August 1, 2022

AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE

ADM Rachel Leland Levine, USPHS, MD
Assistant Secretary for Health
U.S. Department of Health and Human Services
200 Independence Ave, SW
Washington, DC 20201

Dear ADM Levine:

On behalf of the American Association of Colleges of Osteopathic Medicine (AACOM), thank you for the opportunity to contribute to the U.S. Department of Health and Human Services' (HHS) Initiative to Strengthen Primary Care.

Founded in 1898 to support and assist the nation's osteopathic medical schools, AACOM represents all 38 accredited colleges of osteopathic medicine (COMs)—educating nearly 34,000 future physicians, 25 percent of all U.S. medical students—at 61 teaching locations in 35 U.S. states, as well as osteopathic graduate medical education (GME) professionals and trainees at U.S. medical centers, hospitals, clinics and health systems.

Osteopathic medicine is uniquely positioned to achieve the goal state for primary healthcare. Osteopathic physicians (DOs) are trained to look at the whole person from their first days of medical school. The osteopathic physician focuses on the integrated nature of the various organ systems and the body's capacity for self-regulation and self-healing. Through this holistic approach, osteopathic medical students learn how to integrate the patient as a partner in the healthcare process.

Osteopathic medical tradition holds that a strong foundation as a generalist makes one a better physician, regardless of one's ultimate practice specialty. Primary care is the generalist exemplar and more than half of DOs currently practice in primary care, with 55.8 percent of U.S. DO seniors matching into primary care residencies this year. Moreover, COMs have a proven history of serving rural and underserved communities. Fifty-eight percent of COMs are located in Health Professional Shortage Areas (HPSAs), and nearly 40 percent of physicians who practice in medically underserved areas are DOs. These doctors serve as the backbone of the primary care system.

1. Successful models or innovations that help achieve the goal state for primary healthcare

Osteopathic medical students are taught using a distributed model of medical education where clinical training is received in and from community-based hospitals and physicians, enabling students to learn more about the healthcare needs of the communities where they will eventually practice. The current model of medical education for most MD-granting institutions derives largely from a report developed by Abraham Flexner in 1910. The report recommends basing medical schools in existing universities and establishing a standardized curriculum of two years of classroom and laboratory education followed by two years of clinical experience in a teaching hospital under the direction of physicians who engage in both research and patient care.

Alternatively, the distributed model of osteopathic medical education (OME) uses a variety of settings—large and small community hospitals, community health centers and an array of outpatient settings—to teach clinical medicine. Much more than academic medical centers, which represent only five percent of all hospitals in the U.S. and only 20 percent of all hospital admissions, surgical operations and outpatient visits, this distributed model trains physicians for their future practice. It is much more likely that COMs are training physicians in environments where they will practice. Further, clinical training settings often dictate practice location. In fact, more than 73 percent of DOs practice in the state where they do their residency training, and that number rises to 86 percent when they do both medical school and residency in the state.

There are different models of distribution in OME. Some COMs use a "hub and spoke" model where a campus (often the COM campus) serves as academic home (for academic lectures, simulations, testing, etc.), and students rotate through various smaller affiliated clinical sites. Other COMs have set up clinical campuses, where students spend their full clerkship year(s). Within these two models, there is often the need for a student to leave a site to get training in a specific area. Changes in healthcare—such as hospital mergers, increased care in ambulatory settings, reallocation of less complex care from hospitals to community settings and financial pressures on hospitals and other institutions—result in more physicians being trained in a distributed training model. The distributed model of training has been replicated across the OME community and produces strong outcomes, including more primary care physicians in rural areas, as illustrated below:

- The *William Carey University College of Osteopathic Medicine (WCUCOM)* in Hattiesburg, Mississippi, utilizes the community-based training model for third- and fourth-year programs. Students are placed in hub sites in rural and underserved areas of Mississippi and Louisiana that are embedded with community-based primary care residency programs. Notably, WCUCOM placed first in the nation among all medical schools by *US News and World Report* (2023) for placing its graduates into rural areas. WCUCOM also ranked fourth in the nation in two other areas—highest percentage of graduates practicing in both primary care and HPSAs.

  Through this model, WCUCOM students are inspired to choose primary care and practice in rural and underserved areas. Students build relationships with program directors and communities during training and stay for residency. WCUCOM has a 72 percent three-year rolling average of matching students into primary care. Studies also show that residents stay within 75 miles of where they practice. The WCUCOM model is critical because MS is ranked next to last in overall number of primary care physicians and is a predominantly rural state.

- The *Pacific Northwest University of Health Sciences College of Osteopathic Medicine (PNWU-COM)* in Yakima, Washington is committed to serving the rural and medically underserved of the Pacific Northwest. PNWU-COM data indicates that the following characteristics best predict the students who will practice in rural and/or underserved areas: female; from the Pacific Northwest region; participated in a primary care residency rotation (family medicine or internal medicine); and entered a rural residency. Forty-six percent of PNWU-COM graduates practice in family medicine.

2. Barriers to implementing successful models or innovations

Deans of both MD- and DO-granting medical schools report increased difficulties in recruiting, developing and retaining clinical training sites and clinical faculty. The challenge is greater for COMs because education often occurs at sites that are more rural, remote or difficult to access. The role of the distributed model means faculty are maintaining their medical practice and caring for patients while teaching and sometimes engaging in research. Although these sites offer benefits of exposing students to the unique needs of a wider range of populations, faculty lack financial support compared to academic health centers where they can be supplemented through Medicare funding.

Financial support for faculty is critical. Research on the motivations of clinical preceptors who teach medical students cite internal motivation as the driving force over external motivators (like increased pay, benefits or honors and other supports). However, practical supports for clinician-educators are important. Teaching students impacts a practicing physician's productivity so developing and maintaining these motivators in a busy practice is daunting. This has led to a clinical rotation "arms race" of ever-increasing costs for both recruitment and compensation of teaching physicians. In fact, the Advisory Committee on Interdisciplinary, Community-Based Linkages recommended a National Center of the Health Resources and Services Administration to support site development with a focus on preceptor recruitment and support.

Finally, too many federally funded residency programs exclude DOs or impose costly and unnecessary requirements. Nine percent of residency program directors reported that they never interview DO seniors and an additional 27 percent said they seldom do. In addition, 32 percent of residencies, more than 1,700 programs, only accept the United States Medical Licensing Examination (USMLE), the MD licensing exam. DO students incur significant financial costs (more than $6 million a year), as well as the commitment of time and emotional energy, to take an exam that is not designed for the osteopathic profession or needed for licensure or practice. These restrictive practices frustrate DO delivery of primary care services and pose a significant threat to the agency's goal of achieving high-quality, affordable, person-centered care.

3. Successful strategies to engage communities

The OME community is committed to educating and training more osteopathic physicians who embody the fabric of our nation, not only to address disparities in healthcare, but also to improve the health of all people.

- The Oklahoma State University (OSU) Center for Health Sciences and the Cherokee Nation (CN) established the *OSU Center for Health Sciences College of Osteopathic Medicine at the CN* in 2020. Located in Tahlequah, the CN campus is the nation's only tribally affiliated COM. OSU-COM CN is dedicated to educating primary care physicians who have an interest in serving rural and Native American populations in Oklahoma, which ranks 46th in the nation in the number of primary care doctors per capita.

  The CN campus matriculates approximately 50 students each year. Nationally, only 0.2 percent of medical school students are Native American. The inaugural Class of 2024 at the CN campus is 22.5 percent American Indian/Alaskan Native (AI/AN) and 31.5 percent underrepresented minorities in medicine. A majority of students (90.7 percent) are from Oklahoma, 38.8 percent are from rural communities and 50 percent are female. For the Class of 2025, 24.5 percent of students are AI/AN, 32.1 percent are underrepresented minorities in medicine, 90.6 percent are from Oklahoma, 45.8 percent are from rural communities and 56.6 percent are female.

  Students may pursue a *Tribal Medical Track (TMT)* that stresses the unique nature and characteristics of practicing within a tribal healthcare system or Indian Health Services facility. A key facet of the TMT is clinical training and experience in a variety of tribal healthcare systems. OSU-COM has active clinical partnerships with the CN, Choctaw Nation, Chickasaw Nation, Indian Health Services and other federally recognized tribes in Oklahoma, increasing the likelihood that students will practice in these communities.

- The *A.T. Still University-School of Osteopathic Medicine in Arizona (ATSU-SOMA)* has partnered with the Wright Center for Graduate Medical Education to create a community-based Teaching Health Center GME program within their Community Health Center (CHC). ATSU-SOMA partners with sites to establish the National Family Medicine Residency program, a network of 4 CHCs—El Rio Health in Arizona, HealthSource of Ohio, HealthPoint in Washington and Unity Health Care in Washington, D.C.—in a nationally distributed Accreditation Council for Graduate Medical Education accredited residency program. This very successful partnership has created primary-care focused residency programs that provide training for both medical students and residents interested in providing primary care to rural and underserved communities while embedding future physicians in those communities. The Wright Center is a model for community-based residency training in primary care.

- The *Transformative Care Continuum (TCC)* is a partnership between the Ohio University Heritage College of Osteopathic Medicine (OU-HCOM) and the Cleveland Clinic to educate and train family medicine physicians with an emphasis on community health. TCC selects eight students each year and supports them

to finish their undergraduate and graduate medical education in six years. Instead of relying on board scores and class rank, TCC uses an innovative recruitment process and creates unique, behaviorally based questions and incorporated situational judgment testing into the interview process. TCC students spend the first three years with one half-day per week at residency sites, serving in a variety of capacities including medical scribe, medical assistant and patient educator. Students spend another half-day per week with a healthcare manager examining and designing population health and quality improvement initiatives to improve primary care delivery at the Cleveland Clinic. TCC students and residents are taught osteopathic manipulative treatment (OMT) to support the continued response to the opioid epidemic. The program's first cohort of students started in August 2018 and are scheduled to complete residency in 2024. TCC is part of the American Medical Association's Accelerating Change in Medical Education initiative.

Also, the *Rural and Urban Scholars Pathways (RUSP) Program* at OU-HCOM prepares medical students to practice in urban and rural underserved areas. Since 2013, 155 students have graduated; 67 percent chose primary care residencies; 66 percent entered residency in OH; and 47 percent entered primary care residencies in OH. In 2021-22, RUSP students represented 13.2 percent of the student body at OU-HCOM.

4. Proposed HHS actions

As HHS implements this important initiative, AACOM encourages continuous input and representation from the OME community. AACOM urges HHS to:

- **Include DOs and OME experts on committees, workgroups and task forces associated with this initiative** to reflect the 80 percent of care delivered in community settings and ensure the osteopathic model of training primary care physicians is incorporated into all policies and programs.
- Increase funding and establish programs that **support and expand clinical rotations and residency training for medical students in community-based settings, such as rural health clinics, federal qualified health centers, rural emergency hospitals and other rural hospitals/healthcare facilities**. Programs should facilitate streamlined program requirements that impose minimal administrative and regulatory burdens and provide maximum flexibility for participation.
- **Expand Medicare-funded GME slots** and **lift the statutory cap** to ensure the stability and continuity of medical residency programs.
- **Direct all Medicare-funded residency programs to accept osteopathic medical school applicants and prohibit criteria that impose unnecessary burdens on them**, such as requiring the USMLE.
- Support **evidence-based research for integrative health approaches and recognize the important role of OMT** in addressing pain management, musculoskeletal conditions and many other disorders. AACOM encourages the HHS to partner with the osteopathic community as it seeks to develop non-pharmacological and non-invasive treatments for addiction and other chronic medical conditions.
- Provide **financial support to volunteer or uncompensated preceptors** to help increase the ability of primary care physicians to provide appropriate, quality ambulatory experiences, especially in rural areas.

Thank you for the opportunity to share our views. For further information, please contact David Bergman, JD, Vice President of Government Relations, at dbergman@aacom.org.

Sincerely,

Robert A. Cain, DO, FACOI, FAODME
President and CEO