Impact of the Single Accreditation Agreement on GME Governance and the Physician Workforce

Cynthia S. Kelley, DO

Dr Kelley is a member of the Health Policy Fellowship class of 2014. The fellowship is coordinated through the New York Institute of Technology College of Osteopathic Medicine and the Ohio University Heritage College of Osteopathic Medicine.

Financial Disclosures: None reported.

Support: Dr Kelley's participation in the fellowship is sponsored in part by the Ohio Osteopathic Association.

Address correspondence to Cynthia S. Kelley, DO, Summa Health System/ Akron City Hospital - Family Medicine, 55 Arch St, Suite 3A, Akron, OH 44304-1423.

E-mail: ckelley888@gmail.com

Submitted May 19, 2014; revision received June 5, 2014; accepted June 6, 2014.

On February 26, 2014, the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), and the American Association of Colleges of Osteopathic Medicine (AACOM) announced that they reached an agreement to create a single accreditation system for all graduate medical education (GME), whereby the AOA and AACOM would be integrated into the governance and operations of the ACGME.[1] In this health policy brief, I analyze the impact of this single accreditation system on the governance of GME and how it might shape the future physician workforce.

History and Background

There are 2 primary pathways toward becoming a physician. The majority of physicians are educated in allopathic (ie, MD) degree–granting medical schools followed by postgraduate training in ACGME-accredited residency programs. Further training in fellowships is available. The ACGME is a private, nonprofit council that was established for the purpose of independent evaluation and accreditation of residency programs.

Currently, 7% of the physician workforce is composed of osteopathic physicians (ie, DOs).[2] These individuals graduate from DO degree–granting medical schools and complete their residency training in either AOA-accredited or ACGME-accredited residency programs. As with MDs, further training in fellowships is available to DOs. The AOA serves as the accrediting body for osteopathic medical schools and residencies and the certifying body for graduates of AOA-accredited residencies. Some feel that such linkage—between a dues-paying member organization, accreditation of its training programs, and certification of its graduates—could be viewed as a conflict of interest.

The administration, faculty, and students of all of the osteopathic medical colleges in the United States are represented by AACOM, which serves as a unifying voice for osteopathic medical education.[3] Although AACOM is not involved in osteopathic college accreditation, it is involved in multiple areas of osteopathic medical education such as data collection and analysis, advocacy at the federal government level, and collaboration with various allied organizations.

Although the single accreditation system agreement represents a significant policy shift, the path leading to this point has been decades in the making as a result of 3 primary factors: lack of osteopathic GME availability, increased GME accountability, and the proposed changes to the ACGME common program requirements related to residency and fellowship eligibility.

Shortage of Osteopathic GME

When postgraduate training was added to the pathway to independent medical practice, the osteopathic medical profession was able to accommodate its graduates mostly through its small community hospitals and then through the addition of the military system. Even when, in the 1960s, ACGME residencies began accepting osteopathic graduates into their programs, most DOs remained in the osteopathic training pipeline.[4] However, as the number of osteopathic medical schools grew, coupled with factors that stymied the growth of osteopathic GME, an increasing number of osteopathic graduates entered ACGME programs. Today, according to my calculations of 2013 data, more than half of new DOs train in ACGME residencies.[5,6] In fact, the osteopathic GME system can accommodate only about half of its medical school graduates.[7] This dependence on ACGME has enormous implications for the osteopathic medical profession, which (1) maintains a training-certification-membership relationship, (2) by virtue of its minority status is challenged to maintain a distinct purpose and identity in a rapidly changing health care environment, and (3) cannot provide the postgraduate training necessary for all or even most of its graduates.

GME Accountability

Issues such as unacceptable medical error rates, high cost of care, and uneven geographic and specialty distribution of the physician workforce[8,9] have led to sweeping changes in the health care landscape. Every aspect of how, where, and to whom care is delivered is under the microscope, and GME is no exception. For decades, Medicare has provided billions of dollars ($11.5 billion annually in recent years) to training sites (mostly hospitals) to fund the education of medical residents with little say in how that money was spent.[10] Historically, an institution would identify a workforce need and create a training program to meet that need. Even after GME funding was capped in the Balanced Budget Act of 1997,[11] institutions found creative ways to meet their workforce needs through nongovernment funding or, in some cases, shifting their GME programs toward favored specialties. This uncoordinated training effort has resulted in a physician workforce unable to provide society's primary care needs in a cost-effective manner. In addition, the traditional time-based GME structure has done little to ensure that residents actually acquire the skill sets necessary to enter independent medical practice in this rapidly evolving health care system.[12]

This GME model appears to be ending, as stakeholders increasingly demand accountability for their investment. In its 2010 report to Congress, the Medicare Payment Advisory Committee (MedPAC) recommended a performance-based GME funding structure with payments contingent on desired educational outcomes.[13] In response, the ACGME began developing and promoting the Next Accreditation System (NAS), an outcomes-based approach aimed at ensuring the competency of graduates from ACGME-accredited residency programs.[14] In 2011, the ACGME took a further step toward GME standardization when it announced modifications to its common program requirements related to residency and fellowship eligibility—access to ACGME training would be limited to only those residents who had trained in an NAS program (or the Canadian equivalent, CanMEDS).[15] Therefore, all graduates of AOA-accredited residencies would be unable to apply to ACGME fellowships or transfer into ACGME residency programs.

Common Program Requirements

Although a small number of osteopathic residents ultimately train in ACGME fellowships, the notion that the entire scope of medical practice is available to DOs is highly valued by osteopathic medical students, residents, and leaders. The number and breadth of ACGME-accredited fellowships greatly exceeds those accredited by the AOA. For example, although numerous training opportunities in pediatric surgery are available through ACGME-accredited or nonaccredited fellowships,[16] a search at http://opportunities.osteopathic.org/search/search.cfm revealed that no such AOA-accredited fellowships are available. Searches on the ACGME and AOA websites indicated that there are 71 fellowships in sleep medicine accredited by the ACGME, compared with 2 accredited by the AOA. Should the common program requirements go into effect, they would effectively eliminate several subspecialty options for osteopathic residents.

The potential consequences lead to many unanswerable questions: Would the elimination of ACGME subspecialty training opportunities cause a shift in osteopathic GME toward primary care? Would it shift entirely to primary care? An increasingly recognized strength of osteopathic medical education is its contribution to the primary care workforce, specifically in rural areas; however, could the profession sustain itself in a primary care–only model?[17] Even if it could, is osteopathic medical education prepared for outcomes-based GME funding with its own version of the ACGME's NAS? What would become of osteopathic specialty colleges? With limited specialty options, would potential medical students elect to apply to osteopathic medical schools?

Comparing AOA and ACGME Standards

It is important to acknowledge the differences between AOA and ACGME residency standards. Each specialty has unique requirements, such as faculty-to-resident ratios, required clinical rotations, or guidelines for administrative support. In some specialties, the AOA and ACGME standards are closely aligned. However, in other areas, such as family medicine, important differences exist, and some differences are more challenging to address than others (eg, number of faculty, requirement of a faculty member who practices obstetrics).[18,19] As AOA-accredited programs make the changes to meet the ACGME standards, it is unknown how many will have the institutional support for the financial and personnel resources to make the conversion. Therefore, there is the potential for loss of GME training positions, particularly in institutions that are self-funding a portion of their residencies. Even in institutions that are not engaged in GME self-funding, the current economic climate in which hospitals exist, caught in the transition from volume- to value-based reimbursement, is creating added financial strain, making the proposition of increased monetary support for GME questionable. Another scenario would be the redistribution of GME positions into specialties better able to meet ACGME standards or those that have the potential to generate revenue for the sponsoring institution. Depending on the location of the programs and the degree to which such shifts occur, access to care has the potential to be impacted.

Stakeholders

The 3 organizations drafting this agreement support it for different reasons. The AOA favors a single accreditation system primarily because it preserves access to postgraduate training opportunities for DOs in an outcomes-based accreditation system.[20] The ACGME supports this development because it standardizes the training of those residents transferring into its residency programs as well as those seeking fellowship training. This agreement also increases access to GME training opportunities for MDs, as those residency positions previously accredited by the AOA only become available to both MDs and DOs.[21] As osteopathic medical schools have grown in size and number, the lack of parallel growth in osteopathic GME has been magnified. Thus, AACOM supports this agreement that preserves postgraduate training opportunities for the graduates of its colleges.[22] All 3 entities—the AOA, the ACGME, and AACOM—believe that this agreement ensures greater accountability to the public for its investment in the training of physicians. They also contend that this single accreditation system gives them a unified voice in advocating for GME resources and support.[23]

As the single largest financer of GME, the US Department of Health and Human Services (HHS), through the Centers for Medicare and Medicaid Services, is an important stakeholder in this agreement. In recent years, organizations such as MedPAC and the Council on Graduate Medical Education have studied the GME landscape and have recommended "a more accountable GME payment system that focuses on improving educational performance among institutions and residency programs."[13(p110)] In fact, MedPAC cites the NAS as an example of movement in this direction. Therefore, provided there is not a substantial decrease in GME positions or a shift away from primary care residencies toward specialty training during implementation, this transition to an ACGME-only accreditation system would be viewed as favorable by the HHS.

Although official positions of GME-sponsoring institutions are not known at this time, it is reasonable to conclude that, overall, they would be in favor of this move toward 1 accreditation body. Institutions that support both AOA- and ACGME-accredited residency programs would likely favor eliminating the duplication involved in meeting 2 sets of standards. Those institutions that sponsor AOA-accredited programs only may be challenged by this transition depending on available resources to meet the new standards. However, given the

changing landscape of GME financing and the call for accountability, these institutions face a bigger potential problem of eventually losing financial support for their programs because the AOA has no parallel outcomes-based accreditation system ready for implementation. For this reason, they, too, would likely support this development.

Current osteopathic medical students and residents are also key stakeholders in this agreement. In March 2014, AACOM conducted an online survey of osteopathic medical students to solicit their opinions about this development. Of 5307 respondents, 82% supported this agreement, with 55% indicating strong support; 6% were opposed.[24] Informal sources of information such as student blogs (eg, http://forums.studentdoctor.net) indicate the preservation of training opportunities across all medical specialties as the primary reason for this support. Although there is no official position of osteopathic residents, it is reasonable to believe that they, too, would favor this agreement for the same reason. One caveat is important, however. In the agreement's current form, during the 5-year implementation period, if a resident graduates from an AOA-accredited program that has entered the accreditation process, he or she will have access to ACGME fellowship training (in other words, the proposed common program requirements would not apply). The agreement does not state, however, that a program's mere entry into the accreditation process has any bearing on board certification eligibility. One may infer, therefore, that the current American Board of Medical Specialties (ABMS) rule that requires completion of an ACGME-accredited residency program for ABMS board eligibility will stand. The question then becomes, what will "completion of an ACGME-accredited residency" mean during this transition period? If ACGME accreditation is achieved by the time a resident graduates, is he or she eligible to take the ABMS board certification examination? Consistent with previous policy, the American Board of Family Medicine's Board of Directors confirmed that during the transition to a single GME accreditation system, osteopathic residents will need to complete the final 2 years of training in an ACGME-accredited program to be eligible for ABMS board certification (James C. Puffer, MD, e-mail communication, June 20, 2014). Although the AOA has stated that osteopathic certifying examinations are not a part of the MOU, some feel the future of board certification (including licensing, hospital credentialing, inclusion on insurance panels, and malpractice coverage) is somewhat uncertain.

Perhaps the most important stakeholder in this agreement is the US public. If standardization of GME accreditation produces the desired outcome of practice-ready physicians better equipped to deliver the type of care that is needed where it is needed, then a move to a single accreditation system is in the best interest of the public. Because we do not yet know if this goal will be realized, it is reasonable to presume that any move toward greater accountability to the public would likely be viewed as positive.

There are several stakeholders that support the overall concept of a single accreditation system but do not support the provisions of this particular agreement. Although these conditions may change throughout the implementation process, they exist in the agreement's current form and are barriers to several groups lending their support. For example, the American College of Osteopathic Internists has voiced several concerns. One such concern is the potential loss of smaller, community-based internal medicine residency programs will be unable to sustain the added financial costs that accompany the conversion to ACGME accreditation status. Another concern is the stipulation that current program directors certified by the AOA only may need ABMS-certified codirectors if they wish to retain these leadership positions.[25] The American College of Osteopathic Family Physicians shares this concern and asks that osteopathic specialty board examinations be accepted as alternatives to the ABMS board examinations taken at the conclusion of residency training.[26] Because the agreement states that "no other existing ACGME Institutional, Common, or Specialty Program Requirements are modified by

virtue of this agreement," ABMS board examinations remain the certification examinations required for residency program accreditation.[21]

As alluded to earlier, this board examination issue has several downstream consequences, in part related to the structure of the AOA. If osteopathic board examinations are not accepted as equivalent, then there will be little incentive for DOs to take this examination in addition to the required ABMS examination. Part of maintaining osteopathic board certification is maintaining membership in the AOA. The membership dues support ongoing certification education requirements and the board examination itself. Without membership dues revenue, it is reasonable to question the AOA's ability to maintain its certifying boards. For physicians who are currently certified only through the AOA's Bureau of Osteopathic Specialists, the potential inability to maintain their certification status (which typically involves passing recertification examinations and completing continuing medical education requirements) is an important issue, because board certification is generally required for hospital credentialing and inclusion in most insurance provider panels. Without board certification, it is difficult to practice medicine and generate income.

A final stakeholder is the practicing osteopathic physician, for components of the current agreement have potential implications for the osteopathic medical profession as a whole. Some DOs support this development and see it as a way to provide equal opportunities to medical education for all physicians. Others simply believe that a single system is inevitable and, as such, should be supported. Some of the concerns of those who do not support this agreement have already been stated—the future of osteopathic board certification and factors related to it and the ability of osteopathic training programs, particularly those based in community settings, to successfully transition to ACGME accreditation. A third concern is the potential consequence of the demand for standardization moving into the realm of undergraduate medical education. Whereas leaders of the osteopathic medical profession state that this agreement does not involve undergraduate medical education, some feel that it is reasonable to believe that standardization and the pressure for accountability in the medical education process will not end with GME. If that were the case, then how would osteopathic medical schools fare in a single accreditation system for undergraduate medical education? As the degree-granting institution and foundation of osteopathic medical training, the viability of the osteopathic medical school is fundamental to the viability of the osteopathic medical profession as it currently exists in the United States.

Recommendation

Given the realities of GME financing and the move toward GME accountability, the potential impact of the ACGME's common program requirements on osteopathic GME opportunities and the dependence on the ACGME to provide postgraduate training for more than half of its graduates, my recommendation is to support the implementation of the single accreditation agreement. To ensure the growth of an adequate physician workforce, efforts must be directed at maintaining current primary care GME positions, developing primary care training opportunities in areas of need, recruiting future physicians likely to practice in underserved areas, and supporting policies that will enable AOA-certified physicians to continue to deliver health care to the US population. In addition, leaders of the predoctoral accrediting bodies (those involved in the accreditation of medical schools) must collaborate with each other and key stakeholders, such as the US Department of Education, to enact policies that standardize medical school accreditation while recognizing the strengths and unique contributions of both MD and DO degree–granting medical schools. Such policies must also advance the alignment of the processes and outcomes of training from medical school through GME so that a cohesive educational experience responsive to society's health care needs can be realized. (doi: 10.7556/jaoa.2014.102)

References

1. Allopathic and osteopathic medical communities commit to a single graduate medical education accreditation system. American Osteopathic Association website. 2014. http://www.osteopathic.org/inside-aoa/Pages/ACGME-single-accreditation-system.aspx. Accessed June 13, 2014.
2. Young A, Chaudhry HJ, Thomas JV, Dugan M. A census of actively licensed physicians in the United States, 2012. *J Med Ed*. 2012;99(2):11-24.
3. About AACOM. American Association of Colleges of Osteopathic Medicine website. http://www.aacom.org/about/Pages/default.aspx. Accessed June 13, 2014.
4. Gevitz N. The transformation of osteopathic medical education. *Acad Med*. 2009;84(6):701-706.
5. *National Resident Matching Program, Results and Data: 2013 Main Residency Match*. Washington, DC: National Resident Matching Program; 2013.
6. *First-Year Graduate Medical Education in the United States: 2002-2014*. Washington, DC: National Resident Matching Program; 2014. www.nrmp.org/wp-content/uploads/2014/04/First-Year-GME-in-the-US-rev-for-WWW_4.8.14-FINAL.pdf. Accessed June 16, 2014.
7. *Osteopathic GME Match Report 2012*. Chevy Chase, MD: American Association of Colleges of Osteopathic Medicine; 2013. http://data.aacom.org/aacomas/do_gme_match_report2012.asp. Accessed June 16, 2014.
8. Kohn LT, Corrigan JM, Donaldson MS, eds. *To Err Is Human: Building a Safer Health System*. Washington, DC: National Academy Press; 1999.
9. Council on Graduate Medical Education. *Advancing Primary Care*. 20th report. Washington, DC: US Dept of Health and Human Services; 2010. http://www.hrsa.gov/advisorycommittees/bhpradvisory/cogme/Reports/twentiethreport.pdf. Accessed June 16, 2014.
10. Graduate medical education updated. *Health Affairs*. August 31, 2012. http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=75. Accessed June 13, 2014.
11. Balanced Budget Act of 1997, Pub L No. 105-33, 111 Stat 251.
12. Cooke M, Irby DM, O'Brien BC. *Educating Physicians: A Call for Reform of Medical School and Residency*. San Francisco, CA: Jossey-Bass; 2010.
13. Medicare Payment Advisory Commission. *Report to the Congress: Aligning Incentives in Medicare*. Washington, DC: US Government Printing Office; 2010.
14. Nasca TJ, Philibert I, Brigham T, Flynn TC. The next GME accreditation system—rationale and benefits [special report]. *N Engl J Med*. 2012;366(11):1051-1056. doi:10.1056/NEJMsr1200117.
15. ACGME common program requirements for graduate medical education: summary and impact of proposed revisions. Accreditation Council for Graduate Medical Education website. http://www.acgme.org/acgmeweb/Portals/0/PDFs/CPR_Impact.pdf. Accessed June 13, 2014.
16. Specialty training positions in areas of pediatric surgery. The American Pediatric Surgical Association website. http://www.eapsa.org/Specialty_Training_Positions/3704.htm. Accessed June 16, 2014.
17. Rao A. Osteopathic physicians: an answer to rural health care needs? *Kaiser Health News*. March 11, 2013. http://www.kaiserhealthnews.org/stories/2013/march/11/osteopaths-answer-to-rural-health-care-needs.aspx. Accessed June 13, 2014.
18. American Osteopathic Association, American College of Osteopathic Family Physicians (ACOFP). *Basic Standards for Residency Training in Osteopathic Family Practice and Manipulative Treatment*. Arlington Heights, IL: ACOFP; 2011. http://www.acofp.org/uploadedFiles/ACOFP/Portals/Program_Directors/Basic_Standards_for_Residency_Training_in_Osteopathic_Family_Practice_and_Manipulative_Treatment%281%29.pdf. Accessed June 13, 2014.
19. Accreditation Council for Graduate Medical Education (ACGME). *ACGME Program Requirements for Graduate Medical Education in Family Medicine*. Chicago, IL: ACGME; 2013. http://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/120_family_medicine_07012014.pdf. Accessed June 13, 2014.
20. Vinn NE. Single GME accreditation system: an open letter to the DO community. American Osteopathic Association website. http://www.osteopathic.org/inside-aoa/Pages/acgme-open-letter-to-the-DO-community.aspx. Published March 24, 2014. Accessed June 13, 2014.
21. Nasca TJ. Letter to the community from ACGME CEO Thomas J. Nasca, MD, MACP. http://www.acgme.org/acgmeweb/Portals/0/PDFs/NascaLetterACGME-AOA-AACOMAgreementMarch2014.pdf. Published March 13, 2014. Accessed June 16, 2014.
22. Shannon SC. A single GME accreditation process: forging the future for osteopathic medical education. *Inside OME*. 2014;8(3). http://www.aacom.org/resources/e-news/ome/2014-03/Pages/president.aspx. Accessed June 13, 2014.
23. Allopathic and osteopathic medical communities commit to a single graduate medical education accreditation system. The American Osteopathic Association website. http://www.osteopathic.org/inside-aoa/news-and-publications/media-center/2014-news-releases/Pages/2-26-allopathic-and-osteopathic-medical-communities-commit-to-single-graduate-medical-education-accreditation-system.aspx. Accessed June 16, 2014.
24. *Report on Survey of Osteopathic Medical Students' Views of Unified GME Accreditation*. Chevy Chase, MD: American Association of Colleges of Osteopathic Medicine; 2014. http://www.aacom.org/news/latest/Documents/GME-merger-survey-report_3-25-14.pdf. Accessed June 13, 2014.
25. American College of Osteopathic Internists Board of Directors. ACOI response to 2014 announcement of unified GME system. http://www.acoi.org/NewsUnifiedGME.html. Accessed June 16, 2014.
26. ACOFP Congress of Delegates. Resolution 13 – AOA/AACOM unified residency accreditation system. ACOFP website. Approved March 13, 2014. http://www.acofp.org/About_ACOFP/Congress_of_Delegates_Resolutions/Res_13_-_AOA-AACOM__Unified_Residency__Accreditation_System/. Accessed June 16, 2014.