AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE

Osteopathic Medicine & Medical Education and Health Care Reform

Stephen C. Shannon, DO, MPH
President and CEO, AACOM

Presentation to the 98th Annual Convention of the Maine Osteopathic Association
Samoset Resort, Rockport, Maine
June 14, 2009
Objectives—To Understand:

1. Osteopathic Medicine’s Recent Past
2. Osteopathic Medicine Today
3. Health System Reform
4. Osteopathic Medical Education
5. The Challenges Ahead
6. The Future for Osteopathic Medicine
What is the American Association of Colleges of Osteopathic Medicine (AACOM)?

- Founded in 1898 to lend support and assistance to osteopathic medical schools
- Association of all of the nation’s accredited COMs
- Governed by the Board of Deans (all colleges represented on the Board)
AACOM’s Mission

The American Association of Colleges of Osteopathic Medicine promotes excellence in osteopathic medical education, in research and in service, and fosters innovation and quality among osteopathic colleges to improve the health of the American public.
Private (19) Colleges of Osteopathic Medicine

- Pacific Northwest University College of Osteopathic Medicine, Washington (PNWUCOM)
- Philadelphia College of Osteopathic Medicine (PCOM), Pennsylvania
  - Georgia Campus–PCOM
- Pikeville College School of Osteopathic Medicine (PCSOM), Kentucky
- Rocky Vista University College of Osteopathic Medicine, Colorado (RVUCOM)
- Touro College of Osteopathic Medicine – New York (TOUROCOM)

- Touro University College of Osteopathic Medicine (TUCOM-CA), California
  - TUCOM–Nevada Campus
- University of New England College of Osteopathic Medicine (UNECOM), Maine
- Edward Via Virginia College of Osteopathic Medicine (VCOM)
- Western University College of Osteopathic Medicine of the Pacific (Western U/COMP), California
Private (19) Colleges of Osteopathic Medicine

- A.T. Still University School of Osteopathic Medicine – Arizona (ATSU/SOMA)
- A.T. Still University of Health Sciences/Kirksville College of Osteopathic Medicine (ATSU/KCOM), Missouri
- Arizona College of Osteopathic Medicine of Midwestern University (AZCOM)
- Chicago College of Osteopathic Medicine of Midwestern University (CCOM), Illinois
- Des Moines University – College of Osteopathic Medicine (DMU-COM), Iowa
- Kansas City University of Medicine and Biosciences – College of Osteopathic Medicine (KCUMB-COM), Missouri
- Lake Erie College of Osteopathic Medicine (LECOM), Pennsylvania
  - LECOM–Bradenton Campus
- Lincoln Memorial University Debusk College of Osteopathic Medicine (LMU-DCOM), Harrogate, Tennessee
- New York College of Osteopathic Medicine of New York Institute of Technology (NYCOM/NYIT)
- Nova Southeastern University – College of Osteopathic Medicine (NSU-COM), Florida
Public (6) Colleges of Osteopathic Medicine

- Michigan State University College of Osteopathic Medicine (MSUCOM)
- Ohio University College of Osteopathic Medicine (OUCOM)
- Oklahoma State University Center for Health Sciences – College of Osteopathic Medicine (OSU-COM)
- University of Medicine and Dentistry of New Jersey – School of Osteopathic Medicine (UMDNJ-SOM)
- University of North Texas Health Science Center at Fort Worth/Texas College of Osteopathic Medicine at Fort Worth (UNTHSC/TCOM)
- West Virginia School of Osteopathic Medicine (WVSOM)
Osteopathic Medicine was largely a separate profession, regionally-based:

- Separate schools (15--of which 9 were recent)
- Separate hospitals
- Separate GME (primary care)
- Separate licensing exams
- Separate licensing boards
- Separate specialty boards
- Separate specialty practices (solo or small group)
Osteopathic physicians in 1980:
- 1,059 DO graduates (7% of US MD + DO grads)
- 17,620 practicing DOs (3.8% of active physicians)
- ~5% of DOs Female
- 2/3’s primary care practices

Osteopathic physicians in 2008:
- 3500 DO graduates (21% of US MD + DO grads)
- 55,000 practicing DOs (7% of active physicians)
- 30% of DOs Female
- ~60% primary care practice
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Osteopathic Medical Workforce

- 20% of US Population live in Rural Areas
- 9% of US Physicians Practice in Rural Areas
- Nearly 7% of US Physicians are DOs
- 15% of FP DOs practice in Rural Areas
- 17.4% of all DOs practice in Rural Areas
- 22% of Physicians in Medically Underserved Areas are DOs

American Osteopathic Association Dept of Quality and Research
<table>
<thead>
<tr>
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<tr>
<td>Regional to National</td>
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<tr>
<td>Separate Hospital system gone</td>
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<td>Separate GME system changing</td>
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<td>Separate health care system to integrated systems and practices</td>
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<tr>
<td>Primary care under challenge</td>
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<td>OMM Specialization</td>
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<tr>
<td>Private to public</td>
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<td>Implementing a research mission and culture</td>
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Forces for Change

- Aging population
- Chronic disease epidemic
- Rising expectations for evidence-based education/practice and quality
- Acceleration of technological change:
  - Molecular biology
  - Nanotechnology
  - Imaging
  - Robotics
  - Information technology
Forces for Change

- Globalization
- Public-private innovation (medical home/minute clinics)
- Predictive health (targeting prevention)
- Shifting diversity of US population
- Politico-**economic** changes in US healthcare environment
By 2025 a 20% increase in US population and a 75% increased in those > 65

Total population 2000 – 282,125,000
Total population 2050 – 419,854,000

- Hispanic/Latino will grow from 12.6% to 24.4%
- African-American will grow from 12.7% to 14.6%
- Asian/PI will grow from 3.8% to 8.0%
- Other non-White racial groups will grow from 2.5% to 5.3%
In an environment...

- Without a US Health Care System
- Growing numbers of uninsured
- Lacking diversity in health care professions
- Maldistribution of healthcare resources
- Evidence and predictions of health workforce shortages
Physician Workforce

We are in the early stages of a period of deepening physician shortages.

Approx 2020-2025

Deficit = ~200,000 physicians (~20%)

We are Here

Source: Richard Cooper, MD
Projected National Supply & Shortfall of Physicians with/without GME Expansion

Year
2005 2010 2015 2020 2025
Baseline Supply
Shortfall
Additional Supply from GME Expansion

FTE Physicians (excl. residents)
650,000 700,000 750,000 800,000 850,000 900,000
Physician Workforce

Adapted from a chart prepared by AAMC with data from AMA. Active physicians includes residents and fellows. 1985 data excludes 24,000 DOs.
Half of the Primary Care Workforce 50 Years or Older

2007 AMA Physician Masterfile
Cleese Erikson, AAMC
Recent Reports of Physician Shortages: Specialty Studies

- Allergy & Immunology (2000)
- Anesthesia (2003)
- Cardiology (2004)
- Child Psychiatry (2006)
- Critical Care Workforce (2006)
- Dermatology (2004)
- Endocrinology (2003)
- Family Medicine (2006)
- General Surgery (2008)
- Geriatric Medicine (2007)
- Medical Genetics (2004)
- Neurosurgery (2005)
- Oncology (2007)
- Pediatric Subspecialty (2008)
- Psychiatry (2003)
- Public Health (2007)
- Rheumatology (2007)
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<td>Michigan</td>
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<td>Mississippi</td>
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<td>Nevada</td>
<td>2006</td>
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<tr>
<td>New York (regional)</td>
<td>2007</td>
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<td>North Carolina</td>
<td>2007</td>
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<tr>
<td>Oregon</td>
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<td>Virginia</td>
<td>2007</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>2004</td>
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</table>
Physician Workforce

- Projections continue to show shortage
  - Most plausible scenario based on current trends: 160,000 shortage by 2025 (AAMC-2008)

- Assumptions:
  - Increased utilization
  - Older physicians likely to retire earlier
  - Younger physicians (especially females) likely to perform less clinical care
  - MD schools likely to grow near 30% over next 10-15 years
  - DO schools likely to grow another 30% over next 10 years
  - GME expansion not sufficient to handle DO/MD growth

- Number of IMGs continuing to grow
- Number of PAs/NPs growing rapidly
Clinically Active PAs Have Nearly Tripled in the last 15 Years (in thousands)

Source: American Academy of Physician Assistants and AAMC
Over Last 15 Years, Percentage of PAs Going into Generalist Specialties Decreased While Sub-specialists Increased

Source: American Academy of Physician Assistants and AAMC
The Number of Licensed NPs Increased by 80 Percent Between 1999 and 2006

Note: Represents sum of all NPs licensed in all states; it is estimated that an unduplicated count would reduce these numbers by 10%.

Mortality Amenable to Health Care

Deaths per 100,000 population*

* Countries’ age-standardized death rates before age 75; including ischemic heart disease, diabetes, stroke, and bacterial infections.
Source: Commonwealth Fund National Scorecard on U.S. Health System Performance, 2008
International Comparison of Spending on Health, 1980–2006

Total expenditures on health as percent of GDP

Average spending on health per capita ($US PPP)

Data: OECD Health Data 2008 (June 2008)
Five Key Strategies for High Performance

1. Universal and well-designed coverage that ensures affordable access and continuity, with low administrative expenses

2. Incentives aligned to promote higher quality and efficient care

3. Care that is organized around the patient

4. Investment in public reporting, evidence-based medicine, and health information technology to deliver the best care

5. National policies and collaboration to set and achieve goals

JOINT PRINCIPLES OF THE PCMH (FEBRUARY 2007)

The following principles were written and agreed upon by the four Primary Care Physician Organizations – the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association.

Principles:
1. Ongoing relationship with personal physician
2. Physician directed medical practice
3. Whole person orientation
4. Coordinated care across the health system
5. Quality and safety
6. Enhanced access to care
7. Payment recognizes the value added
The PCMH Joint Principles have received endorsements from 13 specialty health care organizations:

The 13 organizations endorsing the Joint Principles are:

- The American Academy of Chest Physicians
- The American Academy of Hospice and Palliative Medicine
- The American Academy of Neurology
- The American College of Cardiology
- The American College of Osteopathic Family Physicians
- The American College of Osteopathic Internists
- The American Geriatrics Society
- The American Medical Directors Association
- The American Society of Addiction Medicine
- The American Society of Clinical Oncology
- The Society for Adolescent Medicine
- The Society of Critical Care Medicine
- The Society of General Internal Medicine

The PCMH Joint Principles have recently also received an endorsement from the American Medical Association.
Defining the Medical Home

**Superb Access to Care**
- Patients can easily make appointments and select the day and time.
- Waiting times are short.
- E-mail and telephone consultations are offered.
- Off-hour service is available.

**Patient Engagement in Care**
- Patients have the option of being informed and engaged partners in their care.
- Practices provide information on treatment plans, preventative and follow-up care reminders, access to medical records, assistance with self-care, and counseling.

**Clinical Information Systems**
- These systems support high-quality care, practice-based learning, and quality improvement.
- Practices maintain patient registries; monitor adherence to treatment; have easy access to lab and test results; and receive reminders, decision support, and information on recommended treatments.

**Care Coordination**
- Specialist care is coordinated, and systems are in place to prevent errors that occur when multiple physicians are involved.
- Follow-up and support is provided.

**Team Care**
- Integrated and coordinated team care depends on a free flow of communication among physicians, nurses, case managers and other health professionals.
- Duplication of tests and procedures is avoided.

**Patient Feedback**
- Patients routinely provide feedback to doctors; practices take advantage of low-cost, internet-based patient surveys to learn from patients and inform treatment plans.

**Publically available information**
- Patients have accurate, standardized information on physicians to help them choose a practice that will meet their needs.

Source: Health2 Resources 9.30.08
<table>
<thead>
<tr>
<th>TODAY’S CARE</th>
<th>MEDICAL HOME CARE</th>
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<tbody>
<tr>
<td>My patients are those who make appointments to see me</td>
<td>Our patients are those who are registered in our medical home</td>
</tr>
<tr>
<td>Patients’ chief complaints or reasons for visit determines care</td>
<td>We systematically assess all our patients’ health needs to plan care</td>
</tr>
<tr>
<td>Care is determined by today’s problem and time available today</td>
<td>Care is determined by a proactive plan to meet patient needs without visits</td>
</tr>
<tr>
<td>Care varies by scheduled time and memory or skill of the doctor</td>
<td>Care is standardized according to evidence-based guidelines</td>
</tr>
<tr>
<td>Patients are responsible for coordinating their own care</td>
<td>A prepared team of professionals coordinates all patients’ care</td>
</tr>
<tr>
<td>I know I deliver high quality care because I’m well trained</td>
<td>We measure our quality and make rapid changes to improve it</td>
</tr>
<tr>
<td><strong>Acute care is delivered in the next available appointment and walk-ins</strong></td>
<td><strong>Acute care is delivered by open access and non-visit contacts</strong></td>
</tr>
<tr>
<td>It’s up to the patient to tell us what happened to them</td>
<td>We track tests &amp; consultations, and follow-up after ED &amp; hospital</td>
</tr>
<tr>
<td>Clinic operations center on meeting the doctor’s needs</td>
<td>A multidisciplinary team works at the top of our licenses to serve patients</td>
</tr>
</tbody>
</table>
The Patient-Centered Primary Care Collaborative recommends a three-part payment methodology,

**Including:**

A) A monthly care coordination payment for the physician’s work that falls outside of a face-to-face visit and for the health information technologies needed to achieve better outcomes,

B) A visit-based fee-for-service component that is recognized for services that are currently paid under the present fee-for-service payment system, and

C) A performance-based component that recognizes achievement of service, patient centeredness, quality and efficiency goals.
Primary Care — Will It Survive?

Thomas Bodenheimer, M.D.
Family Medicine Residency Positions and Number Filled by U.S. Medical School Graduates (Bodenheimer, NEJM: 355, 861-864)
Third-Year IM Residents Choosing Career as Generalists, Subspecialists and Hospitalists (Bodenheimer, NEJM: 355, 861-864)
Primary Care Income Far Less than most Other Specialties
(Median Salary by Specialty, in Thousands of Dollars)

Anesthesiology
Urology
Radiology & Diagnostic Radiology
Orthopedic Surgery
Otolaryngology
Pathology
Dermatology
Ophthalmology
General Surgery
OB/GYN
Emergency Medicine
Psychiatry
General Internal Medicine
General Pediatrics
Family Medicine/General Practice

$50 $100 $150 $200 $250 $300 $350 $400 $450

MGMA Physician Compensation Survey 2006
…and Differences Between Primary Care and Other Specialties Is Growing (Median Salary by Specialty in Thousands of Dollars)

MGMA Physician Compensation Survey 2001-2006
Growth of Osteopathic Medical Colleges
(1968 – 2008)

Total Enrollment and Number of Colleges

- **Total enrollment**
- **Number of colleges**

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<th>Year</th>
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<td>2003</td>
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<table>
<thead>
<tr>
<th>Year</th>
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<td>1968</td>
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<td>2003</td>
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<td>2008</td>
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</table>

Five-year intervals
Factors in Growth of OME

- Success of DO graduates
- Distribution of DO graduates
- Increased integration of DOs into medical education & health care system
- Physician shortages
- Financial Model
- Primary care focus
Distribution of Osteopathic Physicians and Schools

2004-05

Data Source: AOA
Allopathic Medical Students and Colleges

- Allopathic Medical Students (all)
- Allopathic Medical Colleges

Number of students

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Students</th>
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Number of colleges

- Allopathic Medical Students (all)
- Allopathic Medical Colleges

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<td>2005</td>
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The current projections of U.S. physician workforce supply. The factors influencing the need/demand for physician services. The factors influencing physician workforce supply. The developments in osteopathic medical education related to the physician workforce in the U.S.
Osteopathic Medical Schools: New Since 2000 or In Active Planning

Source: AACOM, AOA
New COM Campuses/Additional Locations: in Development or Planned  (Source: COCA)

- LECOM – additional location (2009) at Seton Hill, PA
- MSU-COMP— additional locations (2009) at Detroit and Clinton Township, MI
- Western University COM—additional location (2010) in Corvallis, OR
- William Carey University—new COM (2010) in Hattiesburg, MS
- Heartland University of Health Sciences—new COM (2012) in Kansas City, MO
- Virginia College of Osteopathic Medicine—Branch Campus in Spartanburg, SC
- Alabama Medical Education Consortium—new COM
COM Deans Growth Survey Results (preliminary 2008)

DO First Year Medical School Enrollment

- 1992: 2,035
- 1997: 2,692
- 2002: 3,079
- 2003: 3,308
- 2004: 3,646
- 2005: 3,908
- 2006: 4,055
- 2007: 4,408
- 2008: 4,732
- 2009: 4,994
- 2010: 5,219
- 2011: 5,404
- 2012: 5,449
- 2013: 5,519

Projected
COM Deans Growth Survey Results (preliminary 2008)

First year Enrollment, Public/Private

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<th>Public COM FY enrollment</th>
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Total Applicants to AACOMAS

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<tr>
<td>2008</td>
<td>11,742</td>
</tr>
<tr>
<td>2009</td>
<td>12,791</td>
</tr>
</tbody>
</table>

1 Based on total applicants received by AACOMAS – 2009 data as of 03/20/2009

Source: AACOMAS, American Association of Colleges of Osteopathic Medicine Application Services
Medical School Applications

Number of Medical School Applications for each available first year seat

2008 Osteopathic projection is based on an increase of 7% in the application pool.

Allopathic data for 2007 and projections for 2008 have not been published by AAMC as of 09/26/2007.
Matriculant Grade Point Averages

Source: Until 2006 - AACOM, Annual Osteopathic Medical School Questionnaires
From 2007 – Applicant data on AACOMAS application
Mean GPA Scores: Applicants vs. Matriculants

Source: Applicant data on AACOMAS application
Mean MCAT Scores: Applicants vs. Matriculants

Source: Applicant data on AACOMAS application
Number and Source of Physicians Entering GME Training in 2004

24,012 Entered MD and DO Training in 2004

- **IMGs** 6,013 (25%)
  - US IMGs 1,300 (5%)
  - Non-US IMGs 4,713 (20%)
- **Osteopathic Graduates** 2,756 (11%)
  - Osteopathic Graduates in DO Programs 1,285 (5%)
  - Osteopathic Graduates in MD Programs 1,471 (6%)
- **Allopathic Graduates** 15,099 (64%)
- **Other+** 144 (0.6%)

*Total IMGs = 6,013; Distribution among US and Non-US IMGs is estimated.*
+ Includes Canadian Graduates (72)
Source: AAMC GMETrack and AOA Master File
Less than half of DO grads entering osteopathic match
Declining percentage of DOs entering osteopathic primary care programs
Declining percentage of DOs choosing primary care programs ACGME or AOA
AOA Match Results (2009 pre-scramble)

Current Senior Match Results:

<table>
<thead>
<tr>
<th>Category</th>
<th>Matched</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matched</td>
<td>1399</td>
<td>(38%)</td>
</tr>
<tr>
<td>Unmatched</td>
<td>307</td>
<td>(8%)</td>
</tr>
<tr>
<td>Military</td>
<td>202</td>
<td>(5%)</td>
</tr>
<tr>
<td>Non-participants</td>
<td>1816</td>
<td>(49%)</td>
</tr>
</tbody>
</table>

AOA Family Medicine:

<table>
<thead>
<tr>
<th>Category</th>
<th>Matched</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matched</td>
<td>319</td>
<td>(51%)</td>
</tr>
<tr>
<td>Positions</td>
<td>629</td>
<td></td>
</tr>
</tbody>
</table>

All AOA (funded) Positions:

<table>
<thead>
<tr>
<th>Category</th>
<th>Matched</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matched</td>
<td>1433</td>
<td>(59%)</td>
</tr>
<tr>
<td>Positions</td>
<td>2435</td>
<td></td>
</tr>
</tbody>
</table>
DO Graduates (% OGME)

Percentage of DO Graduates Participating in and Matching in Osteopathic GME (including scramble)

80.0%
60.0%
70.0%
40.0%
50.0%
20.0%
30.0%
0.0%
10.0%


% of osteopathic graduates participating in DO GME match % of osteopathic graduates matching in DO GME match (including scramble)

## DOs in ACGME Programs (2007-2008)

ACGME Total Residents: 106,012

<table>
<thead>
<tr>
<th>Category</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>US MD Grads</td>
<td>70,056</td>
<td>66.1%</td>
</tr>
<tr>
<td>IMGs</td>
<td>28,824</td>
<td>27.2%</td>
</tr>
<tr>
<td>DOs</td>
<td>6,784</td>
<td>6.4%</td>
</tr>
<tr>
<td>Canadian</td>
<td>341</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

Source: JAMA, Sep 10, 2008
75% of DOs in ACGME Programs are in:

<table>
<thead>
<tr>
<th>Program</th>
<th># DO</th>
<th>(% DO)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Medicine</td>
<td>1305</td>
<td>(14.0%)</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>1246</td>
<td>(5.7%)</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>542</td>
<td>(6.7%)</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>488</td>
<td>(9.8%)</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>403</td>
<td>(9.0%)</td>
</tr>
<tr>
<td>Obstetrics/Gynecology</td>
<td>365</td>
<td>(7.7%)</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>349</td>
<td>(7.5%)</td>
</tr>
<tr>
<td>Physical Medicine &amp; Rehabilitation</td>
<td>310</td>
<td>(26.2%)</td>
</tr>
</tbody>
</table>

**TOTAL** 5008

JAMA, Sep 10, 2008
Change in Intent to Pursue Primary Care

Plan to Specialize in Primary Care as First Year Students and as Graduates
(matched cohorts)

Data Source: AACOM Survey of First Year Students and Graduating Seniors
Primary Care Career Plans and Educational Debt

Data Source: AACOM Survey of Graduating Seniors
Graduate Self Reported Debt

Medical School Grad Self Reported Mean Education Debt -- All students

Data sources -- ACOM Survey of Graduating Seniors, AAMC Graduating Student Questionnaire
Medical Student Debt Level (2006)

- DO Graduates: $154,000 average debt
  - $134,000 Public Schools
  - $160,000 Private Schools

- MD Graduates: $113,000 average debt
  - 2/3’s attending public institutions
  - $160,000 Private Schools

Source: AACOM and AAMC 2006 Graduate Survey
DOs in Primary Care Residency Position
(Family, Internal and Pediatric Medicine)

- Percent of DOs in AOA Residency in Primary Care
  - 97-98: 56%
  - 98-99: 56%
  - 99-00: 55%
  - 00-01: 55%
  - 01-02: 53%
  - 02-03: 52%
  - 03-04: 50%
  - 04-05: 49%
  - 05-06: 48%

- Percent of DOs in ACGME Residency in Primary Care
  - 97-98: 51%
  - 98-99: 49%
  - 99-00: 48%
  - 00-01: 46%
  - 01-02: 44%
  - 02-03: 41%
  - 03-04: 37%
  - 04-05: 35%
  - 05-06: 32%

- Percent of DOs in AOA and ACGME Residencies in Primary Care
  - 97-98: 45%
  - 98-99: 46%
  - 99-00: 44%
  - 00-01: 41%
  - 01-02: 37%
  - 02-03: 35%
  - 03-04: 32%

AAMC}

American Association of Colleges of Osteopathic Medicine
US graduates/GME Projection Scenario
(GME growth rate continues at current rate)

- 25,400 (estimate) PGY1 GME positions 2006
  - 13% DOs (2700)
  - 27% IMGs (6800)
  - 60% LCME (15800)
  - LCME + DO grads = 18500

- In 2016 expect:
  - 5500 DO grads
  - 19,000 MD grads
  - LCME + DO grads = 24,500 for 28,000 PGY1 positions

- Current scenarios, by 2020 expect 27,000 MD + DO grads, 8500 more than 2006 for 29,500 PGY 1 positions
AMA’s Initiative to Transform Medical Education (2007)

1. While US MD schools had strength in conveying knowledge and skills, there were gaps that affect quality:
   - Patient advocacy
   - Loss of altruism
   - Ability to communicate with patients
   - Patient-centeredness
2. Some proposed solutions:

- Apportion more weight in admissions decisions to characteristics of applicants that predict success in the interpersonal domains of medicine.
- Increased faculty and institutional focus on teaching and education.
- Service and community orientation throughout medical education experience, starting with admissions.
- Early community-based patient experiences.
Medical schools should … give greater priority to the teaching mission of faculty.

Medical school leadership should improve institutional culture to prioritize social needs.

Medical school missions should be aligned with the health needs of the society

Renew focus on Primary Care
Medical school admissions should broaden the definition of merit and downgrade the importance of standardized tests and GPAs.

Medical schools have an obligation to substantially reduce the level of student debt.

The AAMC and AACOM should accelerate their efforts to reassess and update the MCAT examination and the pre-medical requirements for admission to medical school.
Osteopathic Distinctiveness

OME Leadership Conference Discussion:

- OMM/Hands-on/Touch
- Admissions process
- Primary care/patient-care focused curriculum
- Early patient interaction
- Patient-centered
- Education- vs research-focused
- Community-based clinical education
The Challenges Ahead

- Osteopathic Medical Education and practice in time of shortage
- Innovation and evaluation
- Evidence-based transformation
- The political-economic environment
Today’s Issues for OME

- Growth: Need and capacity
  - Clinical training (volunteer faculty system)
  - Faculty and academic resources
  - GME/OGME
- Development of a research/evidence-based culture
  - Study/Validation of OP & P/OMM
- New curriculum models
  - Competency-based
  - Health care reform-related, e.g. interprofessional
- Shifting specialty interest of students
  - Will primary care focus survive?
  - OMM Specialization
- Resources/Student Debt
- Recognition and place in health care system
Advocacy Issues

- GME
- Title VII
- Health Care Reform
- Primary Care
- Scholarship and Loans
- Diversity of the medical workforce
- Osteopathic Medicine Research
  - NIH
  - AHRQ
- Higher Education
- HRSA advisory bodies
The physicians produced by osteopathic medical education are the physicians this country needs....
The American Association of Colleges of Osteopathic Medicine promotes excellence in osteopathic medical education, in research and in service, and fosters innovation and quality among osteopathic colleges to improve the health of the American public. – AACOM Mission Statement