AMERICAN ASSOCIATION OF
COLLEGES OF OSTEOPATHIC MEDICINE

AMERICAN OSTEOPATHIC ASSOCIATION
TREATING OUR FAMILY AND YOURS

MEDICAL EDUCATION SUMMIT I & II FINAL REPORT

EXECUTIVE SUMMARY

MEDICAL EDUCATION SUMMIT I (MES I)

The first Medical Education Summit (MES I) held January 26-29, 2006 in Chicago, IL, was a historic event that brought together approximately 70 key leaders in the osteopathic profession to discuss important education issues and develop recommendations through a process of consensus. It is the expectation of the leaders of American Association of Colleges of Osteopathic Medicine (AACOM) and the American Osteopathic Association (AOA) that the work of Medical Education Summits will be the catalyst to transform osteopathic medical education over the next five to ten years. The profession must develop full, robust strategies, analyze the impact of external and internal forces on osteopathic medical education and implement necessary changes to ensure that high quality, competitive osteopathic undergraduate and graduate medical education programs are valued by practicing osteopathic physicians, students and trainees. The profession must bring all stakeholders into this process to develop goals and objectives and integrate quality initiatives that will ultimately meet the needs of our patient population and communities in terms of improving patient care. Building a supportive educational infrastructure throughout the continuum of education is critical to the osteopathic profession. We want osteopathic physicians to be recognized for their contribution to the medical community and serving patients in the US and abroad.

Sixty-one consensus statements were developed and approved during MES I process. AOA and AACOM Leadership asked the Board of Deans and AOA Bureau of Osteopathic Education to review the consensus statements, prioritize them and develop recommendations to go forward.

The BOE further divided the consensus statements into six categories: Data, Quality, Marketing, Growth, Recruitment (UME and OGME) and Accreditation. Each statement was prioritized as “high”, “medium” or “low.” High indicated the recommendation should be given immediate attention and resources to address the issue. Medium indicated issues that should be addressed soon, but not before High issues were addressed. Low indicated the statement was of importance, but not an immediate concern at this time.

DATA

The following four consensus statements (CS) (20, 25, 32 and 33) were assigned to the “Data” category and ranked as “high” priority.

1. CS 20 recommended that the AOA Trainee Information, Verification, and Registration Audit (TIVRA) system should provide timely and accurate information and that the COPT should stiffen oversight and penalties for programs not in compliance. The Bureau rated this statement as a "high" priority. The COPT and BOE submitted a resolution (R 30 A/06) to the AOA Board of Trustees for the COPT to assign fines and other penalties in monitoring compliance. AOA staff has indicated since this penalty has been in place, there have been no programs out of compliance in completing the required electronic submissions

2. CS 25 recommended that the AOA, AACOM, hospitals and OPTIs should work together to improve web-based systems including OPPORTUNITIES and DO-Online, and they should interlink and accurately reflect all available OGME programs nationwide. It was reported that AACOM and the AOA have implemented new website designs and the AOA Division of Postdoctoral Training upgraded OPPORTUNITIES in 2006-2007. The Trainee Information, Verification, and Registration Audit was launched in September of 2005. Upgrades to both TIVRA and Opportunities have been made by the AOA IT Division on an annual basis. An agreement has been developed between the AOA and AACOM regarding data sharing that has been implemented since 2006.

3. CS 32 recommended that specialty colleges check the accuracy of OPPORTUNITIES and CS 33 recommended that the Bureau of Osteopathic Specialty Societies and specialty colleges evaluate the accuracy and acquisition of the data on OPPORTUNITIES. The statement proposed that a "report card" be created to include quality measures, board pass rates, faculty to resident ratios, didactic education programs, affiliate programs, percentages who stay in the program, and information on those who leave the state.

The Bureau recommends that the COPT develop this report card and send letters to the Specialty Colleges to start the process by July 2007 so that the graduating class of 2008 benefits from this initiative.

2011 Update: Opportunities is monitored by AOA staff. All training programs are required to complete designated fields on Opportunities on a yearly basis prior to the start of recruitment season. AOA staff monitors compliance and reports to the Secretary of the COPT when the final date of compliance is required. The COPT has instituted standards that if a training program is not in compliance by the designated due date, fines are in effect. In the past five years, no training program has missed the deadline.

QUALITY

At the first Medical Education Summit, five consensus statements were assigned to the "Quality" category, three ranked as "high" priorities.
Recommended was that the COPT enhance, promulgate and enforce OGME standards in conjunction with the specialty colleges using available benchmarks, and specialty societies should review standards to enhance quality and value to their education.

The COPTI proposed new standards that were approved by the AOA Board of Trustees in February. The COPT continually reviews the specialty college standards and develops required standards for all specialty colleges that will enhance education.

The Bureau recommends the following action steps:

1. Strengthen the OPTIs and give them authority to act and enforce standards;
2. Facilitate the OPTI clearinghouse as the place to post best practices;
3. Improve enforcement of post review action plans; and
4. Analyze quality training benchmarks in medical education training to adapt profession wide training standards – propose a committee or task force be formed and the committee should include both DOs and PhDs familiar with data and literature.

CS 36 recommended that OGME programs be expanded to ensure credibility among osteopathic medical students via increasing the number of programs in desired specialties and locations while ensuring high quality. Though this recommendation was given a medium priority and was ranked third, it was noted that there is discussion by the Steering Committee for MES II to focus on this recommendation. Recommendations from CS 23 and 64 will also apply to this statement (also see CS 29 under "Growth").

CS 56 recommended the AOA, AODME and specialty colleges develop assistance to hospitals who need consultative services to start new programs (increase funded osteopathic training programs and caps). The OGME Development Initiative started in January 2007. The initiative includes a cadre of advisors who are available to hospitals and osteopathic physicians who would like to start a program at their institution. From business experts to training experts, the advisors are available to provide support to new institutions and their leaders. [Need to get update from Margaret Hardy, Secretary to the Initiative]

MARKETING

Four consensus statements (21, 35, 41, and 60) were assigned to the "Marketing" category. CS 41 was given a "high" priority and ranked first in the "Marketing" category. CS 21 was given a "high" priority and ranked second. CS 35 was given a "high" priority and ranked third. CS 60 was given a "medium" priority and was ranked last.

CS 21 recommended that AOA, AACOM and COMs work collaboratively over the next 3-5 years to develop and implement a marketing approach for the industry using the "branding" campaign and that promotional information for students in UME and OGME be included in the branding campaign. AACOM recruited a Director of Communications in 2006 who will be working with the AOA and COMs to develop a branding campaign. The Council of Interns and Residents already presents AOA materials at their COM visits.

In addition, the BOE recommended that a Public Relations Group in the AOA and AACOM and COMs work collaboratively to develop innovative communications about the profession (new media, TV, podcasts, etc.) and that focus groups be conducted with those in practice to research if members are satisfied with their educational choices and the AOA. To evaluate if this recommendations are being met the profession should see an increase in the number of trainees choosing AOA training programs and increase AOA membership and activity levels of members.

CS 35 recommended that the AACOM create ongoing education programs that target undergraduate medical education (UME) students and faculty to teach about UME opportunities. The AACOM Board of Deans endorsed this recommendation as their number one strategic initiative at their June Board meeting.

The Board recommended the osteopathic profession (AOA and AACOM):

1. Educate the community on the benefits of DO involvement in the community – i.e. promoting the impact of graduates on COMs in their states;
2. Encourage more interaction of students and DOs with the community to promote the profession;
3. Increase efforts to education premed advisors about the profession;
4. Encourage COM alumni of COMs promote the profession to students where they earned their undergraduate (BS) degrees;
5. Encourage state societies to mobilize DOs in their state to promote the profession; and
6. Expand these into ideas to promote OGME training. In particular to watch the hidden and overt messages we give to our COM students regarding ACGME and AOA training.

To evaluate if these expectations are being met the profession will see: 1. An increase in the number of applicants to COMs, 2. A change in the profile of applicants to see if more elect COMs as their first choice for medical school; and 3. An increase in OGME trainees and retention of AOA members.

CS 41 recommended the AOA/ACGME Task Force build stronger relationships between the osteopathic specialty boards and the specialty colleges to encourage DOs to take osteopathic board certification; increase the number of parallel track programs and convince the ACGME to recognize and accept osteopathic board certification. The leadership of the ACGME changed in 2009. AOA leadership has met several times with ACGME leaders in 2010 to discuss possible projects that would enhance a closer working relationship and will continue discussions in 2011. Parallel track programs as opposed to dual programs have grown slightly since the original recommendation in 2006, however, because there are limits to growth of new osteopathic programs in institutions that already have Capped limits on residency slots, it is unlikely many new parallel training slots will be added.

CS 60 recommended that the AAO, AODME and OPTIs work collaboratively to support and publicize existing efforts to achieve equitable direct GME payment. The AOA is publicizing activities through conference calls and written material to the AODME, BOFHP and BOH. It should be noted that CMS recognizes AOA and ACGME programs equally. There are relatively fewer funded AOA positions and a growing number of AOA positions at risk of losing funding from CMS if not filled. Since the first summit, CMS has reallocated slots from unfilled positions to programs that are maintaining their capped positions. The osteopathic slots that do no fill are primarily in primary care positions in 2010. The AOA filled 85% of their first year positions in 2010 as opposed to 69% in 2006. This is due to continued growth in number of new trainees, the restructuring of internship slots to residency slots in 2008 and the loss of slots from CMS restructuring. The osteopathic profession needs to encourage specialties and state societies to look for opportunities for growth, particularly in specialties and locations that are attractive to medical students and in primary care.

GROWTH
Six consensus statements (17, 28, 29, 37, 42, and 58) were assigned to the "Growth" category. CS 58 was given a "high" priority and ranked first in the "Growth" category. All other statements were given a "low" priority. CS 17 and 37 were linked together as the same recommendation and ranked second. CS 28 was ranked third. CS 29 and 51 were linked together as the same recommendation and were ranked fourth. CS 17 recommended that the AOA and AACOM study dual and parallel track programs and the opportunities to maximize outcomes. Whereas, CS 37 recommended that the AOA collect more data on fill and certification rates for trainees in dually accredited programs and depending on the results either discourage or encourage programs. The AOA, BOSS, COPT and specialty colleges should develop recommendations based on the data. The AOA provided a white paper with this information to the BOE members. The white paper showed in 2006 that 66% of those in dual programs choose to take AOA boards, 37% only took osteopathic board certification. In 2008, 60% sat for AOA board certification, but that number was up again to 68% in 2010. Many of the physicians in dual programs take both AOA and ABMS board examinations, however, so there is a need to continue review if AOA recertification continues).

CS 28 recommended that the osteopathic profession develop/approve unique osteopathic programs such as IM/NMM, FP/Hospitalists, etc. through the Committees on Evaluation and Education (CEEs) of the specialty colleges and writing standards for CAQs.

The Bureau recommended that more input be solicited from the Bureau of Osteopathic Specialty Societies (BOSS), specialty colleges and the Council on Interns and Residents regarding demand for programs and thoughts on this consensus statement. The BOSS has been updated regularly on the growth of trainees in each of their specialties in both osteopathic and ACGME trainees. Charts are updated annually and are available at the MEDEDSUMMIT website.

ACCREDITATION
Four consensus statements (30, 57, 62 and 63) were assigned to the "Accreditation" category. CS 30 was given a "high" priority and ranked first in this category. CS 57 was given a "low" priority and ranked fourth. CS 62 was given "high" priority and ranked second. CS 63 was given a "high" priority and ranked last.

CS 30 recommended that the AOA Board instruct staff to identify, with the intent to remove, bureaucratic obstacles for AOA approval of programs. The COPT continually has been conducting some research on the length of time it takes to approve programs. A table is available showing the amount of time AOA staff has taken to complete their segment of the process and the average times it takes specialty colleges to complete their responsibilities. The AOA is meeting with several specialty colleges to work out strategies to improve processes. The Bureau recommended the following steps:

1. Survey students, residents, AODME, OPTIs, specialty colleges and other stakeholders to find the obstacles and help identify critical specialty areas and needs;

2. Consider allowing ACGME trained DOs and MDs to be directors in critical specialty programs on a temporary basis The Basic Document for Postdoctoral Training allows this practice already. Though some specialties resist this practice, programs may allow an MD to provide leadership for three years, with the intent to find a DO leader within three years, but this time frame can be extended.
3. Create a cadre of professional inspectors (EPPRC III – to be determined at the 2011 Board of Trustees meeting); and
4. Coordinate intern and residency inspections to occur at the same time.

RECRUITMENT

Five consensus statements (2a, 16, 22, 31 and 40) were assigned to the "Recruitment" category. CS 2a was given a "high" priority and ranked first in this category. CS 16, 22 and 31 were recommended to be rolled into CS 2a, and were therefore also given a "high" priority and ranked first. CS 40 was given a "medium" priority and ranked last.
CS 2a recommended that the osteopathic profession develop a broad and rigorous recruitment plan to provide qualified applicants and ensure successful matriculates. AACOM adopted this statement and hired a recruiter to implement a variety of interventions. It should be noted that applications were has gone up significantly each year since this recommendation was approved. There is an emphasis also to work with underrepresented minority students.

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The Bureau recommends linking this statement to CS 2a and its recommendations.
CS 22 recommended the Deans of Clinical Education promote mentoring and professionalism. AACOM has included specific mentorship related discussions in a variety of its component councils (COSGP and Student Affairs). The AOA has a formal recognition program for mentorship called iLEARN.

The MES I Survey on Quality currently in progress should address many concerns expressed by leaders on Quality.

<u>MEDICAL EDUCATION SUMMIT II (MES II)</u>

MES II was held in November 2007 and focused on the future of osteopathic graduate medical education. Discussion covered a range of topics in three general categories: global issues, resources, structural issues, and issues related to specialty mix. Fifteen concepts were generated by MES II and ranked by the Medical Education Summit Progress Task Force (MES PTF) as outlined below.

1. **Concept 6: Enhance the collaboration between UME and GME:**
    - COCA create standard for all COMs seeking class size increase to create training programs to ensure there is an OGME position for each student
    - Establish 3rd and 4th year core rotations at hospitals with OGME training programs.
2. **Concept 2b: Expand OGME for DOs**
    - Appoint Task Force to study admitting MDs into OGME training.

3. **Concept 1a: Strengthen and enforce training approval standards**
    - Standardize inspection process
    - Benchmark perception of current standards
    - Market programs to enhance perceptions
4. **Concept 8a: Support and enhance OGME**
    - Establish common minimal standards, require more rigorous standards, measure outcomes
    - Form group to define OPTI mission and role
    - Clearly define roles of AOA, OPTI, specialty colleges
    - Identify and establish resources and funding to enhance quality
5. **Concept 9a: Study OPTI**
    - 360 degree analysis
    - Conduct independent analysis of value of OPTI
    - Evaluate mandatory requirement of OPTI
6. **Concept 9: OGME**
    - 360 degree analysis of what we do best in OGME
    - Define healthcare needs of future
    - Formulate appropriate actions for OGME
    - Comparative analysis of DOs in AOA vs ACGME programs

7. **Concept 5: Enhance OGME educational program**
    - Distribute a structured educational plan that defines educational expectations and outcomes for residency training programs
    - Develop an annual program evaluation review of the trainees, trainers, program and facilities
8. **Concept 3: Advance research**
    - Foster OGME clinical research
    - Foster a culture of research in OGME
    - Foster QI through specialty college developed outcome measures
    - Foster multi-center trials
    - Develop a database of residency research
    - Publish CAP research
    - Increase usage of CAP in residency training programs
9. **Concept 7: Preserve, protect and expand GME funding**
    - Explore new federal funding sources VA, DOD, CMS, HRSA
    - Increase non-federal funded residencies
    - State dedicated tax revenues, community initiatives
    - Private payor funding, specialty practice groups
    - Increase GME programs in 'virgin' hospitals
10. **Concept 10: Advocate for financial incentives for primary care**
    - Develop innovative programs to manage medical school debt
    - Establish clearinghouse of financial aid opportunities for students, interns and resident (grants, scholarships, loan forgiveness, state programs, local programs, hospital programs, etc.)

11. **Concept 12: Advocate for new practice models in primary care**
    - Task the primary care specialty colleges to develop and fund residency programs training residents in "new models for primary care".
12. **Concept 11: Improve the perception of primary care during undergraduate medical education**
    - Create a positive culture for students during medical school education.
    - Track primary care issues from students, interns, residents and practicing primary care physicians.
13. **Concept 13: Support initiatives that enhance the quality of primary care training programs**
    - Develop patient-centered outcomes-based standards for excellent programs
    - Support enforcement of existing and future standards through all levels of appeal.
14. **Concept 15: Develop a policy for interaction with Non-physician clinicians (PA, NP, etc)**
    - AACOM to develop educational modules to train undergraduates in integration of health care teams including physicians and NPCs.
15. **Concept 14: Educate society (patients, payers, etc) on the capabilities of primary care physicians**
    - Identify appropriate research on impact of primary care physicians on health care
    - Disseminate within the osteopathic profession the positive findings on primary care

1. **Policy 4 Define "osteopathic" as it relates to OGME**
    - History Committee study osteopathic physicians and allopathic physicians
    - AACOM and AODME study the **hidden** curriculum
    - AACOM and AODME review the **explicit** curriculum of allopathic and osteopathic program.
    - Specialty colleges should survey practitioners experience in OGME residencies.
    - The AODME, the AOA and AACOM Board of Deans should define the term "Osteopathic."

From these concepts the Medical Education Summit Progress Task Force (MES PTF) provided the AOA Board of Trustees and the AACOM Board of Deans with a number of action plans and recommendations. (See Appendix A) Those governing bodies, as cited above, reviewed the action plans and approved further actions as needed.

The MES PTF made further adjustments to both the consensus statements and concepts. They linked together statements from both Summits, it was clear to the MES PTF that seven major topics had emerged: Advocacy; Marketing/Recruitment; Accreditation; Growth; Curriculum; Data Research; and Specialty Mix.

The Progress Task Force (PTF) was divided into three main working groups (A, B and C). These working groups were tasked with bringing the consensus statements to fruition.

Group A was tasked with postdoctoral issues; Group B with predoctoral issues; Group C with Specialty Mix and the remaining topics were tasked to various individuals.

Group A, consisting of Drs. Opipari, Slocum and Mr. Crosby have dealt with global issues related to Osteopathic Graduate Medical Education (OGME). The majority of the issues relate to the individual specialty standards requirements, as well as, the AOA Basic Documents which serve as common minimal standards for all specialties. The basis of all OGME is compliance with high quality standards and the measurability of their functionality. The progress on the development of clearly understandable and measurable standards has been raised repeatedly by both Medical Education Summits I and II, including enhancing and enforcing, benchmarking to ACGME, restructuring, communicating, evaluating and intensifying standards, all for enhanced quality.

These issues have been addressed through the AOA Board of Trustees (BOT) approved Uniform Standards Policies. COPT has required all specialties to initiate this process, and to be completed by April 2011. In addition, AOA Basic Documents functioning as common minimal standards among all specialties are currently also being rewritten and clarified as requirements for the specialty college Evaluating Committees. Additional major related issues involve intensification and improvement of program inspections. This is currently being addressed by COPT with a request for approval for professional program reviewers. A final major issue debated and approved for review and evaluation involve the "potential acceptance of MD's into AOA training programs." This white paper has been reviewed and approved by the PTF, COPT, BOE, BOT and now moves on to the AOA House of Delegates (HOD).

Policy and resolutions for this section that have been approved by the AOA and AACOM Leadership are listed below.

AOA/AACOM Policy

Res #	AOA Policy Name	Approval
28	SEPARATE AOA MATCH, MAINTENANCE OF	A/05
19	RESTRUCTURING OF THE OSTEOPATHIC INTERNSHIP	A/06
30	PENALTIES TO ENFORCE AOA STANDARD REQUIREMENTS	A/06
33	JOINT MATCH	A/06
34	OSTEOPATHIC POSTDOCTORAL TRAINING PROGRAMS – PROGRAM DIRECTORS	A/06
35	OSTEOPATHIC POSTDOCTORAL TRAINING PROGRAMS—WAIVERS TO OBTAIN PROGRAM DIRECTORS	A/06
36	POSTGRADUATE TRAINING PROGRAMS	A/06
	UNIFORM STANDARDS	I/06
14	RECOMMENDATIONS REGARDING ADMITTING MDS INTO OSTEOPATHIC GRADUATE MEDICAL EDUCATION PROGRAMS	A/09

Res #	COPT Policy Name	Approval
	INDEPENDENT REVIEWERS PROPOSAL	10/09

Res #	PTRC Policy Name	Approval
57	IMPLEMENTATION OF NEW PTRC ADMINISTRATIVE PROCESSES	4/07

Group B, consisting of Drs. Shannon, Watson and Willsie primarily dealt with all Osteopathic Undergraduate Medical Education (OUME). The 'infrastructure' group has focused on the broad issues related to the clinical training of osteopathic physicians amidst this changing environment. Driven by issues that were identified in Summit's I and II, a "Joint Statement of Principles on the Relationship between Undergraduate and Graduate Osteopathic Medical Education" was developed and endorsed by the American Osteopathic Association and the Association of American Colleges of Osteopathic Medicine. This statement has been used to guide work on standards for osteopathic colleges, graduate medical education programs (OGME), and osteopathic postgraduate training institutions (OPTI). More specifically, a study designed to assess the OPTI concept was drafted and is now in completed. The recommendations are as follows for improving OPTI:..

- Develop an agreed upon new vision, mission and goal statement for the OPTI system.
- Maintain some flexibility in the OPTI system, but strive for more uniformity in OPTI structure, operation and performance in the future.
- After this first step is completed, a new set of national measures should be developed to determine how OPTIs are moving toward the agreed upon performance expectations
- Create a new OPTI membership organization to encourage more cooperation and information sharing among OPTIs.
- Improve the OPTI accreditation process by providing a more effective assessment process, more guidance on conformity issues, but still maintain and enforce a "high bar" for all OPTIs to help ensure more consistency in the OPTI system. Encourage more effective OPTI oversight of OGME.
- AOA and OPTIs working through their new organization should develop a program of targeted technical assistance to help all OPTIs that need help in meeting OPTI accreditation standards and in better serving the needs of their membership.
- This assistance should also include information to help OPTIs participate in joint ventures, various forms of resource sharing, and potential mergers and other forms of partnership deemed appropriate in specific situations.
- OPTIs should continue to look into various methods of dealing with the problems of geographic barriers, dramatic fee differences among OPTIs, and the challenges of OPTI "shopping/hopping" for various reasons. While some participants in this study wanted new rules or restrictions in these areas, the consensus of the last focus group in this study was that any new rules placing limits in these areas would interfere with the fundamental free market approach to the OPTI system and potentially create more problems than benefits for OPTIs and their members.
- OPTI affiliation should remain mandatory for all COMs and hospitals with

OGME programs.

- Residents should receive more orientation to the OPTI concept and they should be encouraged to have more active involvement in their OPTIs.
- Efforts should be undertaken to improve the working relationships between specialty colleges and OPTIs to provide a more comprehensive improvement in quality assurance in OGME.
- OPTIs need to work on improving their own operations and place more emphasis on marketing/customer service.
- All of the key stakeholders in the OPTI movement should mount a national effort to secure additional financial resources for the smaller and struggling OPTIs. This could include grants, gifts, loans, and various forms of targeted federal/state assistance. The availability of adequate financial resources will have a major impact on the capability of some OPTIs to meet the performance improvements needed and to remain viable providers of needed assistance to their members.

Ongoing improvements in quality and relevance of the clinical training of osteopathic physicians will play a large part in the continued importance of osteopathic medicine in changing and reforming the future of American medicine. The clinical training of osteopathic physicians is at the heart of the changes occurring within osteopathic medical education as the profession seeks an appropriate direction amidst the socio-politico-economic-driven environment impacting the medical education and health care infrastructure in the US.

Policy and resolutions for this section that have been approved by the AOA and AACOM Leadership are listed below.

Res #	AOA/AOA Policy Name	Approval
	JOINT STATEMENT OF PRINCIPLES ON THE RELATIONSHIP BETWEEN UNDERGRADUATE AND GRADUATE OSTEOPATHIC MEDICAL EDUCATION	6/18/08
	AACOM Policy Name	**Approval**
	AACOM POLICY ON CLINICAL CLERKSHIPS FOR OSTEOPATHIC MEDICAL STUDENTS	4/16/09
	AACOM POLICY ON GRADUATE MEDICAL EDUCATION	6/28/07

Group C, consisted of Drs. Juhasz, Moorman, Tooke-Rawlins and Wickless this group dealt with the promotion of Primary Care programs and Patient-Centered Medical Home. Progress has been made in the areas of Awareness, Advocacy and Active Strategies for Curricular change.

It appears that combining consensus statements with similar issues was a key element. For example, statements 6, 13, II.I.6, and II.I.2 were combined under one task force with the objective being to study current workforce and demand models to aid in curricular planning for both pre and postdoctoral education. In addition, the recommendation to develop a

"Think Tank" approach among the specialty colleges to render new updated and modernized models of Primary Care Clinical Education was made. Also, the incorporation of the three basic components of the Patient Centered Medical Home Model into specialty standards was referred to the Council on Postdoctoral Training for monitoring.

In statement II.I.9 a white paper was developed by the American Osteopathic Association Health Policy Fellowship Program entitled *Returning to Primary Care Roots: Charting a Future for Medicine in the United States.* This white paper offers eight specific suggestions, under three headings, to guide federal and state legislators, health policy makers, and leaders of allopathic and osteopathic medical organizations as comprehensive, meaningful, affordable means to health system reform as it is advanced by President Obama and the U.S. Congress.

These headings and recommendations include:

I. Investment and support of undergraduate medical education (UME) and graduate medical education (GME).
    A. **Recommendation #1.** The U.S. Congress should pass, and President Obama should sign into law, the Resident Physician Shortage Reduction Act of 2009, which would create a resident redistribution pool, expand full-time equivalent (FTE) resident slots by 15%, establish certain priorities for primary care specialist physician training, preserve training capacity in the event of certain hospital closures, remove barriers to training in non-hospital clinical settings where primary care specialist physicians usually spend the bulk of their time following training, and change Center for Medicare and Medicaid Services (CMS) rules on counting the time residents spend in education.
    B. **Recommendation #2.** With nearly all U.S. medical school graduates - M.D. and D.O. - now pursuing residency training of at least three years' duration, and the fourth year of undergraduate medical education primarily for training in elective fields of study and for residency interviews, consideration should be given to limiting the duration of medical school training to three years. Such a move would instantly lower medical student debt while improving nationwide physician shortage concerns on a faster timeline but will require some degree of financial support of medical schools, which would lose one-quarter of their tuition revenue.
    C. **Recommendation #3.** Federal funding should be provided to incentivize opportunities for the health insurance industry, hospitals, philanthropic and charitable foundations, federal, state and local governments, and communities to financially support UME and GME in PCSP career fields among under-represented minorities. The National Health Service Corps, which already offers scholarships, loan repayment and loan deferment opportunities, should be strengthened and made more robust.

II. Strengthen access to primary care medicine by enacting federal reforms in Medicare and Medicaid that strengthen the ability of PCSPs to remain in practice.

    D. Recommendation #4. Meaningful changes in Medicare and Medicaid reimbursement must be enacted by federal lawmakers (and state

lawmakers, in the case of Medicaid) that adequately recognize and value evaluation skills and preventive medicine activities (including counseling) by physicians. This will enable PCSPs to remain in practice, especially in a recessionary economy, and ensure greater access to care for the greater numbers of patients who will have health insurance under comprehensive health system reform.

E. **Recommendation #5.** To facilitate the retention of PCSPs into primary care medicine careers following their initial training, student loan forgiveness (coupled with favorable or zero interest rates for medical students committed to pursuing PCSP fields) plus stipends and bonuses for those who agree to work in Health Professions Shortage Areas (HPSA) or in Federally Qualified Health Centers (FQHC) should be adopted.

F. **Recommendation #6.** Meaningful medical liability insurance reforms should be enacted that help to limit the costly defensive medicine practices of all physicians, such as ordering expensive tests or procedures unnecessarily, while supporting the ability of patients to have their grievances redressed when there has been gross negligence or malpractice.

III. <u>The patient-centered medical home (PCMH) should be physician-directed and encouraged as a model of health care delivery that achieves cost-savings and improves the quality of health care overall.</u>

G. **Recommendation #7.** There should be implementation of significant payment reforms that provide support for many of the services made available through a patient-centered medical home, led by a primary care specialist physician, including

1. Care coordination outside the context of a specific office visit.
2. The adoption and use of health information technology, electronic medical records, and personal health records.
3. Interaction with patients by telephone or electronic mail.

H. **Recommendation #8.** Research on the appropriate roles of Nurse Practitioners and Physician Assistants, important providers of many primary care health services, in the patient-centered medical home concept should be funded and explored.

The Progress Task Force unanimously approved the primay care paper and felt the paper should be published by the health Policy fellows in various venues. In addition, the paper should be roled out to the osteopathic community for information.The MES Progress Task Force felt that there is a need for a communication strategy on multiple levels: Firstly, an analysis of the fifteen statements adopted by the Summit participants suggests that Summit participants are not familiar with the impressive number of efforts undertaken by the Bureau of Federal Health Programs to address GME funding over the years. The American Osteopathic Association (AOA) has been working on GME funding for more than a decade. The AOA Bureau of Federal Health Programs has worked on graduate medical education funding issues by developing white papers on alternative graduate medical education

funding, participating on coalitions to address GME funding issues, and assisted in the development of federal bills to address the funding issues. In addition, the Bureau's staff has met with Veteran Affairs officials to encourage the establishment of osteopathic programs in VA hospitals. Bureau's staff is currently working on placing a bill on student-loan forbearance into the Senate or House of Representatives. Despite the Bureau's best effort, advancing issues at the federal level is very difficult and dependent on the current environment in Congress. The Bureau of Federal Health Programs will write a one-page report each year regarding GME funding.

Dr. Juhasz was tasked with advocacy issues. Volumes have been written on the problems with graduate medical education funding. Summit participants approved 14 statements directly related to the funding of OGME. These statements had three overarching concerns to be addressed:

1. The unequal allocation of federal funds between residency training programs;
2. The artificial cap on the number of residency training funded by Medicare; and
3. The declining financial support for residency training programs must be reversed through higher program remuneration, forbearance of loans while in training, expanded loan forgiveness and scholarship opportunities.

There is considerable evidence that the remuneration between similar training programs is unequal. The disparity of payment per resident across the country is rooted in the methodology for developing the cost basis for each hospital.[1] "The Balanced-Budget Refinement Act of 1999 made a modest change to reduce disparities in the Medicare per resident amounts. The provision raises the minimum payment to 70% of a national wage adjusted per resident amount. The annual inflation updates for per resident amounts that are above 140% of the wage adjusted national average are reduced for FY 2001-FY 2005."[2] The Summit participants concluded that much more needs to be done to reduce the continuing inequity in payment between training programs.

The Balanced Budget Act of 1997 froze the number of residents the Medicare program would reimburse per hospital. This cap was put into place at a time when the general consensus was that there was an adequate supply of physicians. Since 2000, however, the general consensus has shifted to concern over a shortage of physicians, particularly with the aging of the baby-boom generation and their need for chronic care. This Summit participants believe that the cap will have unintended consequences for the Nation and should be eliminated.

The Balanced Budget Act of 1997 reduced the Medicare formula for the indirect cost of graduate medical education from 7.7% in 1997 to 5.5% in 2001. While later laws slowed the decline in indirect reimbursements, the direction has clearly been to reduce payments to hospitals. These Summit participants believe that more financial resources should go into graduate medical education to lessen the future anticipated shortage of physicians.

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[1] Council On Graduate Medical Education: Proceedings of the GME financing stakeholders meeting, April 11, 2001.
[2] Council on graduate medical education: financing graduate medical education in a changing health-care environment, December 2000.

A clear benefit to all parties would be an annual status report on the activities of the Bureau of Federal Health Programs on GME funding. Audiences for this report would include the AOA Board of Trustees, AACOM leadership, Student Osteopathic Medical Association (SOMA) leadership, and the Council of Osteopathic Student Government Presidents (COSGP). The annual report should be available for the Mid-year meeting of the AOA Board of Trustees and the AACOM Annual meeting shortly thereafter. The report should reiterate the importance of the issue, discuss the current GME funding environment at the federal level, and inform the reader of the activities to address the issue. Joint AOA and AACOM activities on this issue should be highlighted in the report.

Recommendation: The Medical Education Summit Progress Task Force recommends to the AOA Board of Trustees that the Bureau of Federal Health Programs be directed to write a one-page report each year regarding GME funding. The report should include a brief description of the importance of the issue, discuss the current GME funding environment, and describe current activities to enhance GME funding. The report should be distributed to the AOA Board of Trustees at its mid-year meeting, to the AACOM leadership at its annual meeting, to the SOMA leadership, and COSGP leadership. This directive should sunset after five years unless reaffirmed by the AOA Board of Trustees.
Policy and resolutions for this section that have been approved by the AOA and AACOM Leadership are listed below.

AOA/AACOM Policy

Res #	AOA Policy Name	Approval
256	MODIFYING THE FTE RESIDENT CAPS TO FACILITATE GROWTH AND CHANGE IN OSTEOPATHIC MEDICAL EDUCATION	A/06
15	FUNDING FOR OSTEOPATHIC GRADUATE MEDICAL EDUCATION	A/09

Dr. Nichols was tasked with data and research. The osteopathic profession is moving forward on all fronts with medical education research. It is believed that the overarching issues of medical education research raised by the Medical Education Summits continue to be addressed.

A major element to medical education research is having the data. Several consensus statements from MES I and II relate to the availability of data. Resources for data include the AOA and AACOM databases on students and osteopathic physicians, OSTMED.DR, the Clinical Assessment Program (CAP) data, published data, and purchased data on ACGME-trained DOs.

In 2008, the AOA agreed to share its education specific data on osteopathic students and physicians to the AACOM for research purposes. This includes providing AACOM with quarterly updates. Combining databases is difficult work and the AACOM is looking for ways to combine the databases efficiently. In 2009, AOA staff was successful in matching AOA data to AACOM data. There were also preliminary discussions of having a three-way agreement among AOA, AACOM, and the Association of American Medical Colleges but

the details were too complex. Staff is currently working on a series of individual agreements between the organizations.

The Virginia College of Osteopathic Medicine continues to maintain and expand OSTMED.DR, an online database of osteopathic journals, publications, and articles. OSTMED.DR has completed its scanning of *Journal of the American Osteopathic Association* articles and is now scanning other peer-reviewed, osteopathic documents. Part of its goal is to develop a database of research reports produced by osteopathic resident physicians (see Statement II.G.5). This new database has two primary goals: 1) to encourage research (both clinical and medical educational); and 2) to provide incoming residents with a database of information with which to build upon. (see Statements II.G.2, and II.G.5).

Two major medical education research papers were concluded in 2009. A study on "Dual and Parallel Postdoctoral Training Programs: Implications for the Osteopathic Medical Profession" was published in March 2009[3]. This study provided heretofore unavailable trend data on the growth of dual and parallel training programs. The research paper in 2009 was published in the JAOA. It defined the difference between dual and parallel training programs as dual programs permit trainees to sit for AOA and ABMS board certification. In parallel programs, trainees may train independently or integrate with allopathic trainees, but at the conclusion of training, DOs may only sit for AOA board certification. In addition, the article noted that 67% of all trainees who completed dually accredited training programs since 2006 compared to 61% in 2008 sat for AOA Board Certification, 37% solely for AOA Board Certification in their specialty. Membership in the AOA also ranked more favorably for trainees who completed a dual program compared to DOs who completed ACGME programs that were not dual. In 2010, 78% of DOs who went through AOA dual programs were AOA members, though not yet boarded by either the AOA or ACGME. The JAOA will have an update on dual and parallel programs in their 2011 April issue.

The second study examined the complexities of admitting MDs into DO training programs through a appointment of a Task Force to study the impact of admitting MDs into osteopathic graduate medical education programs. In addition to a literature review and statistical data and analysis, the Task Force sent a survey to stakeholders in AOA graduate medical education. Directors of Medical Education, Program Directors, OGME leaders and Chairs of Education related Bureaus and Councils, the Council on Interns and Residents and two student leadership groups (SOMA and COSGP) responded to the survey. There was little support for the admission of international medical school graduates (IMGs), including U.S. born IMGs. However 70% of the respondents agreed MDs who graduated from LCME-accredited medical schools should be considered in accepting MDs into OGME programs. The Final recommendation was that the osteopathic profession study, prepare and observe the impact of the projected 30% additional LCME MD graduates entering ACGME training programs until 2015 and federal legislation affecting the number of graduate medical education positions before making a final decision on whether or not to support new policy that would permit osteopathic graduate medical education programs to admit MDs.

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[3] Burkhart DN, Lischka TA: Dual and Parallel Postdoctoral Training Programs: Implications for the Osteopathic Medical Profession. *J Am Osteopath Assoc. 2009;109:146-153.*

There was concern that the number of osteopathic training positions may not be sufficient if the increase in U.S. medical school graduates could result in fewer training opportunities for DOs in MD programs, the closing of dual training programs and slots and little opportunity to grow osteopathic positions in existing OGME training programs, particularly in specialties and locations that would be attractive to graduating DOs.

Data on clinical outcomes is also available. The standards for training in family practice and internal medicine require usage of the Clinical Assessment Program (CAP) for residencies. This program requires training programs to submit data periodically on various conditions, such as diabetes mellitus, low back pain, coronary artery disease, immunizations, hypertension, and women's health. CAP data are available to researchers and are being used for research and quality assurance. (see Statements II.G.3, II.G.6a, II.G.6b). Recently, the Osteopathic Heritage Foundations commissioned five analytical papers using CAP data and several papers were published in peer-reviewed journals. CAP is being considered by several certifying boards an element in osteopathic continuous certification and one certifying boards may use CAP in the initial certification of candidates (see Statement II.G.3). Preliminary research using CAP data shows a positive correlation between the number of years of approval a postdoctoral program has been awarded and the training program's use of CAP. The AOA Council on Postdoctoral Training is currently studying the data.

Two medical education research surveys are currently in the field. One research project is on the perceived quality of osteopathic graduate medical education. The other research project is a 360-degree analysis of OPTIs.

Other medical education research news is that the Brentwood Foundation established the Theodore F. Classen (DO) Chair for Osteopathic Education and Research. Leonard Calabrese, DO, is the holder of that Chair. Dr Calabrese has developed research a proposal to study empathy development in osteopathic and allopathic medicine students.

Policy and resolutions for this section that have been approved by the AOA and AACOM Leadership are listed below.

AOA/AACOM Policy Res #	**AOA Policy Name**	**Approval**
15	MEDICAL EDUCATION RESEARCH	A/09

Lastly, Dr. Shannon is working on Marketing/Recruitment. Working through its councils, the colleges and collaborating with other organizations as appropriate, AACOM places a high priority on recruiting qualified, diverse applicants, developing curricular models that embrace an inter-professional approach to health care and providing mentoring and information to facilitate effective student career decision making. In addition, there is an ongoing effort to promote financing models that maximize the affordability of osteopathic medical education.

Policy and resolutions for this section that have been approved by the AOA and AACOM Leadership are listed below.

AOA/AACOM Policy Res #	COPT Policy Name	Approval
58	RESPONSE TO THE OR^{2}CA PILOT PROJECT	4/07
12	CORE COMPETENCY INTEGRATION	4/10

Res #	AOA Policy Name	Approval
	JOINT STATEMENT OF PRINCIPLES ON THE RELATIONSHIP BETWEEN UNDERGRADUATE AND GRADUATE OSTEOPATHIC MEDICAL EDUCATION	6/18/08

AACOM Policy Name	Approval
AACOM POLICY ON CLINICAL CLERKSHIPS FOR OSTEOPATHIC MEDICAL STUDENTS	4/16/09
AACOM POLICY ON GRADUATE MEDICAL EDUCATION	6/28/07

CONCLUSION

Major Accomplishments

1. The meetings brought together all undergraduate and graduate education leaders.
2. A new, collaborative spirit was developed between undergraduate and graduate education leaders and between their representative organizations.

Major Outcomes

1. Production of a White Paper on Dual and Parallel internship and residency programs showing that dual programs have benefited the osteopathic profession;
2. A Joint Statement of Principles on Osteopathic Medical Education were agreed to by the AOA/AACOM leadership;
3. Uniform Standards Policy - approved by the AOA BOT at there 2006 Interim Meeting;
4. Restructuring of the Osteopathic Internship - approved by the AOA BOT during their Annual Meeting in 2006;
5. Development of a Task Force and White Paper on MDs in Osteopathic Programs; which the Board of Trustees in 2009 and House of Delegates in 2010 agreed with the Task Force recommendation that the osteopathic profession study statistics on growth of medical students on funded osteopathic training program fill rates through 2015 to ensure there would be sufficient positions available to osteopathic graduates.
6. 360° OPTI Study which includes OPTI concept, process, function, structure;
7. Quality Survey
8. The formation and execution of a third Education Policy and Procedure Committee (EPPRC III) which resulted in 83 recommendations in CME, Certification and Postdoctoral Training and restructuring committee membership and functions; and
9. A production of a White Paper on Primary Care with recommendations to include investment and support of UME and GME. Strengthening access to primary care and encouragement of the patient centered medical home as a model of healthcare delivery.

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