10-2020

Impact of the Single Accreditation System on Missouri Osteopathic Graduate Medical Education

Richard J. LaBaere II

Kerrie J. Jordan

Impact of the Single Accreditation System on Missouri Osteopathic Graduate Medical Education

by Richard J. LaBaere, II, DO & Kerrie J. Jordan, MS

ATSU A.T. Still University
FIRST IN WHOLE PERSON HEALTHCARE

The transition to the Single Accreditation System has eliminated costly duplication of institutional accreditation processes and ensured all medical student applicants are eligible to enter accredited programs after graduation.

Richard J. LaBaere, II, DO, MPH, FAODME, (above), is Associate Dean for Graduate Medical Education and Designated Institutional Official, Still Osteopathic Postdoctoral Training Institution; Kerrie J. Jordan, MS, is Designated Institutional Official GMEC Chair, KCU-GME Consortium. Both are at the College of Osteopathic Medicine, Kansas City University, Kansas City, Missouri.

Abstract

The single accreditation system (SAS) through the Accreditation Council for Graduate Medical Education was introduced in 2014. Its goals included increasing consistency in training and providing a dedicated place for delivery of osteopathic educational competencies. From 2015 to 2020, most osteopathic primary care and specialty residencies in Missouri successfully achieved accreditation. Nearly all osteopathic surgical specialty residencies and traditional internships did not make the transition. The current article examines the challenges and opportunities of SAS.

Background

In early 2014, the Accreditation Council for Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), and the American Association of Colleges of Osteopathic Medicine (AACOM) entered into a memorandum of understanding to transition all graduate medical education (GME) in the United States to a unified single accreditation system (SAS) by July 2020.[1] This agreement arose from preliminary discussions among the three groups in 2012. The official launch of SAS was July 1, 2015, at which point AOA-accredited programs could apply for ACGME accreditation. The SAS created access to GME for all allopathic (MD) and osteopathic (DO) medical school graduates and generated unique opportunities for growth in both professions nationwide. In Missouri, the birthplace of osteopathic medicine in the United States, we have seen this transition evolve and have identified its effects on medical education. In the current article, the perspective of two Missouri osteopathic medical education institutions was explored to convey the present landscape and share the challenges and opportunities that impact the future of the healthcare workforce in Missouri.

Transition to the Single Accreditation System

The conditions for change to a SAS began in 2009.[2] At that time, the ACGME shifted its accreditation structure to include educational outcomes that focused on six core competencies. Likewise, the AOA identified seven related osteopathic competencies, which included a specific competency for osteopathic practice. In 2011, the ACGME announced changes in their common program requirements that limited the

eligibility of DO graduates from moving into fellowship programs. Early in 2012, representatives from the ACGME, AOA, and AACOM met to address concerns of exclusion and consider strategies that would serve all invested stakeholders. After almost two years of meetings that included negotiations, planning, and an initial proposal that was not accepted, a memorandum of understanding was signed to create a unified SAS. Afterwards, the appropriate governing bodies approved the agreement developed by these three principal organizations.[3]

To encourage stakeholder onboarding, several benefits of the SAS were outlined. For instance, the SAS preserved the access of DO graduates to accredited GME training during a time when the number of DO graduates was expanding beyond the capacity of AOA-accredited programs to provide training.[1] Further, the unified SAS provided consistency of quality in relation to the curriculum and training requirements of both professions.[1] Another benefit was the inclusion of osteopathic elements into the framework of GME so both MDs and DOs were exposed and developed those competencies.[1] A benefit for the osteopathic profession meant they had a unified voice for GME access and funding issues, strengthening the profession's advocacy. Finally, the SAS hardwired distinctive characteristics of the osteopathic profession into GME.[1]

After approval of the SAS, many changes in GME followed that benefited the osteopathic profession, such as the appointment of AOA and AACOM representatives to the ACGME Board of Directors, the appointment of DOs to review committees, the modification of requirements so DOs could fully participate as faculty and program directors, the creation of an osteopathic principles committee, the formation of an osteopathic neuromuscular medicine review committee, and most notably the creation of a new ACGME designation called Osteopathic Recognition.[4]

Transition Process and Timeline

As part of the transition to a unified SAS, the memorandum of understanding indicated that AOA institutions and programs would "have until June 30, 2020, to apply for ACGME accreditation."[5] Failure to apply had severe negative consequences because the AOA would no longer accredit academic sponsors or GME programs after that date.[5] Once an AOA program applied for ACGME accreditation, however, they had to achieve "initial" ACGME accreditation no later than June 30, 2020.[5]

To protect residents from being misplaced during the transition to ACGME, the AOA set deadlines for AOA programs.[6] Specifically, the programs had to apply for ACGME accreditation or stop accepting new residents by the deadline. One-year and two-year programs had until January 1, 2019, to apply for ACGME accreditation. Three-year programs had until January 1, 2018, to apply, and four-year and five-year programs had until January 1, 2017, to apply. Any program that had not achieved initial or continuing accreditation from the ACGME by June 30, 2020, was allowed to finish teaching out any residents remaining under the AOA accreditation system but only if the program had an approved plan from the AOA to ensure the quality of residency training. After remaining residents were finished, the program was required to close.[6]

Osteopathic Recognition

During the transition to SAS, the ACGME designation of Osteopathic Recognition was created so that the distinctive characteristics of osteopathic medicine continued in GME training. For instance, the ACGME created a new chapter for osteopathic medicine and established the Osteopathic Principles Committee. The purpose of the committee was to designate, through an application process, which ACGME programs incorporated Osteopathic Principles and Practice into the GME curriculum. Therefore, programs with Osteopathic Recognition have different educational program and resident experiences. According to the AOA, programs that achieve Osteopathic Recognition "help ensure the unique principles and practice of osteopathic medicine" continue to provide benefits and advantages to students who receive this specialized training.[7]

Another consequence of Osteopathic Recognition is that graduates of allopathic can obtain osteopathic training during residency if they match in a program that is accredited for Osteopathic Recognition by the ACGME. Further, Osteopathic Recognition has been proven to reduce costs and improve patient care because it emphasizes patient communication and alternatives to medication.[6] As such, Osteopathic Recognition programs anticipate attracting more qualified applicants who want to complete an

Osteopathic Recognition focused training program and advance their osteopathic manual skills and practice.

Status of American Osteopathic Association Accredited Programs in 2015

Before SAS, the AOA accreditation of GME programs required that each program be part of an accredited Osteopathic Postdoctoral Training Institution (OPTI). An OPTI is an AOA-accredited educational consortium that consists of a program in a college of osteopathic medicine that serves as an academic sponsor of programs. In that role, OPTIs provided oversight of accreditation and support for curricular development and assessment, faculty development, and research. In Missouri, there are two OPTIs: Kansas City University Graduate Medical Education (KCU-GME) Consortium and Still OPTI, which is affiliated with A.T. Still University's Kirksville College of Osteopathic Medicine (ATSU-KCOM) and School of Osteopathic Medicine in Arizona (ATSU-SOMA). Together, these OPTIs provided academic support for 21 programs in Missouri and 21 additional programs in other states, including Arizona, Arkansas, Colorado, Florida, Illinois, Indiana, Ohio, and Wisconsin.

After the Single Accreditation System

Starting July 1, 2015, applications were accepted under SAS for sponsoring institution accreditation. Both Missouri-based OPTIs—KCU-GME Consortium and Still OPTI at ATSU-KCOM—applied for and achieved initial accreditation. Further, these sponsoring institutions currently have ACGME continuing accreditation.

During the transition to the SAS, the majority of primary care, internal medicine, and family medicine residencies successfully achieved continuing accreditation. Five of six programs achieved this status (Table 1). One program, a community-based internal medicine program, chose to not pursue ACGME accreditation. It was believed at the time that the necessary resources relative to adequate faculty were not available to sustain the program. Specialty-type residencies, such as emergency medicine, dermatology, and osteopathic neuromuscular medicine, all had a successful transition into continuing accreditation.

Surgical and surgery-related programs were less successful. Two of three otolaryngology, both general surgery, and both anesthesia programs in Missouri failed to progress. One of two orthopedic surgery programs achieved initial accreditation. One anesthesia program achieved initial accreditation but received a warning after initial review. In that instance, the sponsoring institution withdrew from accreditation and completed the training of their residents through the AOA pathway because they were concerned remaining residents would be displaced if accreditation was withheld by the ACGME beyond 2020. Although the anesthesia review committee recognized progress (the program was getting guidance, being creative, and striving to address shortcomings), numerous citations for faculty and program director scholarship, faculty qualifications in specialty areas, and inadequate resident complement (5 vs 9 minimum) were insurmountable barriers to compliance.

The three traditional osteopathic internships were not pursued for conversion to transitional year programs by sponsoring institutions. Commonly, these traditional intern positions were not filled. However, it seems somewhat ironic that what was once the foundation of osteopathic GME has now disappeared from the landscape in Missouri. Despite this loss, the two AOA-accredited OPTIs have both achieved ACGME accreditation.

Discussion

Challenges

Initially, the unified SAS left many GME programs with unanswered questions. In addition, it was challenging for administrators and educators to learn new accreditation requirements. However, through involvement in dedicated ACGME and AOA educational offerings, 58% of all programs and 83% of primary care, internal medicine, and family medicine programs are now ACGME accredited. Another challenge experienced and overcome was related to condensing two different residency matches into a single match. Historically, AOA programs participated in a match called the National Matching Service. Programs that were accredited by the AOA and ACGME could participate in the National Matching Service and the National Resident Matching Program. After the transition, in spring 2020, only the National Resident Matching Program was used to enroll eligible candidates into residency programs. As a result of program directors, faculty, and staff successfully learning the new system, all positions but one were filled in the 2020 match season.

Table 1. Collated Data on the Number of Accredited Missouri Graduate Medical Education Programs and Sponsoring Institutions from 2014 to 2020[8,9]

Specialty	Total ACGME Programs/SI 2020-2021	Former AOA Currently ACGME Accredited	AOA Accredited Programs in 2014	Net Change	Osteopathically Recognized 2020
Anesthesia	4	0	2	-2	0
Dermatology	3	1	1	0	1
Emergency Medicine	4	1	1	0	0
Family medicine	9	3	3	0	3
Internal medicine	9	2	3	-1	0
ONMM	1	1	1	0	0
Orthopedics	5	1	2	-1	0
Otolaryngology	4	1	3	-2	0
Surgery	5	1`	3	-2	0
Transitional year/traditional intern	1	0	2	-2	0
SI	14	2	NA	+2	NA

Abbreviations: ACGME, Accreditation Council for Graduate Medical Education; AOA, American Osteopathic Association; ONMM, osteopathic neuromuscular medicine; SI, sponsoring institutions.

Another challenge of the SAS is that ACGME-accreditation requirements for institutions and programs have specific language that drives up residency costs; such requirements were not stipulated by the AOA. One example of this expense-generating difference is related to the requirement of an associate program director in family medicine. The ACGME requirements mandate that an associate program director be designated and that their effort must be at least 40% dedicated to the administration of the program.[10] The AOA has no equivalent requirement.[11] Also, all ACGME-accredited programs must have a dedicated program coordinator who contributes a minimum of 50% of their time to the program.[12] The AOA program requirements do not indicate any required coordinator full-time equivalent.[11]

The ACGME requirements also define new, additional activities for faculty that require dedicated time.[12] For example, ACGME programs must have an appointed clinical competency committee consisting of at least three faculty members who are required to meet semiannually to review resident evaluations and milestone progress. These review sessions can take a full day to complete. Further, each ACGME program must have an appointed program evaluation committee that meets annually to review the training program that monitors faculty development, graduate performance, program quality, and areas for program improvement. The ACGME also expects faculty to maintain a

scholarly environment by funding resident and faculty scholarly activity.[13] However, programs can define how they will assist the scholarly activity of faculty, such as by providing faculty development opportunities.[14]

Programs that are currently part of the SAS need to focus on outcomes, scholarly activity support for research, and quality improvement projects. Creating protected time for these activities has increased staffing costs for programs. These process challenges—protected program director and faculty time for research, curricular issues, mandated transplant rotation and required specialty faculty, required companion programs, and dedicated coordinator staff—were contributing factors to why programs in Missouri did not fully transition to ACGME accreditation.[15] In addition, another challenge has been that some programs lack sufficiently trained faculty who can provide Osteopathic Recognition training, so those programs are unable to offer that training.

Opportunities

All medical schools and colleges of osteopathic medicine in Missouri are either a sponsoring institution or part of a consortium-type sponsoring institution. Each of these organizations have expertise in program accreditation and teaching resources across nearly all disciplines. External collaborations with these institutions, like Missouri's Health Care Workforce coalition, may be able to assist struggling or new GME programs by coordinating support through sharing clinical resource rotations and providing partners for community-based scholarship. Through advocacy and collective and innovative action plans, training positions in Missouri may be preserved in the communities served, and clinical care and population-based research advanced.

Another opportunity for GME-training programs involves taking advantage of rural and community-based faculty in programs that are sunsetting their AOA-accredited programs. These faculty are committed and have expertise in providing meaningful clinical learning experiences related to the development of required skill sets in programs like general surgery and anesthesia. Since research suggests recruitment of graduates from programs that provide a rural track result in successful rural-based community practices,[16] there is benefit in taking advantage of the experience of current anesthesiology and general surgery faculty who have the skills and passion for teaching these specialties in relation to the needs of rural Missouri. In addition, creating rural training track or other elective experiences in conjunction with other Missouri-based GME could meet the healthcare workforce demands of the state.

Outside rural areas, rural training track programs are generally allowed to receive additional or alternative funding for urban teaching hospitals that may have a Medicare GME reimbursement cap. Further, urban hospitals may receive a new rural track full-time equivalent limit that allows additional Medicare GME funding, which may make these programs more appealing. However, rural training track programs require residents to spend at least 50% of their time training in rural areas. This approach may also boost and maintain more osteopathic graduates who want to train in rural areas. In addition, osteopathic training programs faced with closure may be able to leverage rural training track programs to entice DO and MD candidates who want to be in rural areas and gain additional Medicare GME funding.

Another opportunity of SAS arises from collaboration with the ACGME so that options for programs and training capacity that are rurally based can be more fully explored. Recently, the ACGME hired a director of medically underserved areas/populations and graduate medical education (Paul Johnson, email communication, April 22, 2020). This person will lead a new programmatic unit of the ACGME that will coordinate efforts to address health and healthcare in medically underserved areas and populations and that will participate in the development of relevant educational programming and outreach activities. In conjunction with a better understanding of the needs of these patients and of what programs are able to offer for training, this unit can establish innovative ways to deliver training and produce the types of physicians needed for those vulnerable populations. Perhaps the requirements themselves may evolve and provide some additional flexibility to meet training and population needs.[17]

A final opportunity provided by SAS in Missouri includes harnessing the potential of osteopathic training and Osteopathic Recognition support available through both of our state's osteopathic medical schools. The Kansas City University College of Osteopathic Medicine and ATSU-KCOM offer guidance and support for developing curricula,

assessment tools, face-to-face workshops, faculty development, and opportunities to participate in related scholarship activities. There are now over 215 osteopathically recognized programs in the United States, and osteopathic medical students have expressed a desire to pursue osteopathic training beyond their DO degree.[14] Therefore, providing an Osteopathic Recognition track or other types of osteopathic training experiences in a residency program will help distinguish that program from others. Broadening the exposure for all residents creates a diversity of perspective that enables residents to better understand patients who seek care from osteopathic physicians and the approach provided by those physicians in the delivery of their care.

Conclusion

The unified SAS introduced by the ACGME in 2014 was intended to benefit the entire GME community. Further, the SAS established and maintained consistent evaluation and accountability for the competency of resident physicians across all accredited residency and fellowship programs. It also provided a mechanism for the ongoing development of osteopathic clinical skills that was accessible to both DOs and MDs. Further, the transition to SAS has eliminated costly duplication of institutional accreditation processes and ensured all medical student applicants are eligible to enter accredited programs after graduation. The SAS was fully implemented in the 2020 match season and allows graduates of osteopathic and allopathic medical schools to complete their residency or fellowship training in ACGME-accredited programs while demonstrating achievement of typical milestones and competencies. In addition, the SAS creates diverse opportunities for everyone by opening up more programs that maintain osteopathic identity through the ACGME Osteopathic Recognition designation, which in turn amplifies the value of DO and MD residents training side-by-side. The five-year transition to SAS has served our medical institutions and the healthcare of the public by enriching the education of the next generation of physicians. Although SAS created challenges that resulted in some programs not transitioning to ACGME, most osteopathic primary care and specialty residencies in Missouri successfully achieved accreditation. A lasting benefit of SAS is that it has highlighted the needs of rural training in Missouri, opportunities for growth, and the dedicated resources available through our osteopathic medical schools that will advance the medical training and the healthcare workforce of Missouri.

References

1. Ahmed AH, Schnatz PF, Adashi EY. Allopathic and osteopathic medicine unify GME accreditation: a historic convergence. Fam Med. 2017;49(5):374-377.
2. Buser BR, Swartwout J, Gross C, Biszewski M. The single graduate medical education accreditation system. J Am Osteopath Assoc. 2015;115(4):251-255.
3. Nasca TJ. Letter to the graduate medical education community. http://www.acgme.org/acgmeweb/Portals/0/PDFs/NascaLetterACGME-AOA-AACOMAgreementMarch2014.pdf. Published March 13, 2014. Accessed April 18, 2020.
4. Buser BR, Swartwout J, Lischka T, Biszewski M, DeVine K. Single accreditation system update: gaining momentum. J Am Osteopath Assoc. 2017;117(4):211-215.
5. Antoline-Wang D. AOA and ACGME combine accreditation programs. http://www.acepnow.com/aoa-acgme-combine-accreditation-programs/. Published February 28, 2014. Accessed April 23, 2020.
6. Buser BR, Swartwout J, Lischka T, Biszewski M. Single accreditation system for graduate medical education: transition update. J Am Osteopath Assoc. 2019;119(4):257-262.
7. Osteopathic Recognition. American Osteopathic Association website. https://osteopathic.org/graduate-medical-educators/single-gme/osteopathic-recognition/. Accessed May 29, 2020.
8. FREIDA: the AMA residency and fellowship database. American Medical Association website. https://freida.ama-assn.org/Freida/#/. Accessed April 18, 2020.
9. Accreditation Council for Graduate Medical Education (ACGME): public. https://apps.acgme.org/ads/public/. Accessed April 18, 2020.
10. Accreditation Council for Graduate Medical Education. ACGME program requirements for graduate medical education in family medicine. https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/120_FamilyMedicine_2019.pdf?ver=2019-06-13-073936-407. Revised June 9, 2019. Accessed April 29, 2020.
11. American Osteopathic Association. Basic standards for residency training in osteopathic family medicine and manipulative treatment. https://osteopathic.org/wp-content/uploads/2018/02/family-med-basic-standards.pdf. Revised March 2019. Accessed May 29, 2020.
12. Accreditation Council for Graduate Medical Education. ACGME common program requirements (residency). https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRResidency2019.pdf. Revised June 10, 2018. Accessed April 29, 2020.
13. Philibert I, Lieh-Lai M, Miller R, Potts JR III, Brigham T, Nasca TJ. Scholarly activity in the next accreditation system: moving from structure and process to outcomes. J Grad Med Educ. 2013;5(4):714-717.
14. LeVan DJ, Plizga LA, Wiley A, et al. The journey to ACGME accreditation: a program's perspectives and practical guidance from the ACGME. J Grad Med Educ. 2016;8(3):473–477.
15. Cummings M. Meeting ACGME standards under a unified accreditation system: challenges for osteopathic graduate medical education programs. Acad Med. 2017;92(7):936-942.
16. Deveney K, Deatherage M, Oehling D, Hunter J. Association between dedicated rural training year and the likelihood of becoming a general surgeon in a small town. JAMA Surg. 2013;148(9):817-821.
17. Nasca TJ, Carlson D. Graduate medical education specialty mix and geographic residency program maldistribution: is there a role for the ACGME? AMA J Ethics. 2016;18(3):258-263.

Disclosure

None reported. **MM**