

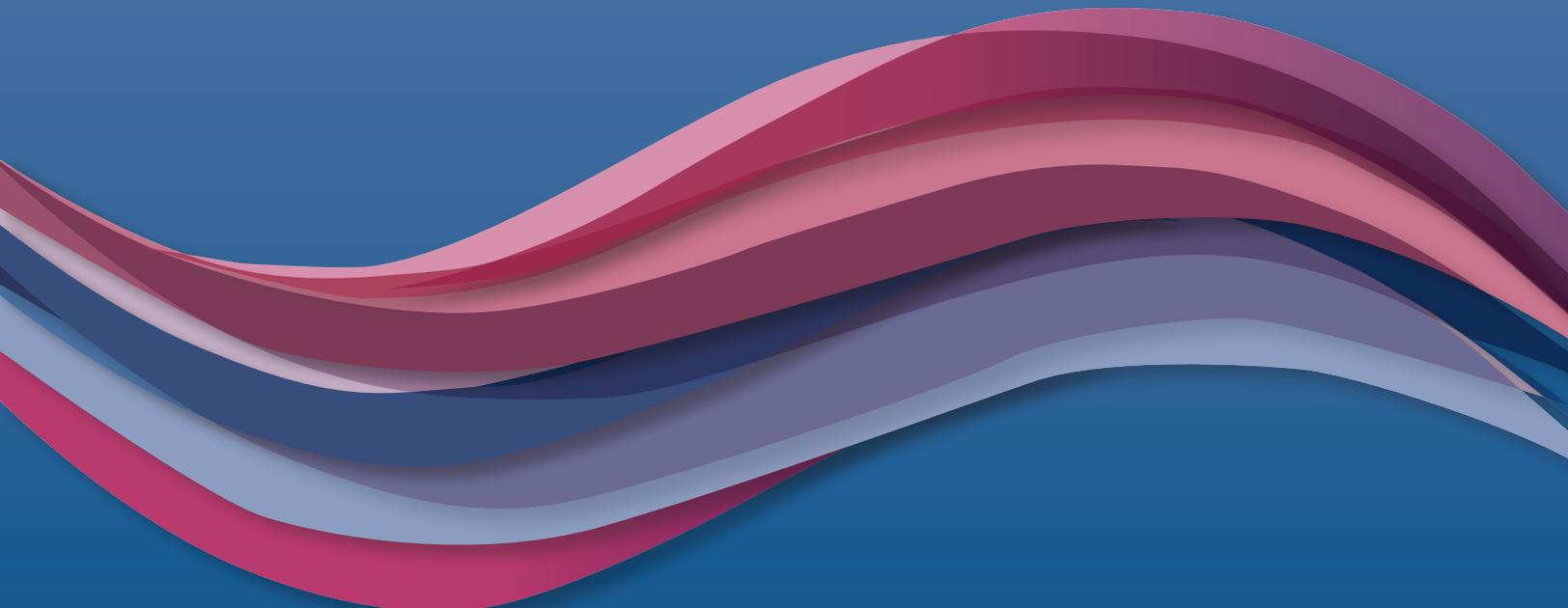
Working Paper: The Value of Collaboration for the Osteopathic Medical Education Clinical Learning Environment

John Kauffman, DO

Thomas Boyle, DO

Stephen C. Shannon, DO, MPH

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COLLEGES OF OSTEOPATHIC MEDICINE

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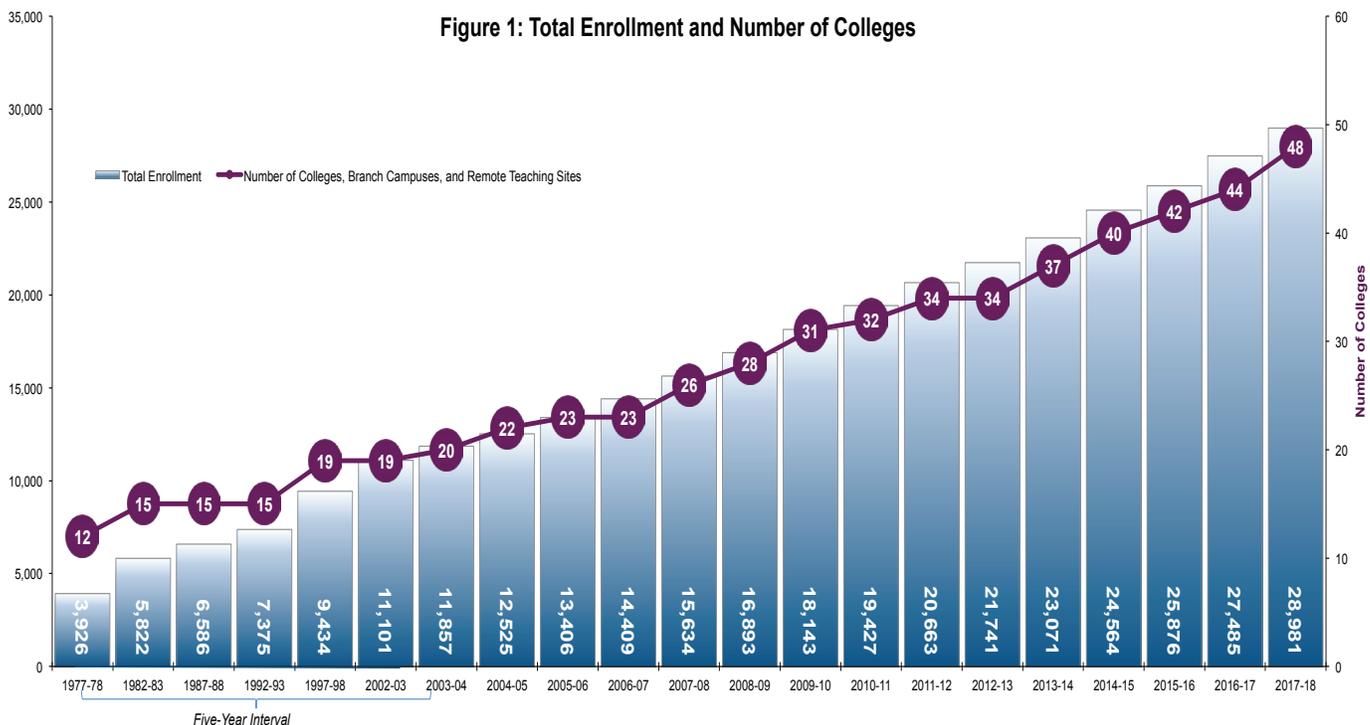
**By Thomas Boyle, DO; John Kauffman, DO
and Stephen C. Shannon, DO**



Osteopathic Profession Trends

Thirty-five years ago, the profession of osteopathic medicine was distinct from allopathic medicine and was more regionally based. There were 15 osteopathic medical schools; osteopathic hospitals and a separate GME training system focused on primary care, osteopathic licensing exams, and licensing boards and specialty certification boards. Most of the osteopathic medicine specialty practices were separate and comprised of small groups of male physicians. Since the 1970s, the osteopathic profession has experienced substantial growth impacting the infrastructure of the delivery of education. In 1976, total applications to osteopathic medical schools numbered 3,707. This

number climbed to 10,213 by 1995.¹ In 1980, there were 1,059 osteopathic medical graduates and 17,620 practicing DOs. By 2017, there were 6,038 DO graduates and 108,118 practicing osteopathic physicians.² DOs now make up more than 7 percent of all physicians and more than 9 percent of primary care physicians. Today, nearly one in five medical students in the United States is attending an osteopathic medical school. There are 34 accredited colleges of osteopathic medicine (COMs) in the United States delivering instruction at 51 teaching locations in 32 states. In the 2017-2018 academic year. These colleges educated nearly 29,000 future physicians.



1. AACOM Reports on Applicants. Applicant Profile Reports. Applicants by Race and Ethnicity 1976-2017. <http://www.aacom.org/reports-programs-initiatives/aacom-reports/applicants>
 2. 2016-2017, graduates: *ibid.* <http://www.aacom.org/reports-programs-initiatives/aacom-reports/applicants>

Table 1. COMs, Branches, and Additional Locations

	2007-08	2017-18
Total COMS	23	34
Private COMs	17	28
Public COMs	6	6
Branch Campuses	3	5
Additional Locations	0	10
Total Campus Locations	26	49
Total Enrollment	15,634	28,981
First-Year Enrollment	4,528	8,113

AACOM. (2017). U.S. Osteopathic Medical Schools by Year of Inaugural Class. Bethesda, Maryland.

Six of the colleges are public and 28 are private institutions. (See *Chart 1. Growth in Osteopathic Medical Colleges and Table 1. COMs, Branches, and Additional Locations.*)

The evolution of the osteopathic profession is progressing from a regional to a national model. The separate hospital system no longer exists. The separate GME system will end in 2020 with the full implementation of the single GME accreditation system. The separate osteopathic health care system is changing to an integrated model, with the majority of physicians now employed by health care systems in group practice models. The profession is experiencing a demographic shift featuring more women in the workforce; an increased focus on research, mission, and culture; new structures for primary care and OMM specialization; and a move from private to public entities.³

Osteopathic Medicine in Rural, Underserved, and Primary Health Care

The osteopathic medical profession’s proud heritage produces primary care practitioners focused on community practice. The mission statements of the majority of COMs clearly state that their objective is the education and training of primary care physicians. Osteopathic medical tradition holds that a strong foundation in primary care makes one a better physician, regardless of the specialty an osteopathic physician may eventually practice. The focus on primary care remains strong, with 56 percent of active DOs practicing in primary care specialties.⁴

Osteopathic medicine has a special focus on providing care in underserved rural and urban areas, which allows DOs to positively impact the U.S. population’s health and well-being.

3. Shannon, Stephen C. (2010). The Future of Osteopathic Medical Education: Physician Workforce Projections and the Response of U.S. Colleges of Osteopathic Medicine. Presentation. Bethesda, Maryland. http://www.aacom.org/docs/default-source/presentations/062008_shannon_mdassn.pdf
4. 2017 OMP Report: Osteopathic Medical Profession Report: 2017. American Osteopathic Association. 2017. <https://www.osteopathic.org/inside-aoa/about/aoa-annual-statistics/Documents/2017-omp-report.pdf>
5. “Doctor of Osteopathic Medicine: A Growing Share of The Physician Workforce,” Health Affairs Blog, October 23, 2017. DOI: 10.1377/hblog20171023.624111

Osteopathic physicians are disproportionately represented in rural areas and in primary care. Forty-five percent of osteopathic physicians practice primary care in comparison to 34 percent of all medical doctors.⁵ In addition, over the past few years, more than one-third of osteopathic medical school graduates indicated that they plan to practice in rural or other underserved areas. Osteopathic medical education has positively impacted the ongoing challenge of the shortage of primary care physicians in the United States.

Background on Osteopathic Graduate Medical Education

Historically, osteopathic graduates relied on the availability of community-based training programs in private hospitals. Many of these hospitals had fewer than 200 operational beds, and few had formal academic affiliations with the graduates' medical colleges other than providing rotation sites for student clerkships. As the number of graduates increased, the number of training hospitals approved by the American Osteopathic Association (AOA) began to diminish through closures or mergers with larger hospital systems.⁶

Osteopathic graduates expanded their search for training opportunities in programs accredited by the Accreditation Council for Graduate Medical Education (ACGME). In this shift, many training positions in AOA-approved programs were left unfilled. The AOA developed new policies that recognized graduates who had completed ACGME training as possessing equivalent credentials to graduates from osteopathic programs.

In response to anticipated growth in the number of accredited colleges and graduates, the AOA sought a strategy that would facilitate the growth and development of new training programs to meet the likelihood

of increased demand. The AOA strengthened its academic foundation for osteopathic graduate medical education (OGME), through the establishment of a new formal structure to ensure a uniform and consistently high level of quality training for all participants.

In 1995, in a special education issue of the *Journal of the American Osteopathic Association (JAOA)*, the chairman of the Council on Postdoctoral Training provided the osteopathic community with the objectives of a new entity—the Osteopathic Postdoctoral Training Institution (OPTI)—to foster this change. (*See Box 1.*) The goal was to develop a single standardized system of review and approval of institutions which sponsored osteopathic postdoctoral training. This standardized system would apply to all sponsoring institutions, whether colleges, traditional osteopathic hospitals, or traditional allopathic hospitals which were AOA-accredited.

OPTI Accreditation and GME Consortia

In July 1995, the AOA Board of Trustees passed new regulations establishing the OPTI system. In 1999 all graduate training programs were required to become members of an OPTI.⁷

OPTIs were created to increase the capacity of the osteopathic community to develop and accredit new training programs while both maintaining quality and providing educational resources. These consortia replaced the previously used hospital accreditation with the newly developed educational accreditation. Hospital accreditation assessed the quality of patient care, while educational accreditation assessed the resources available for quality medical education.

6. Osteopathic Postdoctoral Training Institutions: A Decentralized Model for Facilitating Accreditation and Program Quality. Don N. Peska, DO, Med; Michael I. Opipari, DO; and D. Keith Watson, DO. *Academic Medicine*: June 2009, Volume 84, Issue 6, pp 729-732. https://journals.lww.com/academic-medicine/fulltext/2009/06000/Osteopathic_Postdoctoral_Training_Institutions__A.20.aspx#06-20-4

7. Osteopathic Postdoctoral Training Institutions: A Decentralized Model for Facilitating Accreditation and Program Quality. Don N. Peska, DO, Med; Michael I. Opipari, DO; and D. Keith Watson, DO. *Academic Medicine*: June 2009, Volume 84, Issue 6, pp 729-732. https://journals.lww.com/academic-medicine/fulltext/2009/06000/Osteopathic_Postdoctoral_Training_Institutions__A.20.aspx#06-20-4

In 2004, the AOA Committee on Osteopathic Postdoctoral Training Institutions (COPTI) was formed and committee members were appointed. This committee was the successor to the Council on Osteopathic Postdoctoral Training (COPT) Subcommittee on OPTI Evaluation and Oversight, which was established in 1999.⁸ The OPTI Accreditation Handbook and the current structure of the COPT were established in 2011.⁹ As of July 2012, all OPTIs also assumed roles as academic sponsors of OGME programs. The number of accredited OPTIs has fluctuated over time between 18 and 22. (*See Appendix 1. Current List of OPTIs*).¹⁰

Changes in the osteopathic learning environment prompted by the OPTI system included the establishment of requirements for college co-sponsorship of GME programs and for the numbers of residency programs, interns, and residents, who were to be trained by the OPTI. Each OPTI was created as a community-based training consortium composed of at least one COM and one hospital accredited by the AOA Bureau of Healthcare Facilities Accreditation, the Joint Commission, or another recognized health-facility accrediting entity. Additional hospitals and ambulatory care facilities were also eligible to join this core partnership.

The OPTIs were subject to interval AOA inspections and were required to demonstrate a governance system, mission statement, and organizational structure. Core OPTI responsibilities included assurance of the provision of: student clinical rotations; library and learning resources; inclusion of osteopathic principles and practice in OGME program curricula; assistance, mentoring and recognition of trainee research and scholarly activity;

GME program self-evaluation; ongoing program evaluation of its trainees as they advanced toward program completion; development of an OPTI-wide Graduate Medical Education Committee; development and annual update of an institutional core competency plan; COM faculty appointments for program core faculty members; development of a confidential communication process for trainees to forward concerns about a program, monitoring of trainee work-hours; curricular strength and compliance with specialty college standards; and development of faculty development programs.¹¹ A specialized core focus of OPTIs was the development of new OGME programs.

Characteristics of GME Consortia in Osteopathic Medical Education

For the most part, the osteopathic community no longer owns or controls their own hospitals, and COMs are organized in a variety of ways, generally not along the models seen in the university based allopathic academic health center models. Therefore, there is a substantial difference between the community-based model of GME consortia and the more traditional allopathic academic health center model. Osteopathic GME consortia more closely follow a “community-based academic health center” model, marked by an environment in which students and trainees are learning and practicing within the community.

By building medical education partnerships, OPTIs enhance educational quality, facilitate sharing of educational resources, provide faculty development, foster cooperative training programs, support community-based medical education, encourage clinical research, and create strong linkages among

8. Osteopathic Postdoctoral Training Institutions, <http://jaoa.org/article.aspx?articleid=2092996> (The Journal of the American Osteopathic Association, November 2004, Vol. 104, pp 479-483)

9. Osteopathic Postdoctoral Training Institution (OPTI) Accreditation Handbook, <https://www.osteopathic.org/inside-aoa/accreditation/postdoctoral-training-approval/Documents/opti-accreditation-handbook.pdf>

10. A Non-OPTI Osteopathic GME Consortium: Strategies for the SAS, https://www.aacom.org/docs/default-source/2017-AC/f_mohr_a-non-opti.pdf?sfvrsn=2

11. Thomas Duffy, MPH; Bulmaro Martinez, MPH. Examining OPTI Operations With a New Light. The Journal of the American Osteopathic Association. March 2010, Vol. 110, pp 160-167, <http://jaoa.org/article.aspx?articleid=2094026>

medical schools, teaching hospitals, and ambulatory training facilities. This community-based medical education focus has led to a larger percentage of osteopathic physicians practicing in rural and underserved communities.¹²

Characteristics of osteopathic GME consortia include a focus on: community-based, mission-driven and socially accountable medical education, provision of health care to rural and underserved patients and training in primary care and general specialties. Consortia have a solid niche including building a career pipeline for graduates through faculty development, providing sustainable student rotations, and developing new GME programs.

Impact of Single GME Accreditation on the OPTI System

The ACGME, AOA, and AACOM, signed an agreement in February 2014 to create a single GME accreditation system within the ACGME by June 30, 2020.

OPTI accreditation is not a component in the ACGME accreditation system, though OPTIs can apply for ACGME Institutional Sponsorship. In fact, 13 OPTIs had achieved ACGME accreditation as institutional sponsors as of March 2018. Other models have also emerged due to the transition, including COMs as institutional sponsors and consortia led by a COM.

It is important for the osteopathic community to examine and develop strategies to effectively respond to these changes in order to maintain the osteopathic learning environment. In addition, COMs, through the AOA's Commission on Osteopathic College Accreditation (COCA), have requirements to support osteopathic GME growth and clinical training opportunities for students and graduates.

12. Characteristics of Osteopathic Physicians Choosing to Practice Rural Primary Care. The Journal of the American Osteopathic Association, May 2006, Vol. 106, 274-279. <http://jaoa.org/article.aspx?articleid=2093278>

Conclusion

The rapid growth of osteopathic medical schools, applicants, and graduates led to numerous demands on the profession's educational system and led to the creation of innovative models to meet the needs of the community. The OPTI system, therefore, is a response to meet the demand for OGME, while maintaining quality in the delivery of education. The single accreditation system presents a shift in how OPTIs function and in the role of clinical collaborations. The linkages between colleges, training sites, and the availability of clinical and postdoctoral training should be maintained to promote uniquely osteopathic principles and practice.

AACOM is examining the changing environment and evaluating its responses to ensure that clinical education collaborations are of optimum quality, that best practices are promoted and maintained, and that the needs of the American public are supported now and in the future. Osteopathic clinical education collaborations will continue to play a crucial role in primary care and maintain a community-based focus while providing service to rural and underserved populations.

Box 1. OPTI Objectives¹³

1. Develop a single standardized system of reviewing and approving institutions for sponsoring osteopathic postdoctoral training. This standardized system will apply to all sponsoring institutions, whether hospitals colleges, traditional osteopathic hospitals, or traditional allopathic hospitals with AOA accreditation status. The OPTI replaces the previously used hospital accreditation with the newly developed educational accreditation. Hospital accreditation assesses the quality of patient care, while the educational accreditation assesses resources available for quality medical education. It is inappropriate to continue to base educational training potential on hospital facility and care standards.
2. Introduce well-recognized essentials of academics into osteopathic clinical training programs. These academic standards include the formation of a clinical faculty, professional growth and development of that faculty, development and use of a curriculum, functional educational evaluation, self-evaluation of the program by the institution, requirement of a critical mass of trainees and programs within an OPTI, and the integration of Osteopathic Principles and Practice into all training programs of the OPTI.
3. Assure continuation of federal and other funding levels for osteopathic GME programs by quality enhancement due to incorporation of recognized academic standards. Graduate medical education funding from federal sources will soon be significantly affected, and any federal subsidy of GME that does occur will likely be based on demonstrated quality stratification or ranking as measured by accepted standards.
4. Assure reasonable stability of an institution's commitment and education program, in an era of increasing instability of community hospitals. An increasing number of programs have been lost because of hospital closings, sales, or mergers, and, as a result, have adversely affected trainees.

13. Opipari MI. Osteopathic Postdoctoral Training Institution: The osteopathic 'road map' to graduate medical education viability. *J Am Osteopath Assoc.* 1995;95:666-667.

