPA is as specified for accreditation (2.5).

Most notably, there is a quantification of service, such that service hours are literally counted. Competitive students have a minimum of 100 community service hours with an average of over 500 hours for accepted applicants. A broad definition of service is used to include not just volunteering but also working "in the trenches" such as experience as an EMT. Other factors taken into consideration include where students are from, whether it is from an underserved and rural area, and osteopathic suitability. The Hometown endorsement, as mentioned above, is an additional factor that greatly increases the applicant's success in the process.

It should be noted that admission into ATSU-SOMA is a completely separate process than into its sister campus at Kirksville, involving a separate application. Its admission criteria are also distinct. The most recent statistics of ATSU-SOMA admissions include that it has more applicants per spot than any other osteopathic school (at over 40 applicants per spot). The school interviews 450 in a blinded interview and accepts about 200 for a class of 108. The applicant pool spread is distributed widely geographically. No specific data on socioeconomic or ethnic diversity was provided, but the school readily acknowledges that more needs to be done to recruit a class that reflects the diverse composition of the communities they serve. A limitation to this goal could be lack of scholarship opportunities for underrepresented minority applicants. At the moment, the admissions committee is largely composed of faculty from the central Mesa campus. Current students are part of the recruiting process, but are not yet officially a part of the selection or interview process. Alumni are beginning to become involved, as are the site RDMEs. RDMEs, in particular, are expected to be a useful addition, as they are the faculty who are practicing in the communities, add significant diversity to the committee, and are also the faculty who will be interacting most with the students.

The admissions process is thoughtful and overall matches well with the school's mission. The school appears proud of its track record in selecting students who have heart and a passion for service, but who might have otherwise been screened out of traditional schools that emphasize MCAT/GPA scores. With the increasing number of applicants to the school, the MCAT/GPAs of its accepted students have been climbing, and we urge ATSU-SOMA to continue to look at students with lower objective scores—but who might have the "heart" they are intent on fostering. Continuing to encourage the Hometown program, the 10% advantage, and the addition of RDMEs and alumni on the admission committee, should also aid in this process.

## Curriculum

The ATSU-SOMA Curriculum is unique in two main areas: 1) The use of the Clinical Presentation Curriculum (CPC) and 2) the incorporation of Epidemiology, Biostatistics and Preventative medicine into the core curriculum.

ATSU-SOMA leadership studied various curricular models at the outset and decided to use CPC as the model for basic science and clinical training for their students. The CPC was developed at University of Calgary in Alberta in 1900's. The core schemes are based on inductive reasoning instead of the traditional deductive reasoning teaching based on a differential diagnosis. The presentations start with common chief complaints, signs, symptoms or abnormal lab values that eventually lead students down a pathway to diagnose the disorder. Each school develops their own list of presentations that they will cover throughout the medical school curriculum. This model integrates the basic and clinical sciences together without separate courses. For example, their anatomy course is taught in context with the separate clinical presentations over the first two years.

The students spend a significant amount of time in a small group setting similar to problem based learning (PBL). Given the fact that the students are distributed in the second year many of these lectures are recorded or given live via video conferencing. While both PBL and the CPC use case scenarios to teach clinical reasoning skills, the foundation of the CPC is a list of chief complaints from which all learning activities are structured and sequenced.

Adjunct faculty members are reportedly pleased with this model and the students claimed to be more prepared for their clinical rotations than students taught in a traditional curriculum with deductive reasoning. Some of this added preparation could be attributed to eight hours per week of clinical exposure for every second year student. Four of these hours are spent with a primary care physician within their assigned CHC and the other four hours are spent in interprofessional learning environments such as elder care, dentistry, and pharmacy. When asked how this curriculum aids the social mission of the school the response was that the CPC model helps improve the efficiency of the curriculum and fits well within a distributed learning model.

Epidemiology, Biostatistics, and preventative medicine have been recently added to the second year curriculum. This is a required course for all students and utilizes the team-based learning methods. Most of the exercises and projects built in to the course are related to doing community needs assessment and projects to immediately put into practice what the students are learning in this course. Before this formal addition, students had opportunities to discuss social determinants of health throughout the curriculum using journaling and reflective writing and sharing challenging social situations in patient encounters during weekly student debriefing sessions. A recent alumnus noted, "I have a greater understanding of the health system than my colleagues—because of the health policy exposure, health disparities curriculum, and the exposure to the real model of heath care systems with the CHC than peers that attended traditional medical schools."

**Location of Clinical Experience**

Clinical experience at SOMA both defines and reinforces their social mission. Clinical experiences are focused in eleven CHCs for medical school years two through four. Medical students spend their first year on the Mesa campus. For the second through fourth years, students are distributed to the community campuses based at CHCs throughout the country.

Clinical experiences start in year two with four hours per week spent with the same preceptor, most often located within the CHC, and four hours per week rotating with various professionals

and disciplines both within and outside of the CHC. Years three and four generally follow more traditional core clerkships and elective/selective rotations. Outpatient rotations are in the CHC or local community as much as possible – one CHC estimated 30-40% of the third year is spent at the CHC. Inpatient rotations are generally block rotations. However, in at least one of the CHCs, medical students on their Ob-Gyn rotation follow their patients and preceptors as they move from the outpatient to inpatient setting. Students at another CHC reported continuity in their inpatient experiences as they are located in hospitals where their CHC patients are admitted and their CHC preceptors have hospital privileges.

ATSU-SOMA provides distance education, faculty development, and funding to support educational activities (1.5 FTE RDMEs, 1 FTE administrative, 0.1 FTE osteopathic manipulation preceptor/OPP, and additional funding to support educational activities). The CHCs and RDMEs are often in the best position to identify community preceptors but this structure also ensures preceptors are chosen to be consistent with the mission of the CHC to serve the underserved.

A number of lessons can be learned from the SOMA experience. First, SOMA considered a number of criteria in selecting their CHC partners:

- Size of the CHC
- Participation in Chronic Care Collaboratives
- JACHO accreditation
- Stable leadership
- State Primary Care Association interest in the model
- Geographic (regional and rural/urban) distribution
- Diversity of populations served

At the time, they identified approximately forty potential CHC partners and report the majority of those approached were interested in partnering. The CHCs stressed the importance of establishing a true partnership built on trust – facilitated by the close involvement of the National Association of Community Health Centers and Dr. Gary Cloud of the Arizona Primary Care Association, the creation of a steering committee of the CEOs from each of the CHCs, the organizational location of the RDMEs within the CHC, and short term community campus contracts renewed at 90 day intervals with a requirement to continue teaching for 1 year if the contract is terminated. The organizational structure places significant control of the medical school in each of the community campuses. The steering committee allows CHCs to have direct access to the ATSU-SOMA leadership and establishes an expectation of accountability to the CHCs. And if all else fails, the short term contract structure allows the CHCs to walk away if ATSU-SOMA strays too far from the mission.

ATSU-SOMA has had some growing pains. Our interviews with the RDMEs suggest identifying and recruiting clinical preceptors was a challenge. One of the CHCs interviewed reported a "friends and family" approach where preceptors were largely identified through their own personal and professional connections. Another of the CHCs reported they had more difficulty, in part related to competition in the area with a large University based medical school. Most report over time, it is stabilizing and their students often act as the best ambassadors – identifying and recruiting new preceptors. Preceptors are volunteers and receive an adjunct

faculty position at SOMA. Students report excellent experiences with preceptors, particularly with the significant one-on-one attention they receive.

The widely distributed campuses also pose special challenges that SOMA has been innovative in addressing. Much of their year two curriculum is delivered through webcasts that students can access in a self-directed manner. Live epidemiology/biostatistics courses are being taught through online video conferencing technology. Technology infrastructure has been a challenge at some sites and ATSU-SOMA is working to upgrade bandwidth at some campuses.

While the outcomes of this CHC based education still need to be evaluated, the vocal commitment of the students in all years to serving the underserved and the matter of fact statements of the upper level students of "I can do this," talking about CHC practice, are promising. One recent alumnus stated, "I don't think without this experience I would have considered underserved medicine. It would have been a foreign thought to me. Now I have a deep understanding of what practice in a CHC looks like."

**Tuition Management**

The annual tuition for ATSU-SOMA is approximately $40,000 and the average debt of a graduate is $250,000. ATSU-SOMA is private, non-profit university without state subsidy and is therefore tuition dependent. However, student debt is a significant concern for the SOMA leadership, particularly in light of the school's mission.

When students were questioned on student debt, many reported they planned on practicing in underserved areas and receiving National Health Service Corps (NHSC) loan repayment. Their knowledge of the NHSC loan repayment program appeared to come from both information provided by the financial aid office, faculty, and exposure to clinical preceptors in their CHCs receiving NHSC loan repayment.

Approximately 10% of ATSU-SOMA students receive scholarships – most commonly military with a few NHSC and other scholarships. Arizona's state scholarship program has been defunded in recent years. Another 80% of students take out loans. ATSU-SOMA currently has no internal scholarships for students. However, the board has challenged the school to become tuition free and the leadership is looking for ways to achieve this charge. One of the CHC's has recently proposed an in-house program to financially support a graduating student throughout residency with a commitment that they will return to the CHC upon completion of their training. As the other CHC's and local communities see the benefit of ATSU-SOMA and their students this model may become help alleviate the significant student debt burden.

**Mentoring**

ATSU-SOMA utilizes both formal and informal mentoring strategies to support their students. Each first year student is assigned a faculty advisor on the Mesa campus. This role is transitioned to one of the two RDMEs at their assigned clinical site. This will be their primary advisor and mentor during the remaining three years of medical school. The Mesa leadership mentioned that

they mourn the loss of relationship with the students when they leave Mesa for the clinical sites but the students gain an even greater connection to the faculty at their assigned site.

The RDMEs are chosen and employed clinicians of the CHC, faculty of ATSU-SOMA, and well respected leaders within the communities. They deliver much of the teaching and mentoring, help develop curriculum, and are responsible for identifying, recruiting, and maintaining all community clinical preceptors – both outpatient and inpatient. Approximately 2,200 adjunct faculty precept ATSU-SOMA students nationally. One faculty member commented that the ATSU-SOMA faculty have a "Peace Corps mentality', they went into medicine for the right reasons and they serve as excellent role models" for the students.

During first year, students are able to attend monthly lectures called "Health Care Heroes." This is an opportunity to showcase community physicians that are practicing in underserved areas in needed specialties. It shows students an example of what their future life could look like if they choose a similar path.

Less formal mentoring strategies also exist within ATSU-SOMA. Peer-to-peer mentoring also exists between first and second year students called 'Big doc, little doc' which provides guidance to first year students about CHC site choice. Third year students are also are paired with the second years in the CHC's and get together once a month to share clinical experiences. Second year students also see their preceptors and community leaders for their projects as mentors. One student mentioned that she really enjoyed working with her preceptor during her second year and said "I can do that when I grow up."

**Post Graduate Engagement**

ATSU-SOMA has focused on developing its innovative medical student education model without a concomitant creation of a graduate medical education component. The identified CHC's do not have affiliated residency programs. The presence of residencies in community hospitals in the region of those eleven centers and where students rotate may or may not have resident rotations. Thus, most ATSU-SOMA students have little contact with residents as part of their medical education.

This reality is a double-edged sword. On the positive side, students do not compete with residents for the attention of faculty mentors. Students we talked to valued greatly this one to one attention. On the down side, students miss out on the 'hierarchy' of vertical learning teams—students, residents and faculty typical of post-graduate education. Of greater concern is that an important expectation on the part of the community health centers, their communities and of the ATSU-SOMA faculty is that there will be a substantial return of graduates to training site communities after graduation. However, with a multi-year gap between graduation and practice choice, and with the residencies usually geographically remote from their medical school 'home', the likelihood of return is diminished.

In addition, there is growing concern nationally within the osteopathic community of being 'crowded out' of residency opportunities. As allopathic medical schools increase in number and

as their class sizes grow, fewer openings will be available for osteopathic, international medical and Caribbean school graduates because of the relatively fixed post-graduate positions nationally. So "growing our own" residencies appears an ever more attractive option for osteopathic medical educators which was a statement heard frequently during the site visit.

ATSU-SOMA leadership realizes the importance of completing the educational innovation by building affiliated residencies into the educational continuum. Options include establishing Teaching Community Health Centers where the community health center sites become residency sponsors; partnering with community hospitals that begin their own, new residencies; or strengthening affiliation with existing residencies in community hospitals near the center sites. There are educational and administrative resources available for all osteopathic training programs called OPTI's that can be accessed to help ATSU-SOMA design a GME program more in line with the philosophy and Mission of the school. An OPTI is a resource and administrative bridge between the AOA, the osteopathic medical school, and the individual residency programs. It functions as a supportive evaluator and a continuing education provider and serves as a mechanism to improve quality of GME programs in the osteopathic community.

To combat the "hidden curriculum" that may persuade student to pursue fields with higher remuneration, the leadership have chosen to lead by example and provide significant primary care mentors for the students. By using this method students are able to visualize a career in primary care and have seen several examples of career satisfied physicians. The general undercurrent at ATSU-SOMA is described as caring for the underserved in urban, rural and remote areas.

## Challenges

The admissions committee leadership mentioned that one of biggest deterrents for choosing to attend ATSU-SOMA is the high cost of tuition. ATSU-SOMA is a tuition dependent school and the average debt is higher than most other schools. Leadership recognize this concern and are diligently trying to find strategies to reduce tuition and provide incentives to students choosing needed specialties and practicing in community health centers.

While all second year students participate in various community health projects, there is great opportunity to measure the impact of these projects and potentially improve health outcomes in the surrounding communities of these health centers. The site visit team encouraged ATSU-SOMA leadership to seek ways to assess community needs and employ rigorous research methodology to improve the health of the identified underserved populations.

As forerunners for a new clinical model, ATSU-SOMA has had several challenges with providing sufficient core rotations for students and finding an adequate number of preceptors. Depending on the clinical site, ATSU-SOMA is sometimes in competition with larger university based programs that already have their students in local hospitals. Leadership expressed difficulty in finding adequate placements in pediatrics and intensive care. However, as the various CHC's collaborate and share placement opportunities all students are accommodated.

Students expressed that these "outside" rotations away from the CHC are far removed from the social mission perspective but they continue to seek out like-minded preceptors to build new relationships with ATSU-SOMA.

## Conclusion

ATSU-SOMA has demonstrated a departure from a traditional Flexnerian medical school model and has piloted a unique community health center based education. The students seemed very pleased with their education and are committed to practicing in underserved areas. In the first graduating class over 80% chose a residency in a needed specialty. When students were asked what advice they would give to potential applicants, one student replied "If you want a lot of experience in clinical medicine, and a new learning style, then I would suggest attending ATSU-SOMA." "If you come here and you engage in the least with the program and the mission you walk away changed," said a recent alumna. The partnership with community health centers is a transferable model to other medical schools and should be explored as a unique way to potentially produce more primary care physicians.

## References

1. Anon. About Our University. *A.T. Still University*. 2010. Available at: http://www.atsu.edu/about/our_university.htm [Accessed December 6, 2011].
2. Anon. About Our Founder. *A.T. Still University*. 2010. Available at: http://www.atsu.edu/about/our_founder.htm [Accessed December 6, 2011].
3. Anon. "The Medical School of the Future" - Community Health Centers. *ATSU - School of Osteopathic Medicine in Arizona*. 2011. Available at: http://www.atsu.edu/soma/medschool_future/community_health_centers.htm [Accessed December 6, 2011].