Association of
American Medical Colleges
655 K Street, NW, Suite 100, Washington, DC 20001-2399
T 202 828 0400
aamc.org

August 17, 2020

Mr. Edward Salsberg
Director of Health Workforce Studies
Milken Institute School of Public Health
Mullan Institute for Health Workforce Equity
George Washington University
950 New Hampshire Ave NW #2
Washington, DC 20052

RE: Development of the Children's Hospital Graduate Medical Education (CHGME) Program Quality Bonus System: Goals, Objectives, Measures, Data and Payment Options, Final Report – Draft 1

Dear Mr. Salsberg:

The Association of American Medical Colleges (the AAMC or Association) welcomes this opportunity to comment on the George Washington University (GWU) Mullan Institute's draft report to the Health Resources and Services Administration (HRSA) on the Children's Hospital Graduate Medical Education (CHGME) Program Quality Bonus System (QBS).

The AAMC (Association of American Medical Colleges) is a not-for-profit association dedicated to transforming health care through medical education, patient care, medical research, and community collaborations. Its members are all 155 accredited U.S. and 17 accredited Canadian medical schools; more than 400 teaching hospitals and health systems, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC serves the leaders of America's medical schools and teaching hospitals and their more than 179,000 full-time faculty members, 92,000 medical students, 140,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences.

The draft report recommends QBS measures structured across six goals that broadly aim to address workforce training and education, workforce distribution and diversity, and the community health workforce. The AAMC appreciates GWU's efforts to develop a comprehensive set of recommended metrics and payment mechanisms that accompany the QBS's goals and corresponding measures. We are also pleased to see that the draft report contains some of our previous recommendations to HRSA on the QBS.[1]

[1] See AAMC Comments on "Proposed Standards for the Children's Hospitals Graduate Medical Education Payment Program's Quality Bonus System, Request for Public Comment," Dec. 15, 2017. Accessed on Aug. 10, 2020 at: https://www.aamc.org/system/files/c/1/485356-aamccommentsonhrsaschgmequalitybonussystem.pdf.

This letter provides additional feedback on the recommended metrics included in the draft report. Specifically, the AAMC asks that post-graduate outcome measures be excluded from the QBS, and we support inclusion of a broad definition of underrepresented backgrounds and development of additional cultural competency measures. Additionally, the Association has concerns regarding the validity of several measures, as well as the anticipated reporting burden. Finally, the AAMC supports structuring payment mechanisms to incentivize participation in the QBS system, which we believe is the intent of the program.

ENSURING TRAINING PROGRAM QUALITY

Current Accreditation Processes are Sufficient to Develop High Quality Training Programs

Congress authorized the establishment of a CHGME QBS through the Children's Hospital GME Support Reauthorization Act of 2013[2] and HRSA began engaging stakeholders in fiscal year (FY) 2017 to develop the program. The AAMC acknowledges that the QBS is statutorily required, and we are committed to providing feedback that furthers the development of and participation in the QBS. However, the AAMC maintains that the existing accreditation processes currently in place provide sufficient accountability for institutions to produce high-quality training programs without the need for standalone systems that measure training program quality. Any effort to improve the quality of training should be done in collaboration with the accreditation process to avoid misaligned requirements and goals, to avoid a duplicative and burdensome process for reporting and to avoid an expensive and duplicative process to oversee these different requirements.

The institutional and common program requirements set by the Accreditation Council for Graduate Medical Education (ACGME) are meticulously developed with the specific intent that sponsoring institutions meet rigorous quality standards across all of an institution's training programs.[3] Additionally, the ACGME's New Accreditation System, introduced in 2014, is a continual, outcomes-based accreditation system that permits accreditation to keep pace with changes in the medical field.

Under the system, teaching hospitals and other clinical sites must meet new standards for maintaining a clinical learning environment that includes residents in quality improvement projects, focuses on care transitions and patient safety, and enhances professionalism and cultural competency. Moreover, the residents themselves must meet key educational milestones and core competencies, measured twice a year, specific to their subspecialty under the system. These standards are fully transparent and regularly reviewed by leaders in all specialties, evolving regularly. Through this system each teaching hospital and other clinical and institutional sites

---

[2] P.L. 113-98, "Children's Hospital GME Support Reauthorization Act of 2013," Apr. 7, 2014. Accessed on Aug. 14, 2020 at: https://www.congress.gov/113/plaws/publ98/PLAW-113publ98.pdf.
[3] ACGME, "What We Do: Accreditation," 2020. Accessed on Aug. 14 at: https://www.acgme.org/What-We-Do/Accreditation.

that sponsor programs spend thousands of hours each year maintaining its accreditation for each residency program.

We fully believe the accreditation processes currently established serves as a critical measure of quality and accountability for residency programs. For these reasons, we believe current accreditation standards, Medicare cost reports, and existing program integrity efforts ensure that teaching hospitals and other clinical training sites are already sufficiently accountable to produce high-quality training programs.

QUALITY MEASURES AND METRICS

Eliminate Measures and Metrics with Post-Graduate Practice Outcomes

- **Metric 3:** Percentage of general pediatric residency **graduates** from the past three years practicing in general pediatrics in high need areas.
- **Metric 4:** Percentage of all **graduates** from the past three years practicing in high need areas.
- **Metric 5a and 5b:** Percentage and percentage increase of **graduates** providing care to Medicaid patients based on the most recently available three years of Medicaid data.

Several metrics recommended under Goal 1 (addressing maldistribution of physicians in underserved areas) would require programs to increase the percentage of graduates working in high need areas and with underserved populations. The QBS seeks to reward institutions that promote quality training programs and work across several domains to influence training, education, and distribution of the physician workforce. While training programs may have some influence on graduates' future practice choices the AAMC has significant concerns that a program's influence on graduate practice is limited. **Therefore, the AAMC urges GWU to eliminate recommended metrics that rely on post-graduate practice outcomes.**

Literature reviews have attempted to define core traits and factors that influence physicians to enter rural and underserved practice.[4] Results from these studies provide insight into the difficulty of addressing graduate practice distribution at the graduate medical education level alone. Specifically, studies find few isolated influences that promote practice in rural and underserved areas; instead factors and traits span across educational levels (e.g. high school, college, and medical school) and even beyond personal preference.[5] This includes consideration

[4] "Predictors of Primary Care Physician Practice Location in Underserved Urban or Rural Areas in the United States: A Systematic Literature Review." Goodfellow, Amelia, et al, Academic Medicine, Vol. 91, No 9, p. 1313-1321, September 2016. Accessed on Aug. 7, 2020 at: https://journals.lww.com/academicmedicine/Fulltext/2016/09000/Predictors_of_Primary_Care_Physician_Practice.34.aspx.

[5] "The Road to Rural Primary Care: A Narrative Review of Factors That Help Develop, Recruit, and Retain Rural Primary Care Physicians." Parlier, Anna Beth, et al, Academic Medicine, Vol. 93, No 1, p. 130-140, January 2018. Accessed on Aug. 7, 2020 at:

of graduates' families and partners,[6] having interest in rural or underserved practice prior to medical school, and being prepared for a rural lifestyle.

Additionally, the AAMC has conducted research that suggests practice location is influenced by numerous factors. Notably, AAMC research highlights that both spousal preference and compensation influence practice location, and while many physicians practice in the same state as their training program, this does not specifically influence rural practice in those states.[7] The study also shows that training programs are not among the main reasons cited for a physician's practice location choice – instead the top reasons cited for practice location include lifestyle and proximity to family members.[8]

Among these and other factors, the influence of graduate medical training on graduates' practice preferences and choices is severely diluted. The diverse group of factors that influence practice decisions means that institutions that make efforts toward this end may not see significant increases in graduate practice in rural and underserved areas. The AAMC previously submitted comments on this topic in response to HRSA.[9] **For these reasons, the AAMC urges GWU to exclude metrics that rely on post-graduate practice outcomes from its recommendations.**

Alternatively, the AAMC suggests that these metrics could be replaced with metrics over which institutions have more input and control. The QBS could instead reward the presence of specific clinical training opportunities in underserved and rural areas. **To this end, we also reiterate comments that congressional action is needed to expand Rural Training Tracks (RTTs) to promote residency training opportunities in rural settings.** Currently, urban hospitals can partner with rural hospitals and nonhospital settings to form RTTs to promote training in rural settings.[10] However, RTTs are currently limited to primary care residents. Congress should expand RTTs to include other specialties in order to promote training in rural settings. While the urban hospital within the RTT can increase their resident limit (i.e.,cap) to accommodate residents within the RTT, rural hospitals are not offered this flexibility. In order to promote training in rural areas, rural hospitals should also be able to increase their full-time equivalent resident cap in order to accommodate more residents.

---

https://journals.lww.com/academicmedicine/Fulltext/2018/01000/The_Road_to_Rural_Primary_Care__A_Narrative_Review.35.aspx.

[6] Staiger, Douglas O., Samuel M. Marshall, David C. Goodman, David I. Auerbach, and Peter I. Buerhaus. 2016. "Association Between Having a Highly Educated Spouse and Physician Practice in Rural Underserved Areas." *JAMA* 315 (9): 939–41. Accessed on Aug. 13, 2020 at: https://jamanetwork.com/journals/jama/fullarticle/2497899.

[7] AAMC Research Poster, "What Moves Physicians to Work in Rural Areas? An In-depth Examination of Physician Practice Location Decisions," August 2020.

[8] *Id.*

[9] See AAMC Comments on "Reforming America's Rural Healthcare System," Sep. 6, 2019. Accessed on Aug. 11, 2020 at: https://www.aamc.org/system/files/2019-09/aamccommentsonbipartisanpolicycentersbpcsruralhealthtaskforce.pdf.

[10] AAMC, "Rural Training Track Programs: A Guide to the Medicare Requirements," 2017. Accessed on Aug. 13, 2020 at: https://store.aamc.org/downloadable/download/sample/sample_id/204/.

Diversity and Inclusion Metrics Should Broadly Define "Underrepresented Backgrounds"

- **Metric 7a and 7b:** Percentage and percentage increase of trainees from any of the following underrepresented backgrounds (as defined and collected by HRSA) including rural areas, underrepresented in medicine, or a disadvantaged background

The draft report contains recommendations for two associated metrics to include in the QBS that would promote a diverse and inclusive pediatric workforce. As GWU recommends in the draft report, "underrepresented backgrounds" would be defined by HRSA and include trainees from rural areas, underrepresented in medicine, or a disadvantaged background. **The AAMC strongly supports promoting a diverse and inclusive workforce in pediatrics as in all specialties. As a consequence, we support a broad definition of trainees in underrepresented backgrounds.**

Underrepresentation in medicine often focuses on specific racial and ethnic groups – African American/Black, American Indian and Alaska Native, Hispanic/Latino, and Native Hawaiian or Other Pacific Islander. The AAMC supports increasing diversity in medicine that is inclusive of individuals from a wide variety of backgrounds who have been historically excluded and underrepresented in medicine based on socioeconomic status, race, ethnicity, language, nationality, sex, gender identity, sexual orientation, religion, geography, and disability. Additionally, the AAMC's definition of underrepresentation anticipates the inclusion and removal of groups on the basis of changing demographics and supports a regional or local perspective on underrepresentation.[11] Specifically, by defining underrepresentation based on the needs and diversity of specific regions or localities in which participating institutions are situated, programs can better approach improvement initiatives in ways that directly address the disparities in their regional workforce.

If HRSA is tasked with defining underrepresentation it must accept local and regional definitions of underrepresentation in addition to its national definition. While HRSA's definition appears to broadly include individuals with a diverse set of backgrounds, the AAMC seeks to ensure that underrepresentation is also considered from the local or regional perspective. States, regions, and localities define underrepresentation differently; by permitting a broader definition of underrepresentation that acknowledges the differences between regional and national needs, the QBS can better promote diversity that best serves the needs of participating institutions' patient populations.

Ensure Metrics are Actionable, Valid, and Reliable

- **Metric 10a and 10b:** Assessment of perceived competency and increase in graduates' perceived competency in mental health, substance use disorder, obesity, and/or oral health.

[11] AAMC "Underrepresented in Medicine Definition" Mar. 19, 2004. Accessed on Aug. 12, 2020 at: https://www.aamc.org/what-we-do/mission-areas/diversity-inclusion/underrepresented-in-medicine.

- **Metric 14b:** Percentage of graduates with perceived competence in addressing social determinants of health (SDOH)

To ensure the success of the QBS and best incentivize participation, the system's measures and metrics must be actionable, valid, and reliable. If stakeholders and participants have concerns with a measure's reliability or validity, then institutions may be reluctant to engage or improve in those areas. **Metrics 10 and 14b, as currently developed, should <u>not</u> be recommended in the final report due to concerns about the validity, reliability, or actionability.**

The draft report describes that assessments would be used to measure the "perceived competency" of its graduates, which would be used to evaluate the quality of a trainee's experience with specific clinical topics rather than the time spent training in those areas. As recommended, metrics 10 and 14b would require institutions to create their own assessments and decide how to measure their own graduates' perceived competency. These variable and subjective assessments from participating institutions would inherently lack the level of validity and comparability present in other measures. Additionally, using a points-based payment mechanism in which institutions vie for points in relation to one another in order to measure perceived competency makes the lack of validity and subjectivity particularly inequitable. Without a valid measure, comparing the increase in perceived competency of graduates between institutions is not appropriate. Instead we recommend that the QBS utilize metrics that are already part of the accreditation process and measured via milestones. **These measures should not be recommended unless validity can be improved prior to implementation.**

Ensure Telehealth Measure Implementation Timeframe and Definition are Appropriate, and Include Additional Telehealth Competency Measures

- **Measure 2:** Presence of training policy/curriculum involving telehealth; Percentage of trainees who receive specialized training in providing telehealth; Percentage of trainees who are assessed in providing telehealth at a CHGME grantee hospital.

The longitudinal design of the QBS structures implementation of measures and metrics so that participating institutions have time where needed to build structures and processes before being assessed based on outcomes. Measure 2 seeks to increase competency of trainees in the use of telemedicine.

The draft report does not specify a timeframe for implementation of this measure. Since the inception of the COVID-19 Public Health Emergency (PHE), telehealth practice has advanced and changed dramatically. Temporary relief of federal telehealth regulations to address the PHE may now become permanent, and as a result, wider use of telehealth will lead to changes in practice. In particular, the Centers for Medicare & Medicaid Services (CMS) recently made temporary changes that allow residents to use telehealth under direct supervision and is

proposing to make these changes permanent in the calendar year 2021 Physician Fee Schedule proposed rule.[12]

In response to these changes due to the PHE, the ACGME has also accelerated the use of the Common Program Requirements for supervision of telemedicine visits.[13] As telehealth practice and training becomes more common, it is possible additional changes will be made in the next few years. Alternatively, if telehealth regulation does not remain flexible and instead reverts to the rules in place before the PHE, then telehealth practice will again be severely hamstrung. This scenario presents its own sets of challenges in setting measures and metrics, as it would impede institutions' abilities to train residents in telehealth. For instance, without the recent changes allowing residents to provide telehealth under direct supervision institutions may struggle to provide trainees with the clinical opportunities necessary to improve under the recommended QBS metrics. In addition, the AAMC is in the process of completing a draft document on the competencies required in telehealth, described in greater detail below. These competencies will be promulgated, studied and revised over the next two years. **In order to accommodate the rapidly changing scope of practice, the AAMC recommends that metrics related to telehealth competency should not be implemented until changes to curriculum and assessment of telehealth training and competency can reflect the recent changes to telehealth practice.**

Moreover, the telehealth measure does not define what is considered "telehealth" for reporting under the metric. A definition of "telehealth" should be provided before implementation, or programs should be asked to provide the specific services and/or modalities they are including as "telehealth" when reporting. This will ensure that the quality of a program's offerings can be appropriately measured. **The AAMC recommends using the American College of Physicians' definition, which states: "Telehealth, or telemedicine, is the use of technology to deliver care at a distance."**[14]

The AAMC also recommends that additional telehealth measures should be included in the QBS to promote quality telehealth training and education, and to address additional inequities in telehealth infrastructure. A prerequisite to continued expansion and sustainability of telehealth services is broadband access, which is lacking in many parts of the country. Prior to the PHE, one reason telehealth services were being implemented was to improve access to care, specifically in rural areas. As a response to the PHE pandemic, institutions have implemented and scaled telehealth services not only to ensure access but to better triage patients and to

---

[12] Calendar Year 2021 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies, Display Copy p. 185, Aug. 3, 2020. Accessed on Aug. 11, 2020 at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-17127.pdf.

[13] ACGME Letter to GME Community, Mar. 18, 2020. Accessed on Aug. 11, 2020 at: https://acgme.org/Newsroom/Newsroom-Details/ArticleID/10111/ACGME-Response-to-the-Coronavirus-COVID-19.

[14] American College of Physicians. Telehealth Resources. Accessed on Aug. 11, 2020 at: https://www.acponline.org/practice-resources/business-resources/health-information-technology/telehealth#:~:text=Telehealth%2C%20or%20telemedicine%2C%20is%20the,codes%2C%20and%20ACP%20policy%20guidance.

continue providing care while protecting both providers and patients. As the healthcare system is transformed by this growing adoption of a wide range of health technology services, distinct training measures and metrics are needed.

To this end, the AAMC's Telehealth Advisory Committee is set to release telehealth competencies in August 2020.[15] Developed over the course of 18 months, these telehealth competencies are intended to supplement existing competencies while providing more telehealth-specific guidance to better support educators design and deliver curricula on telehealth and integrate telehealth into training and professional development. The document address six domains, which address among other things, patient safety, data collection, and effective communication in telehealth practice.[16] These competencies may provide a valuable framework to develop future telehealth competency measures for the QBS. We will be happy to share these competencies with the Mullan Institute once released.

Include Additional Cultural Competency Measures and Metrics

With increasing diversity in the U.S. population and continued evidence of health and health care disparities, it is critically important that physicians are educated on how their own and their patients' demographics, cultural factors, and biases influence health, health behaviors, and health care access and quality. **To address these issues the AAMC strongly recommends the inclusion of additional cultural competency measures to the QBS in order to promote QBS Goals 2, 5, and 6.**

Residency training programs are already required to meet the ACGME's common program requirements, which requires cultural competency as a component of its professionalism and communication competencies.[17] As a result, all residency programs are required to include this as part of their curriculum. **For this reason, the AAMC recommends that HRSA rely on the ACGME requirement which currently is in place.**

Additionally, as additional cultural competency measures are considered, the AAMC's Quality Improvement and Patient Safety (QIPS) Competencies offer several possibilities for improving and measuring cultural competency in pediatric training programs. For instance, these include competencies requiring understanding of how sociocultural attributes (e.g., values, customs, beliefs) may influence interactions with the health care system, or demonstrating knowledge about the role of explicit and implicit bias in delivering high-quality care.[18] Similarly, the ACGME's Clinical Learning Environment Review (CLER) Program offers additional options on the best ways to engage training programs through education and initiatives to eliminate health

---

[15] AAMC Telehealth Advisory Committee, Telehealth Competencies, working draft, June 17, 2020. Final Telehealth Competencies available August 30, 2020 at: www.aamc.org.
[16] *Id.*
[17] ACGME Common Program Requirements (Residency), Accessed on Aug. 11, 2020 at: https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2019.pdf.
[18] AAMC, "Quality Improvement and Patient Safety Competencies Across the Learning Continuum," pp. 10-11, 2019. Accessed on Aug. 12, 2020 at: https://store.aamc.org/downloadable/download/sample/sample_id/302/.

care disparities, as described in Health Care Quality Pathways 5 and 6 of their "CLER: Pathways to Excellence" tool.[19]

Limit Administrative Burden on Participating Institutions

As noted throughout the draft report, the recommended measures and metrics should minimize the burden for institutional reporting. **Although many of the measures directly further the QBS's workforce goals, the AAMC is concerned that the reporting burden is too high as currently recommended.** Among the 30 recommended metrics, 15 are identified as having high reporting burden and eight more would have moderate reporting burden. Moderate burden is defined as when "data are not already collected but the required data elements can be obtained through existing data sources" and high burden is defined as when "data are not already uniformly collected and may require new methods or systems of data collection with more detailed reporting." (p. 18). These data collection burdens are on top of the already large burden required for the accreditation process. This does not align with HRSA's goal to minimize the administrative burden for reporting as outlined in its response to stakeholder feedback in 2018.[20]

Certain structure and process measures will create significant burden for institutions that wish to participate in the QBS. Measures that require institutions to develop assessment tools and measure graduates' competencies in specified practice areas are among the most burdensome measures and metrics recommended. To lower burden in these metrics, HRSA could provide a standardized assessment tool that measures competency based on common standards through an expert body (e.g. ACGME). Any standardized assessment tool must be subject to stakeholder comment to ensure participating institutions can feasibly achieve the competencies measured by the tool.

In addition to the heavy reporting burden, institutions that engage in improvement initiatives in the QBS would face significant burdens to develop curriculum, hire additional staff, and modify and expand programs to improve in outcomes dictated by the QBS. For instance, Measure 6 (increasing trainees in high needs pediatric specialties) would require institutions to increase a program's complement and recruit additional trainees with no guarantee that those spots would be filled. If HRSA adopts a system that distributes QBS payments based on points scored across all measures, and awards only the top performers, institutions may avoid participating in the face of better resourced and staffed participants operating within their payment tier that are likely to have better outcomes. Reducing burden associated with the measures would go far in improving participation in the QBS.

---

[19] ACGME, "CLER Pathways to Excellence," 2019. Accessed on Aug. 12, 2020 at: https://acgme.org/Portals/0/PDFs/CLER/1079ACGME-CLER2019PTE-BrochDigital.pdf.

[20] HRSA, "Proposed Standards for the Children's Hospitals Graduate Medical Education Payment Program's Quality Bonus System," 83 FR 29796, 29798, Jun. 26, 2018. Accessed on Aug. 11, 2020 at: https://www.federalregister.gov/documents/2018/06/26/2018-13592/proposed-standards-for-the-childrens-hospitals-graduate-medical-education-payment-programs-quality.

PAYMENT MECHANISMS

The draft report considers three options for how payments should be distributed to institutions that participate and achieve desired outcomes through the QBS. The first option is a points system that awards bonus payments for institutions with the highest score tied to achieving measure outcomes relative to other institutions. The second option is a threshold system where any institution receives bonus payments if it meets predefined performance thresholds for improvement initiatives. Finally, the third option awards payments for the top performance in each of three categories: education/training, workforce, and population/community health outcomes. The draft report notes that the payment methodology may utilize a combination of the recommended payment mechanisms.

The AAMC believes that it is in the best interest of the QBS to structure payment so that it incentivizes participation and in the future rewards improvement. **To best incentivize participation and promote the long-term goals of the QBS, the AAMC recommends that bonus payments should be available to as many institutions as possible, and ensure institutions have an expectation of payment under each of the recommended payment mechanisms.** Payments to support pediatric training programs and institutional improvements to those programs must be long-term, stable, and continuous. Without guarantees of adequate payment to support training programs and improvement efforts, pediatric training programs remain at risk. Long-term, stable, and continuous payments through the CHGME program and the QBS must be assured in order to permit institutions to maintain and improve their training programs without fear that those programs may be in jeopardy due to sudden and unexpected loss of funding. Allowing this uncertainty would cut directly against the QBS's goals and purpose of improving pediatric training.

To this end, QBS awards should be available to more than just the top-performing institutions. Participants that invest in improvement initiatives and work towards thresholds during the performance periods must have tangible opportunity to win awards. The more awards available, the more likely institutions are to engage in the QBS. For any measures paid through a points or activity-based system, more than a few awards should be available to ensure participation.

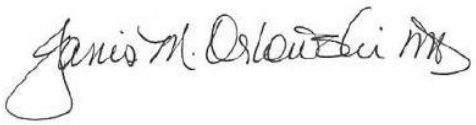
Similarly, institutions need to maintain an expectation of payment if they are to meaningfully participate in improvement initiatives. **The AAMC recommends that awards through a threshold system should be scaled so that the presence of more awardees does not result in lower payment.** Setting a minimum award for meeting measures and metrics paid under a threshold system could help in this regard. If institutions can anticipate or predict bonus payments associated with their efforts, they will be more likely to engage in the QBS.

Additionally, regardless of the payment mechanism, threshold targets and benchmarks need to be set in advance. Engagement with stakeholders concerning achievable benchmarks prior to implementation would help ensure thresholds are neither "too hard" nor "too easy" to meet and would also provide reasonable expectations for hospitals that seek to engage in the QBS.

CONCLUSION

Thank you for the opportunity to comment on this draft report. We would be happy to discuss the issues addressed above or other topics that involve the academic medical community. If you have questions regarding our comments, please feel free to contact Andrew Amari at 202.828.0554 or aamari@aamc.org.

Sincerely,



Janis M. Orlowski, M.D., M.A.C.P.
Chief Health Care Officer

cc: Ivy Baer