



# Breakout Session 3

## Action Plans

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# 1 - Recommendation 1a

- Do research to establish a baseline of the current state of the standards and how they are perceived by the profession, trainees and the public.
- Benchmark ACGME
  - Commonalities
  - Differences
    - rationale
- Reconstruct standards as needed based on:
  - Core values
  - Educational process
  - Standards

## 2 - Recommendation 1a

- Communicate/proactively market our programs and standards to enhance perceptions, including communication with trainees about standards and transparency about program quality.

## 3 - Recommendation 1a

- Re-evaluate and standardize the inspection process:
  - Inspector training and evaluation
  - Consistency of evaluations
  - Avoiding conflicts of interest
  - Process integrity

## 4 - Recommendation 2b

- AOA appoints a task force to study admitting MDs into OGME programs.
- The task force is recommended to include:
  - Legal reviewers
  - Certification experts (BOS)
  - GME stakeholders
  - Program directors
  - EEC representatives
- Conduct a SWOT analysis.

## 5 - Recommendation 3

- OGME should foster research thru funding discovered by researchers, program directors and research entities.

## 6 - Recommendation 3

- OPTIs, specialty colleges, AOA COPT, AODME and AACOM should identify, create and encourage a culture of research in OGME.

## **7 - Recommendation 3**

- The Bureau of Osteopathic Clinical Education and Research should foster quality improvement thru predetermined outcome measures defined by specialty colleges.

## 8 - Recommendation 3

- OPTIs and the ORC should develop multi-centered trials that results in peer publications.

## 9 - Recommendation 3

- A database of research in residency programs should be collated and given to the Bureau of Osteopathic Research and the ORC by specialty colleges. (Number 1)

## 10 - Recommendation 3

- To increase the number of publications, residency program directors and researcher should use CAP data.

# 11 - Recommendation 3

- The CAP data should be used by residency program directors to increase the number of residencies recording and reporting CAPS data.

## **12 - Recommendation 4**

- **The AOA Committee of History and Osteopathic Identity should review the literature that describes the different characteristics between osteopathic physicians and allopathic physicians. (Number 1)**

## 13 - Recommendation 4

- AACOM and AODME should develop and study the **hidden** curriculum in OGME programs vs. ACGME programs to define different characteristics that may better define the Osteopathic in OGME.

# 14 - Recommendation 4

- AACOM and AODME should review the **explicit** curriculum of allopathic and osteopathic program.

## 15 - Recommendation 4

- Specialty colleges should send out a survey developed by AACOM and AODME to the specialty practitioners that studies a task analysis of their retrospective experience in residencies that may define the Osteopathic in OGME.

# 16 - Recommendation 4

- The AODME, the AOA and AACCOM Board of Deans should write a publication that defines the term “Osteopathic.”

## 17 - Recommendation 5

- Develop a structured educational plan that defines educational expectations and outcomes and is distributed at the start of each academic year to residents and DMEs to enhance the perceived quality to students and to be measured by MATCH results, in-service examinations and board certification pass rates.

## 18 - Recommendation 5

- Develop an annual program evaluation review of the trainees, trainers, program and facilities to evaluate the overall performance and to be conducted through 360 degree review process and patient surveys to examine the quality and basis for improvement.

## 19 - Recommendation 6

- COCA should establish a standard for all COMs seeking a class size increase to create training programs to ensure that there is one OGME, or dually accredited position for each student within 5 years of adoption of the standard.

## 20 - Recommendation 6

- COMs should move to establish core hospital training systems for 3<sup>rd</sup> and 4<sup>th</sup> year core rotations to be implemented at hospitals with OGME or dually accredited residency programs.

# 21 - Recommendation 7

- Explore new federal funding sources:
- VA, DOD, CMS, HRSA

## 22 - Recommendation 7

- Increase collaboration with other players
- Lobbying
- Public relations
- Policy development and advocacy

## 23 - Recommendation 7

- Increase non-federal funded residencies
- States—dedicated tax revenues, community initiatives
- Private—payor funding, specialty practice groups

## 24 - Recommendation 7

- Increase GME programs in ‘virgin’ hospitals

## 25 - Recommendation 8a

- Clearly define roles in collaboration-connectivity between the AOA, OPTIs and Specialty Colleges
  - form subcommittee/task force to look at whole picture/process
  - develop a prototype of current process flow as it relates to tracking programs through this system (use task force to lead this prototype development: may use OB/gyn college to develop first prototype)
  - implement tracking mechanisms to follow the progression of program approvals
  - identify ways to be more efficient with processes between AOA IT and specialty colleges

# 26 - Recommendation 8a

- Review and establish common minimal standards between specialty colleges
  - specialty colleges need to develop a matrix
  - increase the depth of standards (e.g. mandate faculty to resident ratios)
  - identify key quality indicators resulting in measurable outcomes
  - meaningful periodic review of standards to ensure up-to-date training concepts

# 27 - Recommendation 8a

- Identify and establish resources and funding to enhance quality
  - infrastructure support needs to be defined and determined if it's a shared responsibility of the AOA and specialty college or if they bear the expense alone
  - educate hospital administrators about resources required to support quality programs
  - design the support/infrastructure to implement quality programs
  - determine how funding will be secured to ensure quality programs
  - administrative resources should be added to AOA to support education, accreditation, and program review

## 28 - Recommendation 8a

- Form an OPTI study task force to include COPT, COPTI, PTRC and BOE
  - develop centralized theme as to the OPTI mission and ensure uniform missions between basic OPTI structure
  - answer the question of the role of the OPTI in accreditation processes
  - synchronize OPTI presence at specialty college review of programs

## 29 - Recommendation 9

- Conduct a 360 degree analysis (obtain qualitative and quantitative data) to identify what it is we do best in OGME (also how/what could we do better).

## 30 - Recommendation 9

- Define needs of healthcare in the 21st century (next 20-25 years) (This step will need to be repeated every 3-5 years).

## **31 - Recommendation 9**

- *Assimilate data from the above to formulate appropriate actions/changes for OGME.*

## 32 - Recommendation 9

- Conduct research study to evaluate outcomes/attributes of DOs who train in AOA accredited programs vs. ACGME accredited GME programs vs. those training in dually accredited programs.

## **33 - Recommendation 9a**

- Conduct a 360 degree analysis (obtain qualitative and quantitative data) to identify perceived value of OPTI (effectiveness, determine critical success factors).

## 34 - Recommendation 9a

- Conduct a third-party driven, non-stakeholder evaluation (non-OGME or accrediting body peers and outside experts) of OPTI in all its versions to assess value.

- OGME slot expansion?

- Outcomes of programs?

- Faculty development?

- True sharing of best practices and resources?

- Established OPTI identity?

## **35 - Recommendation 9a**

- Assimilate data from above to determine whether OPTI should continue as a mandatory requirement for OGME; relationship of OPTI to other initiatives in OGME.

## **36 - Recommendation 10**

- Establish clearinghouse of financial aid opportunities for students, interns and resident (grants, scholarships, loan forgiveness, state programs, local programs, hospital programs, etc.)

## 37 - Recommendation 10

- Identify partners in a primary care coalition to advocate for increased reimbursement.
  - identify rationale for support to increase reimbursement
  - develop coherent strategy for “how” to increase reimbursement
  - continue ongoing AOA/AACOM advocacy efforts

## 38 - Recommendation 10

- Develop innovative programs to manage medical school debt.
  - tuition reduction for primary care students
  - tuition forgiveness for primary care (LECOM model)
  - mechanism to defer loan repayment
  - shorten training program to 36 months while maintaining same or better quality (LECOM model)

# 39 - Recommendation 11

- Create a positive culture for students during medical school education.
  - positive faculty role models at academic and external rotations
  - primary care-centered curriculum
  - student professional primary care organizations on campus
  - student exposure to diverse patient population (all socioeconomic classes)
  - clinical exposure to procedural-based primary care practice

## 40 - Recommendation 11

- Develop a longitudinal study to track primary care issues from students, interns, residents and practicing primary care physicians (family practice, internal medicine, pediatrics, ob/gyn)

# 41 - Recommendation 12

- Task the primary care specialty colleges to develop and fund residency programs training residents in “new models for primary care” including:
  - Increased scope of practice (including procedures)
  - Comprehensive care / medical home models
  - Osteopathic values:
    - OMM
    - Prevention
    - Patient-centered care
    - Nutrition
    - Chronic disease management
  - Utilization of new technologies (EMR, web-based, new equipment)

## 42 - Recommendation 12

- Require primary care residencies to utilize and teach practice-based outcomes research methodology (CAP, PPF, etc.).

## 43 - Recommendation 13

- Develop patient-centered outcomes-based standards for excellent programs and recognize/reward those programs.
- Support enforcement of existing and future standards through all levels of appeal.

## 44 - Recommendation 14

- Identify appropriate research on impact of primary care physicians on health care – see B. Starfield meta-analysis in particular, also D Goodman in Health Affairs, 2006 and Brownlee in The Atlantic, 2007.
- Disseminate within the osteopathic profession the positive findings on primary care impact from various research.

# 45 - Recommendation 14

- Leverage the medical home concept to educate all stakeholders – Physicians, patients, payers, policy makers.

## 46 - Recommendation 14

- Develop specific marketing plans for each stakeholder group, example: office based marketing brochures for patients on the role of the PC physician.

## 47 - Recommendation 15

- AOA to continue gathering scope of practice data by state and profession and disseminate to membership, residents, and others.
- AOA to continue policy activities to address scope of practice of non-physician clinicians.

## 48 - Recommendation 15

- AACOM to develop educational modules to train undergraduates in integration of health care teams including physicians and NPCs.