A NEW OSTEOPATHIC PARADIGM

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For more than a century, the leadership of the American Osteopathic Association (AOA) utilized the profession's minority status to unite DOs against widespread discrimination. By necessity, the profession developed a "separate but equal" healthcare system of colleges, hospitals and osteopathic medical practices to preserve its distinctiveness and gain acceptance in the American health care delivery system. The 2014 AOA Memorandum of Agreement with the Accreditation Council for Graduate Medical Education (ACGME) – which created a unified accreditation system for MD and DO graduate medical education (GME) under ACGME's umbrella – has paved a pathway to a bright future *if* all osteopathic stakeholders embrace change, pull together for a common vision and recommit to the original tenets of osteopathic medicine. To achieve success, the osteopathic profession must fully integrate and institutionalize its heritage and distinctive practices throughout the entire continuum of medical education, physician practice, health care delivery, and health policy formation. As the profession continues a new phase of "assimilation" into mainstream medicine, it must adapt its governance structure and develop a comprehensive new paradigm to build a partnership with the MD community and achieve "intercultural competence" in the healthcare system of tomorrow.

Intercultural Competence Versus Total Assimilation

Lumen's *Introduction to Sociology* defines assimilation as "the process by which a minority integrates socially, culturally, and/or politically into a larger, dominant culture and society. Assimilation usually involves a gradual change of varying degrees. Full assimilation occurs when new members of a society become indistinguishable from native members." [1] **Osteopathic leadership must effectively navigate change and adapt to a new integrated paradigm with the MD community but ensure that total assimilation never occurs. The profession must seek "intercultural competence' as the foundation for future growth instead**. Mitchell R. Hammer, PhD -- in *The Intercultural Development Inventory* -- defines intercultural competence as "the capability to shift perspective and adapt behavior to cultural difference and commonality. Intercultural competence reflects the degree to which cultural differences and commonalities in values, expectations, beliefs, and practices are effectively bridged, an inclusive environment is achieved, and specific differences that exist in your organization or institution are addressed from a "mutual adaptation."[2] **The osteopathic profession can effectively adapt and integrate with "mainstream medicine" by continuing to think like a minority culture and rededicating itself to preserving and injecting the tenets of osteopathic practice and principles at all levels of pre- and post-doctoral education, health care delivery and health policy development.**

A New Unified Umbrella Governance Structure for the Osteopathic Profession

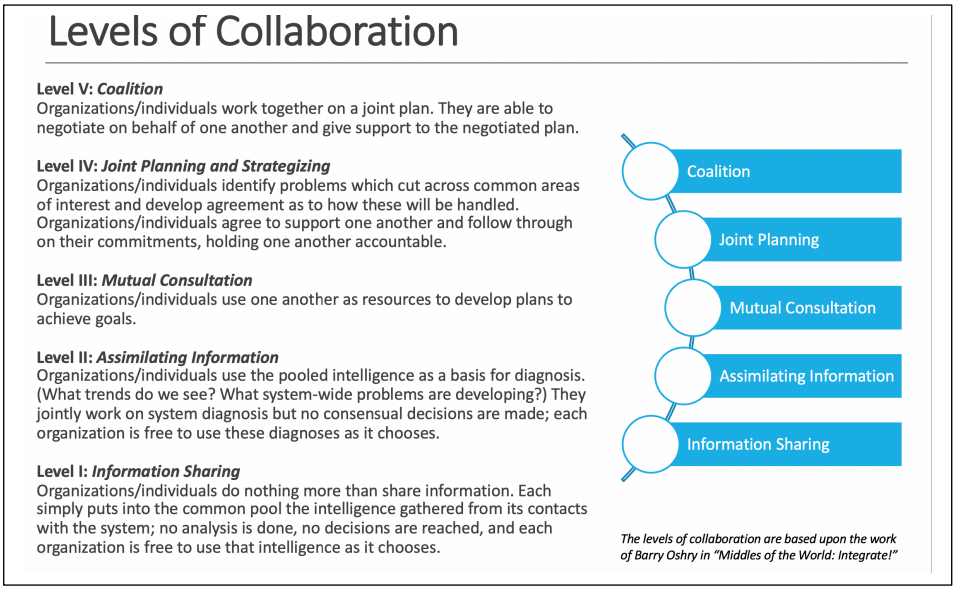
In January 2016, the Ohio Osteopathic Association (OOA), in cooperation with the Osteopathic Heritage Foundations, Ohio University Heritage College of Osteopathic Medicine, and Centers for Osteopathic Research and Education, launched a major planning initiative to set the future direction for the OOA and for osteopathic medicine in Ohio. The planning effort was facilitated by Josh Mintz, of Cavanaugh Hagan Pierson & Mintz, the consulting firm which has been used by many national osteopathic and health related associations to assist in strategic planning processes. The OOA initiative consisted of a four-step process that included (1) "thought leader" interviews, (2) a profession-wide survey, (3) focus groups; and culminated with (4) an in-person strategic summit with leaders from the four sponsoring organizations. The Summit resulted in a strategic vision for osteopathic medicine in Ohio. Major components of that vision are applicable to the national profession as well.

The future of osteopathic medicine is dependent on a new national governance model. Existing organizations within the osteopathic profession must develop a unified umbrella organization with appropriate component

representation to preserve osteopathic cultural differences. The new osteopathic umbrella organization or alliance must address the future of osteopathic medicine in the new osteopathic paradigm from a totally unified and holistic perspective. This new governing structure of educators, thought leaders and practicing physicians should include proportional representation from the American Osteopathic Association, the American Association of Colleges of Osteopathic Medicine, the American Osteopathic Foundation, Osteopathic Specialty Colleges, the National Board of Osteopathic Medical Examiners, the Association of Osteopathic State Executive Directors, and others. Staff representatives from the various stakeholder organizations must also be involved in the new structure. The umbrella organization must develop the highest level of collaboration possible among existing osteopathic organizations with the following goals:

1. To advocate on behalf of the osteopathic profession to create the enabling environment to improve the health of all Americans and achieve the quadruple aim (better outcomes, lower cost, improved patient experience and improved physician experience and well-being).
2. To serve as the unifying platform for osteopathic medicine in the world, supporting cross-system connections and learning, linking policy, practice and education, and promoting osteopathic identity.
3. To provide high quality predoctoral, postdoctoral and continuing medical education programs that support physicians in achieving the quadruple aim.

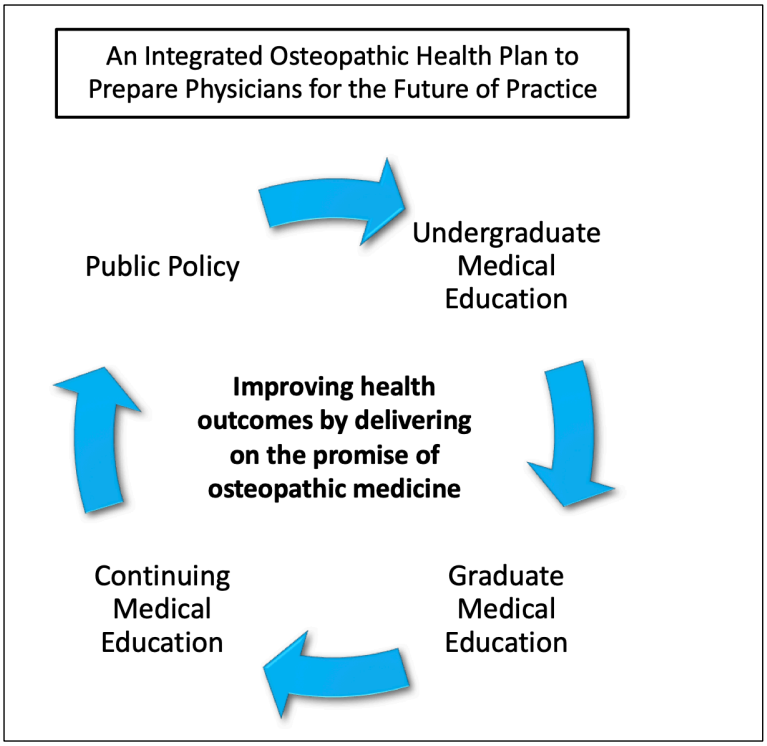
The diagram below shows the various levels of collaboration based on the work of Barry Oshry in *Middles of the World: Integrate.*[3]



Historically, osteopathic organizations have functioned at Level II or Level III on the Collaboration Scale. In the new osteopathic paradigm, all osteopathic organizations and institutions must commit to work together at Level V and practice "holistic leadership," placing the needs of the entire profession over individual stakeholder organizational interests. All osteopathic organizations must understand their constituencies are mutually dependent on each other and need a collective vision for future success based on mutual trust and delegation of tasks. Once a collective vision is developed, all stakeholders must work to accept the unique role each plays in attaining that vision. Each organization must define the primary duties it performs, agree to shift some primary responsibilities to partner organizations, develop a culture of mutual trust, and endorse a shared governance model and agree to aggressively implement delegated responsibilities while they support the actions that are assigned to others. Public Policy, Undergraduate Medical Education, Graduate Medical Education, Continuing Medical Education and Medical Practice and Policy Formation are interconnected as a continuum. All osteopathic organizations have a stake in each area, but each organization should have primary responsibility for specific areas. A Level V Collaborative Leadership Structure will promote osteopathic intercultural competency as the profession integrates fully into the American healthcare system.

A Continuum of Osteopathic Education, Clinical Practice and Health Policy Development

Bridges must be built with allopathic institutions to provide Osteopathic Practice and Principles elective courses for MD students during clerkship rotations and residency training. Osteopathic education at all levels of the continuum must instill pride in the profession's heritage and encourage individual DOs to conduct osteopathic research and scholarly work in their practices. The following diagram illustrates the interconnectivity of osteopathic education (pre and postdoctoral), osteopathic practice, and the formation of health policy to meet societal needs.



The Tenets of Osteopathic Medicine, as adopted by the AOA House of Delegates, express the underlying philosophy of osteopathic medicine and include: (1)The body is a unit; the person is a unit of body, mind, and spirit; (2) The body is capable of self-regulation, self-healing, and health maintenance; (3) Structure and function are reciprocally interrelated; and (4) Rational treatment is based upon an understanding of the basic principles of body unity, self-regulation, and the interrelationship of structure and function. In addition to stressing osteopathic tenets, the profession must develop physician leaders who perfect and provide primary care, holistic patient-centered care, and wellness care. These four areas should be stressed by the profession throughout the continuum of predoctoral and postdoctoral osteopathic medical education, medical practice, continuing education and public health policy development.

Focus on Osteopathic Tenets. *To find health should be the object of the doctor. Anyone can find disease." – A.T. Still MD, DO.* Osteopathic tenets clearly place DOs at the forefront of transforming the American health care system from a "sick care" model to a "well-care" model. The profession must continue to train physicians to partner with their patients to maintain health through proper nutrition and lifestyle changes. In order to do so, the profession must develop an integrated continuum of promoting osteopathic tenants and wellness care in practice settings as well as educational institutions.

Primary Care Focus. The Institute of Medicine, in 1996, defined primary care as "the provision of integrated accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."[4] Osteopathic colleges must become the dominant institutions for training primary care

physicians *and* specialists who "think like primary care physicians" as they diagnose, treat, and communicate with patients. Bridges must be built with allopathic institutions to provide OPP elective courses for MD students who train with DOs and become interested in pursuing osteopathic recognition during residencies.

Patient Communication and Cultural Competency. The profession must develop innovative, osteopathic-branded patient education tools and apps that emphasize the patient's role in maintaining health. These tools must be given to patients as part of the routine office visit. Personal responsibility and lifestyle changes should be emphasized before chronic diseases begin to develop. The profession must strive to reclaim preeminence as the profession that provides holistic and patient-centered office experiences with emphatic listening and effective interpersonal communication skills. Osteopathic education must also train DO students throughout pre- and post-doctoral education to be physician leaders, who are culturally competent and participate as health care advocates in schools, communities, health care organizations, advocacy groups and on health policy boards and commissions. Rotations should include leadership experiences.

Physician Educators and Researchers. Osteopathic colleges must continue to strengthen the DO's commitment to giving back to the profession by training osteopathic students to be life-long physician educators. Practicing DOs must embrace osteopathic-focused research and scholarly work while they mentor students and residents in their practices. DOs in active practice must be given a dominant role in shaping and revising medical school curriculums, serving as mentors, and precepting students and residents. In short, DOs must be trained and credentialed with appropriate skills to serve as role models for future generations of DOs. This credentialing should ideally occur *before* they graduate from medical school.

Osteopathic Manipulative Medicine. To continue to reduce reliance on opioids for pain management, the osteopathic profession must promote Osteopathic Manipulative Treatment as a procedure that is clearly defined in ICD diagnosis and CPT procedural codes. The codes should be designed to be used by all DOs and MDs who achieve osteopathic recognition. For decades, Osteopathic Manipulative Treatment (OMT) was promoted as the cornerstone of osteopathic medicine and an integral part of every DO's practice. The reality today: it is not. Currently, many MDs are looking for training in osteopathic manipulative treatment and have embraced integrative, holistic medical practice – an area once used to explain the difference between DOs and MDs. Osteopathic medical education must go back to the basics and strengthen and promote courses that can also be used to instruct MDs in osteopathic practice and principles and OMT; at the same time, osteopathic organizations must welcome "osteopathically trained MDs" with unrestricted membership to avoid discriminatory policies like DOs experienced from MD organizations in the past. Somatic disfunction diagnosis and manipulation codes must be redesigned with the help of the reimbursement community to be used without a modifier to ensure claims data can be extrapolated for future research to validate the impact of manipulation and ensure proper reimbursement is received when utilized in physician practices.

Educating the Health Care Team. Policymakers and educators have been shifting more and more primary care modalities to physicians' assistants, nurse practitioners, and clinical pharmacists. The profession should aggressively train allied health professionals in osteopathic practice and principles and actively supervise or collaborate with these professionals as a part of a distinctive "osteopathic team." The profession should also provide osteopathic recognition mechanisms in pertinent allied health professions and develop certification programs for allied health care professionals that include OPP in their curriculums.

Physician Placement in Health Profession Shortage Areas (HPSAs). The allopathic profession has traditionally viewed urban Academic Teaching Centers as meccas for graduate medical education. The osteopathic profession has relied on community hospital settings. The profession must continue to educate ACGME about the potential of Osteopathic Postdoctoral Training Institution concept to expand the number of residency programs in rural areas to improve access to care in areas of greatest need.

Diversity and Cultural Competency. To address systemic racism in America, the profession must aggressively recruit students from different minorities and economic backgrounds. Clinical rotations should

be designed to develop cultural competency and address population health. Cultural competency proficiency measures should be incorporated into postdoctoral training programs and licensing exams.

A Question of Osteopathic Identity

The most significant challenge for the profession is inculcating and strengthening osteopathic self-identify. Findings from OOA's education and student focus groups --identified in *Results of the 2016 OOA Focus Groups Report* – are particularly insightful and are included here to help provide answers. Ohio focus group participants identified three distinctive levels of osteopathic identity within the profession: (1) DOs who view themselves as osteopathic physicians; (2) DOs who practice osteopathically; and (3) DOs who only view themselves as physicians. As one participant in the GME focus group said: "Being an osteopathic physician used to be a *group* identity. Historically, DOs trained within the osteopathic community, practiced in osteopathic hospitals and referred to other osteopathic physicians. Today, having won the battles for professional equality, being an osteopathic physician is more of an *individual* sense of identification. DOs are now osteopathic by choice, not by requirement." This presents both opportunities and challenges to the profession as it implements strategies for the future.

Student participants in the Ohio focus groups noted there is a split within their classmates between those who "identify osteopathically" and those who don't beginning the very first day of medical school. This split seems to grow over time for a number of reasons:

- In OMS 1 there is a split between those with a strong sense of osteopathic identity and those that "just want to be physicians." This leads to some frustration with the COM about who they admitted to the class. In general, OMS 1 students are excited (and a bit anxious) about their new professional journey. They are looking to understand what "a day-in-the-life" of a DO looks like and the career options available to them. They need strong general mentorship by DOs (and MDs) who are good role models and demonstrate a clear appreciation for osteopathic practice and principles regardless of specialty.
- In OMS 2 there is a primary focus on passing national boards. Students perceive COMLEX to be more "random" and therefore difficult to study for, while USMLE is more structured and makes preparation easier. In addition, some students complained the COMLEX doesn't emphasize OMM. Given the high stress environment, this causes some resentment about students' osteopathic identity and raises questions about why such an emphasis is placed on OMM if it isn't central to either examination.
- OMS 3 students are beginning to think more specifically about career options and are entering into their clerkships. They are looking for high quality clerkship opportunities with DOs who practice osteopathically (e.g., are good role models with strong focus on OPP, providing some exposure to OMT in practice regardless of specialty). OMS 3 students occasionally experience clerkships with DOs who don't practice osteopathically and don't serve as good role models in general. One student observed that one of his MD preceptors, who embraces integrative medicine, practiced more osteopathically than many of the DOs providing rotations. This has led students to question the connection between what they are learning in school and the realities of practice.
- In OMS 4, students are focused on their residencies. Students start splitting into specialty interest groups and the sense of connection with the larger osteopathic community is reduced. They are looking for help navigating the residency selection process (e.g., which programs are DO friendly, how to select a residency, and how to identify specialists who practice osteopathically as mentors)
- In Residency: A significant percentage of students go into allopathic residencies, limiting their connection to the osteopathic community. For those that enter OGME (now osteopathically recognized programs), OPP still matters, but GME focus group participants noted there isn't a lot of time for OMT in the hospital setting. If physicians in the hospital are not utilizing OMT, their residents won't either.
- DOs in Practice: Participants in OOA Board and GME focus groups noted that for many years, DOs wanted to be "the same" as MDs. Now, for all practical reasons, they are. The new challenge is to show how DOs are "different. If DOs aren't different, there may not be a need for separate osteopathic associations. OPP and OMT are seen as the two key differentiators.

Participants noted that all physicians who practice osteopathically embrace OPP; however, changes in osteopathic diagnosis and treatment codes should be explored to eliminate the use of modifiers and more precisely define how manipulation is being used as a procedure in conjunction with general medical diagnosis codes and diagnosis for somatic dysfunction. The new osteopathic paradigm should coordinate research to demonstrate the value of OPP in terms of health outcomes and increased patient satisfaction, which are important metrics in today's value-based care system. All osteopathic stakeholders can play a critical role in engaging the practice community in data collection efforts and research studies which investigate the impact of OPP on health outcomes.

Participants also suggested that there may be opportunities to increase utilization of OMT among the practice community. Osteopathic CME providers should offer highly practical introductory and refresher courses on OMT *linked to specific situations* (i.e., the impact of OMT on specific disease, the use of OMT for pain treatment in lieu of a prescription for pain killers; the use of manipulative medicine as part of differential diagnosis). These courses should be highly practical, demonstrate how to use the technique easily in a physician's practice, the impact on health, *and how to bill for it*. With the increase in interprofessional practice and collaborative care, participants also suggested that osteopathic CME providers should consider offering an "Introduction to Osteopathic Medicine" for MDs and other healthcare providers who work in osteopathic practices.

The Future of Osteopathic Medicine

In conclusion, many components of a separate but equal osteopathic education and health care delivery system remain. The road to assimilation with allopathic medical practice began long before the ACGME memorandum of agreement was signed. Dramatic disruption in hospital systems and health care financing necessitated changes in osteopathic education and graduate medical education due to costs associated with maintaining a separate but equal model of health care delivery. The profession must return to the basics and embrace the tenets of osteopathic medicine to avoid becoming indistinguishable. The distinctive DO degree is central to maintaining osteopathic identity, but other remaining components of the old osteopathic paradigm are not. A new osteopathic collaborative governance board must develop a new osteopathic paradigm to achieve mutual adaptation in a unified health care system. The profession must act decisively using a high-level collaborative leadership governance structure to make difficult and potentially controversial decisions in order to work with the MD community to achieve "intercultural competence' in the unified health delivery system of the future.

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[1] Lumen's *Introduction to Sociology* *https://courses.lumenlearning.com/cochise-sociology-os/chapter/assimilation/*

[2] *The Intercultural Development Inventory,* Mitchell R. Hammer, PhD , http://idiinventory.com/

[3] *Report from the May 12-13, 2016 Ohio Osteopathic Association Strategy Summit*, prepared by Cavanaugh Hagan Pierson & Mintz, May 2016 http://www.ooanet.org/aws/OOSA/pt/sd/news_article/130735/_self/layout_details/false

[4] *White Paper: Redefining Primary Care for the 21st Century*, Agency for Healthcare Research and Quality https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/primary-care/workforce-financing/white_paper.pdf