A Structural Examination of Medical Education Reform

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Osteopathic medical education is currently navigating stormy waters because of unprecedented changes from the Patient Protection and Affordable Care Act, the Institute of Medicine report *Graduate Medical Education That Meets the Nation's Health Needs*,[1] and a new single graduate medical education (GME) accreditation system. In response to health care reform, the osteopathic medical education system has focused on increasing the size of the physician workforce by rapidly establishing new colleges of osteopathic medicine (COMs) and increasing class sizes of existing COMs.[2] However, increasing the number of physicians will not provide the solution unless those physicians are trained to meet the needs of our changing health care delivery system. Osteopathic medical education must widen its focus beyond quantitative workforce solutions and align its education with the efforts of the care-delivery redesign that is driving health care today.

To address how medical education can prepare physicians for the changing health care system, the American Osteopathic Association (AOA) and the American Association of Colleges of Osteopathic Medicine (AACOM) established the Blue Ribbon Commission for the Advancement of Osteopathic Medical Education (BRC). The BRC's report, *Building the Future: Educating the 21st Century Physician*,[3] provides a comprehensive framework to fundamentally change osteopathic medical education and optimize the alignment between osteopathic medical education and health care delivery. Simultaneously, the Accelerating Change in Medical Education Initiative from the American Medical Association (AMA) arrived at many of the same conclusions as the BRC and created 11 pilot programs to evolve medical education to meet these needs.[4]

The benefit of increasing physician supply as the main response to predicted physician shortages has been debated. In the November 2013 issue of *Health Affairs*, Ricketts and Fraher[5] promoted the increase of nonphysician health care providers as a workforce solution. That same month, Ian Morrison, PhD, a futurist, remarked about the physician shortage at the Association of American Medical Colleges 2013 Annual Meeting:

> …it is only a problem if we keep doing things the same way. We don't sit around worrying about the bank teller shortage.[6]

The Institute of Medicine report[1] also concluded that quantitative workforce solutions were not the whole answer. Although the report has resulted in a brisk stakeholder debate, few can argue with its first goal:

> Encourage production of a physician workforce better prepared to work in, help lead, and continually improve an evolving health care delivery system that can provide better individual care, better population health, and lower cost.

The BRC's recommendations outline strategies that directly align osteopathic medical education with innovations in health care delivery. These strategies include[3]:

- Increase focus on the new competencies to improve population health, embrace individual care, and reduce costs.
- Transition education from time-based milestones to a competency-based system.
- Remove educational inefficiencies to promote accelerated training.
- Link the osteopathic predoctoral education and osteopathic GME continuum longitudinally.

Although many of the BRC recommendations align with those of the AMA's initiative, the linkage between osteopathic predoctoral education and osteopathic GME distinctively separates the BRC's strategies from all but 1 of the AMA's 11 pilot

Table.
Medical Education Strategies of the BRC and the AMA in Response to Health Care Reform

	Strategy				
Program	**OPP**	**Competency Based**	**Linked Predoctoral and Graduate Medical Education**	**Health Care Delivery Competencies**	**Accelerated Training**
BRC	X	X	X	X	X
AMA Pilot Program[a]					
Indiana University School of Medicine				X	
Mayo Medical School		X		X	
NYU School of Medicine		X		X	X
Oregon Health & Science University School of Medicine		X		X	X
Pennsylvania State College of Medicine		X		X	
The Brody School of Medicine at East Carolina University				X	
The Warren Alpert Medical School of Brown University				X	
UC Davis School of Medicine		X	X		X
UC San Francisco School of Medicine				X	
University of Michigan Medical School					X
Vanderbilt University School of Medicine		X		X	

[a] Created as part of the Accelerating Change in Medical Education Initiative from the American Medical Association (AMA).[4]

Abbreviations: BRC, Blue Ribbon Commission for the Advancement of Osteopathic Medical Education; OPP, osteopathic principles and practice; NYU, New York University; UC, University of California.

programs (*Table*). By linking osteopathic predoctoral education with osteopathic GME, COMs would become more integrated with and add value to the health care system. For example, by assigning learners (ie, medical students and residents) to fewer health care settings, fewer resources would be needed to transition learners to a system's procedures and health records and to sort out the myriad logistics required when one joins a care team. Another benefit is that the linkage would stabilize GME placement patterns needed by COMs to meet their missions and the increasing accreditation demands for GME. Finally, the linkage could foster new business models that would replace rising cost-per-rotation fees with sustainable models of in-kind support, such as faculty time dedicated to quality improvement activities, as well as new models of integrated ambulatory care in which learners care for a patient population throughout osteopathic medical school and residency. These learners would provide tremendous value in an environment of mutual benefit for COMs, osteopathic GME programs, and delivery systems. The osteopathic GME programs would play a vital role in the transition to a linked system between the COMs (vis-a-vis osteopathic postdoctoral training institutions) and the health

care systems that they serve. The osteopathic GME leaders speak both languages of education and care delivery and could ensure we are training physicians who meet the highest standards and who are prepared to lead health care teams of the future.

The BRC also describes[3] training students and residents in new competencies such as population health, quality improvement, medical informatics, and leadership skills. Nine of the 11 AMA pilot programs also recognize the importance of increased training in these competencies. Physicians need these skills as health care payment systems transition from rewarding volume to rewarding value. Although learners in our proposed linked system should be individually evaluated as they achieve these new competencies, training programs should be evaluated on measurements of improved population health and decreased cost to the communities that they serve in addition to learner outcomes. Faculty should be evaluated (and even compensated) for achieving improved population health outcomes. Training programs must be built so that impact on care outcomes can be measured. A curricular model should include early study of the fundamentals of health care systems, population health, leadership, communication, and medical informatics. Osteopathic medical students would spend a portion of their clinical training with continuous quality improvement teams tasked with implementing the needed changes. Residents would lead their own teams of learners and health system staff as part of scholarly requirements. The proposed educational model would involve learners with these teams throughout the education continuum as part of their education and service.

The programs supported by the AMA's initiative incorporate goals to address specific problems in the current education system. The pathway delineated in the BRC report,[3] however, treats the education and health care delivery continuum as a unit and outlines a holistic approach for educators to adapt the current educational structure to meet the future needs of health care. A reductionist approach that maintains separations between medical school, residency, and health care delivery will not be successful in the new health care environment. Adding focused curriculum during this time of rapid change in health care may not be effective because the material changes too quickly. The BRC's solution is to create a single system in which the health care delivery team and the learning team make changes together as a unit. (doi:10.7556/jaoa.2015.039)

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