

Medical Education Summit Report to the AACOM Board of Deans and the AOA Board of Trustees

April 9, 2009

To date The Medical Education Progress Task Force (MES PTF) has made many strides in conquering consensus statements reported from Summits I and II. As the task force linked together statements from both Summits over the many months, 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.

To date the PTF has made a significant amount of progress. The major issues that have been in progress for the past twelve months are as follows:

1. Joint Statement of Principles on Osteopathic Medical Education
2. MD's in DO Residencies Task Force
3. Study OPTI concept, process, function, structure
4. Improving Marketing/Recruitment of the Osteopathic Educational Programs – UME/OGME
5. Specialty College Initiative
 - Provide more education, more resources Infrastructure Enhancement
 - Redoing standards for OPTI, specialty colleges
 - Improving internal and inspection processes
6. Dual/Parallel Programs
7. Internship Restructuring
8. Promote Primary Care Programs
 - Promotion of Patient-Centered Medical Home
9. Supporting the ongoing Osteopathic Identity Work
10. Quality Survey
11. Governmental OGME Funding Advocacy
12. Support OGME Initiative to increase # positions
 - Supporting Osteopathic Research
13. Data Repository (Opportunities/TIVRA)
14. UME Curriculum Items
 - Mentoring
 - Professionalism

Advocacy

Volumes have been written on the problems with graduate medical education funding. Summit participants approved 14 statements directly related to the funding of OGME (see attachment 1). 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.

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

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.

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.

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.

Growth & Curriculum – (Postdoctoral Education)

Group A has 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 in April, 2009 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 has been reviewed by a BOE appointed task force, a white paper written and it will be brought to the Summit Progress Task Force for recommendation to the AOA and AACOM Boards of Trustees.

Accreditation

In Group B, 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 U.S. 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, a researcher identified, and an assessment of feasibility is underway prior to its implementation. Consideration of a similar evaluation and assessment of improvements that can be made in OGME to meet the U.S.'s health care needs in the 21st Century awaits approval of the OPTI study. 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.

Specialty Mix

Group C has dealt with the promotion of Primary Care programs and Patient-Centered Medical Home. A significant amount of 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.

There is a need for a communication strategy on multiple levels: 1) an analysis of the 14 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. 2) Joint communication efforts between AOA/AACOM on Patient Centered Medical Home curricular elements and the importance of Primary Care within the osteopathic profession.

Finally, the Osteopathic National Health Policy Fellowship Program has taken on the task of researching and developing white papers on the development of a longitudinal study to track

primary care issues from students, interns, residents and practicing primary care physicians and the positive impact of primary care physicians on health care.

In Summary, all assigned issues and actions tasked to these groups have either been completed or are being closely scrutinized as their activity proceeds to completion.