AACOM

American Association of Colleges of Osteopathic Medicine

AiAMC

Alliance of Independent Academic Medical Centers

Evolving Landscape of Medical Education: Where do IAMCs and Community-Based Teaching Hospitals Fit in this Ever-Changing Space?

Webinar | June 13, 2023

Welcome

Kimberly Pierce Burke
Executive Director

Alegneta Long
Vice President, Graduate
Medical Education Initiatives

Introductions and Agenda Review

Today's Objectives

- Inform and discuss national trends and their relevance to IAMCs and community-based teaching hospitals.
- Equip you with the tools to articulate the value of community-based education.
- Identify opportunities for collaborative work to expand and enhance community-based education.

Agenda

Welcome and Opening Remarks
Kimberly Pierce Burke, Executive Director, AIAMC
Alegneta Long, Vice President, GME Initiatives, AACOM

Overview of Agenda and Format

Setting the Stage – Community-Based Medical Education
Leah Gassett, Partner & Academic Health Lead, ECG Management Consultants

What is Community-Based Education?
Large Group Discussion

Shared Experiences and New Opportunities
Breakout Group Exercise

Elevator Pitch – The Value Proposition of Community-Based Education
Large Group Exercise:

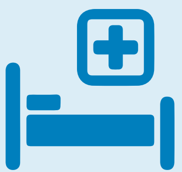
Closing Remarks
Alegneta Long, Vice President, GME Initiatives, AACOM
Kimberly Pierce Burke, Executive Director, AIAMC

Setting the Stage – Community-Based Medical Education

Community Hospitals Play a Critical Role in Care and Training

N = 4,525 Hospitals from the HCRIS data set 2022

Small hospitals (<250 beds) make up 82% of US hospitals and account for…



239,595 beds (~39%)

$417 B Net Pt Revenues (~37%)

15,343 Residents (~14%)

Large hospitals (250+ beds) make up 18% of US hospitals and account for…

376,417 beds (~61%)

$704 B Net Pt Revenues (~63%)

97,993 Residents (~86%)

75% of hospitals do not teach (3,383).

25% of hospitals are teaching (1,142).

Measured by resident to bed ratio.

34% Major (0.25+)

14% Moderate (0.16 to 0.24)

10% Minor (0.11 to 0.15)

42% Any (0.01 to 0.10)

Source: Health Financial Systems, HCRIS. (FY 2022)

National Medical School Growth

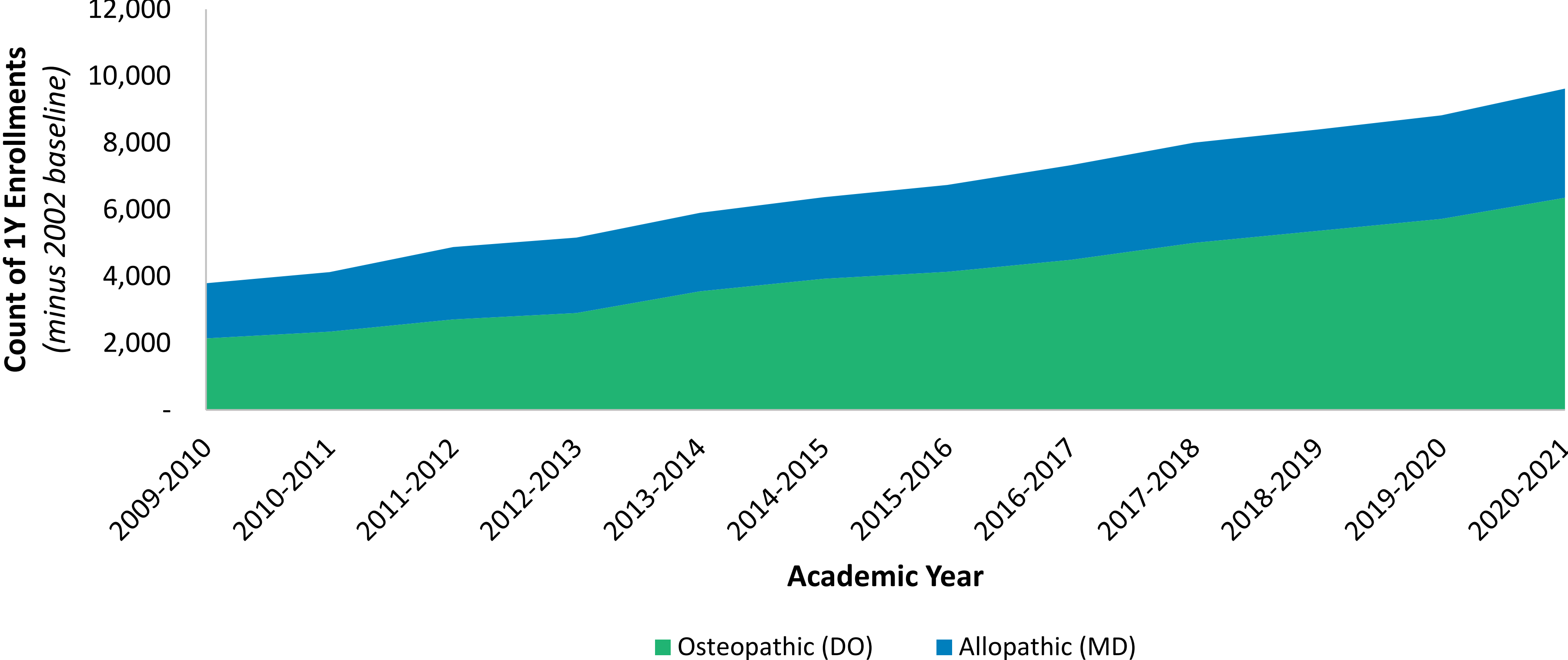
New MD-/DO-Granting Schools, 2010 to 2022

WSU Floyd
Idaho College of Osteopathic Medicine
California Northstate University
Roseman University COM
Noorda COM
University of Nevada, Las Vegas
CHSU–COM
California University of Science and Medicine
Charles R. Drew Univ. of Medicine and Science COM
UC Riverside
Kaiser Permanente SOM
Arizona–Phoenix
Burrell College of Osteopathic Medicine
Kansas College of Osteopathic Medicine
Kansas Health Science Center
AR College of Osteopathic Medicine
TCU–UNTHSC
Dell Medical School at UT Austin
Incarnate Word
SHSU COM
UT–Rio Grande Valley
University of Houston
UT at Tyler
Belmont University COM
Alice L. Walton SOM
Carle–Illinois
VCOM–Louisiana
William Carey University
VCOM–Carolinas
AL College of Osteopathic Medicine
VCOM-Auburn
Orlando COM
Western Michigan
Central Michigan
Oakland–Beaumont
Marian University
Duquesne University COM
Liberty University
NYU–Long Island
CUNY
Hofstra Northwell
Quinnipiac Netter
Hackensack
Cooper Rowan
College of Henricopolis
Campbell Wallace
Methodist Univ SOM Cape Fear
South Carolina Greenville
Florida Atlantic Schmidt
Nova Southeastern
Univ US Virgin Islands SOM

- Fully Accredited
- Provisionally Accredited/Preaccredited
- Preliminarily Accredited
- Applicant or Candidate School

Sources: COCA, February 2023.
LCME Medical School Directory, February 2023.

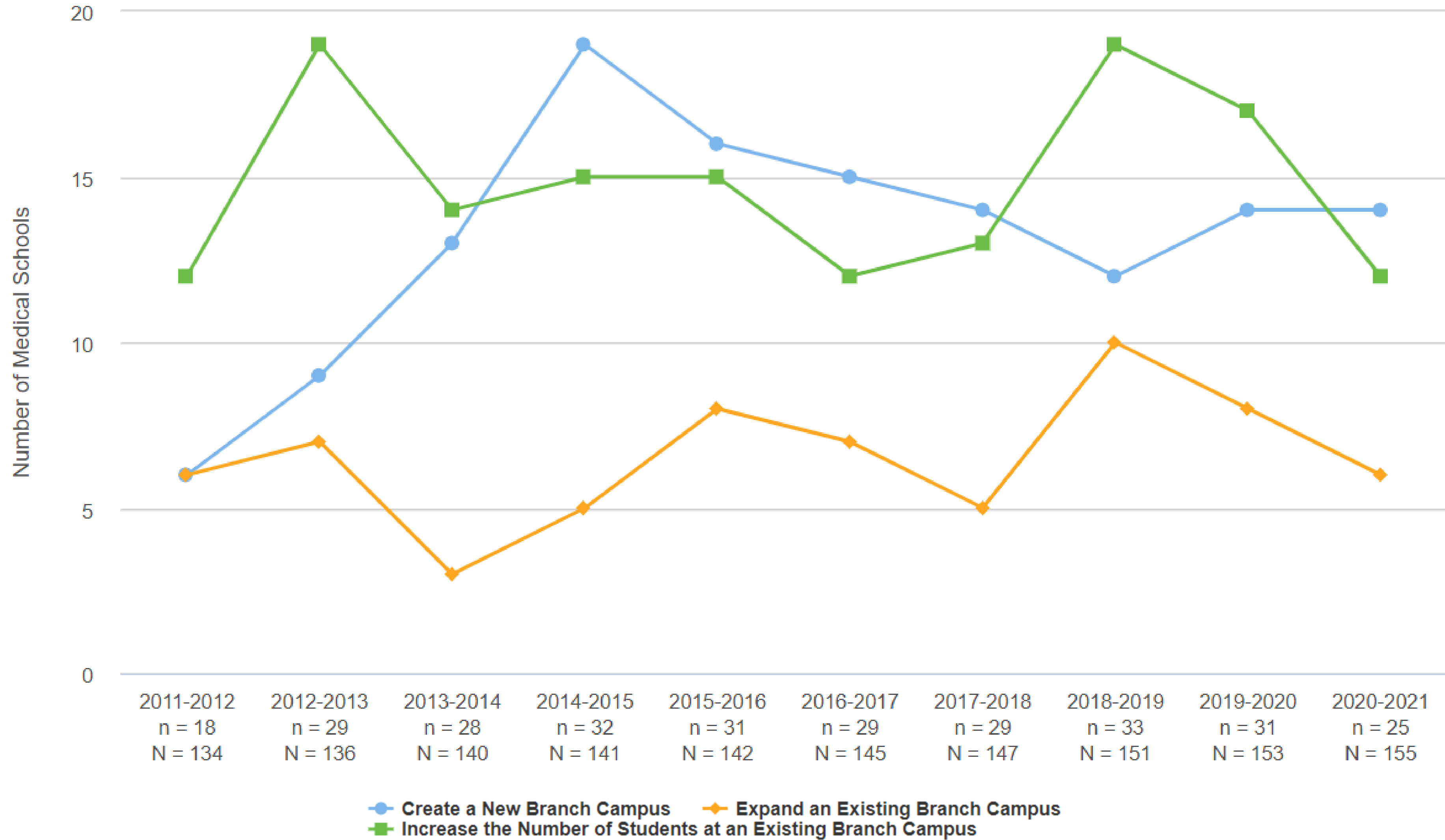
Leading to Significant Increases in Enrollment…



First-year enrollments have grown more than 1.5 times across both DO and MD programs since academic year 2010.

Sources: Commission on Osteopathic College Accreditation (COCA), February 2022.
Liaison Committee on Medical Education (LCME) Medical School Directory, February 2022.

Expansion through Branch Campuses Is Expected to Continue

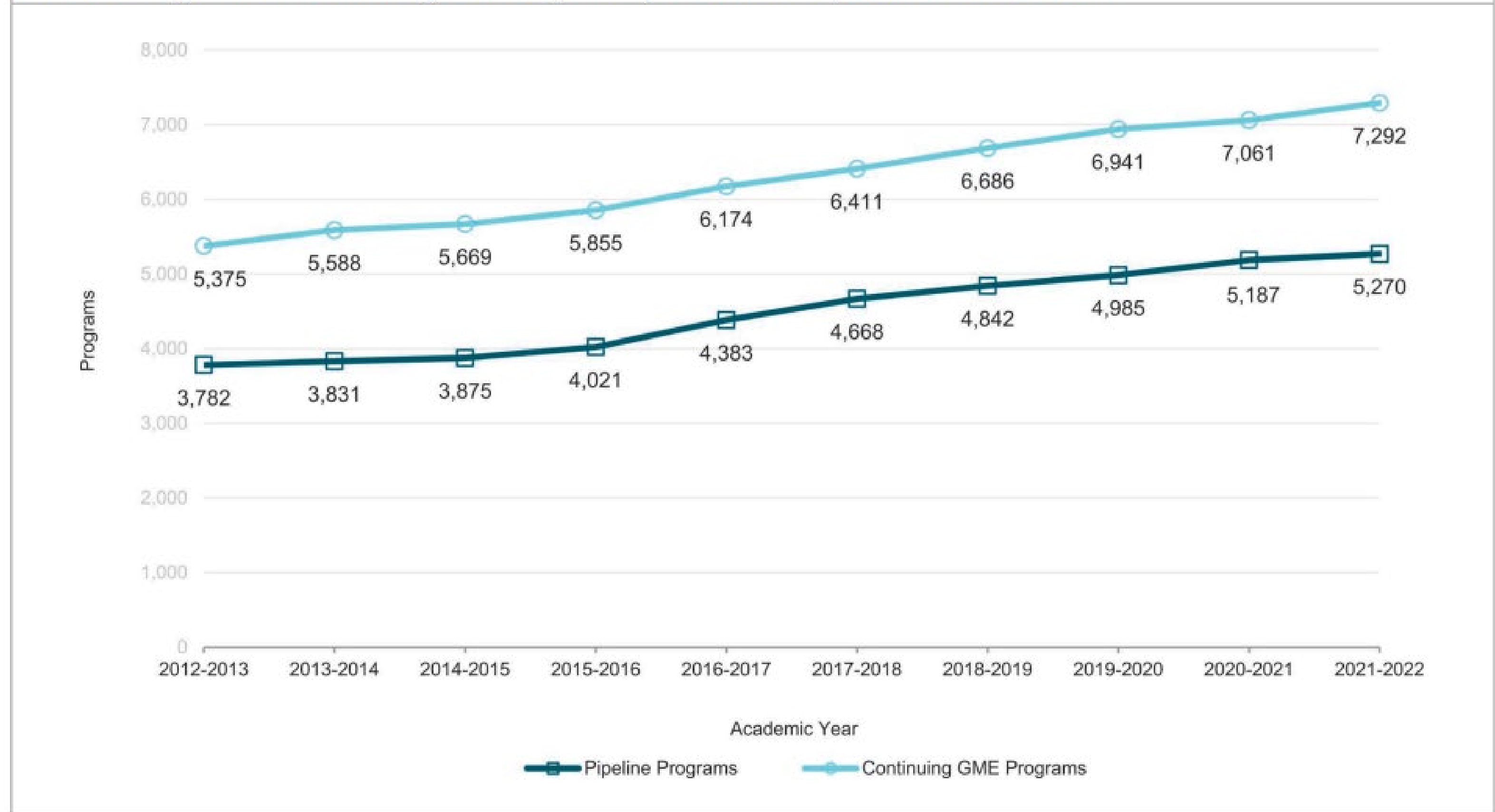


Note: n indicates the total number of medical schools that responded to the question. N indicates the total number of schools that participated in the survey.
Source: LCME Annual Medical School Questionnaire Part II, 2011–2012 through 2020–2021.

Steady Growth in Pipeline and Continuing GME Programs

2021 Match offered 35,194 PGY1 positions

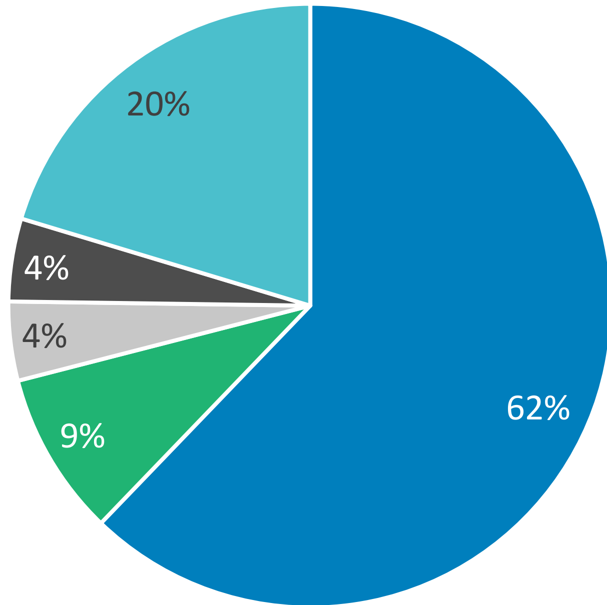
29,967 US MD and DO seniors were seeking PGY1 positions



Source: ACGME Data Resource Book Academic Year 2021-2022
Source: Salsberg, Chen; Graduate Medical Education Positions And Physician Supply Continue to Increase: Implication Of The 2021 Residency Match; Health Affairs; May 21, 2021

Sources of Revenue for U.S. Medical Schools

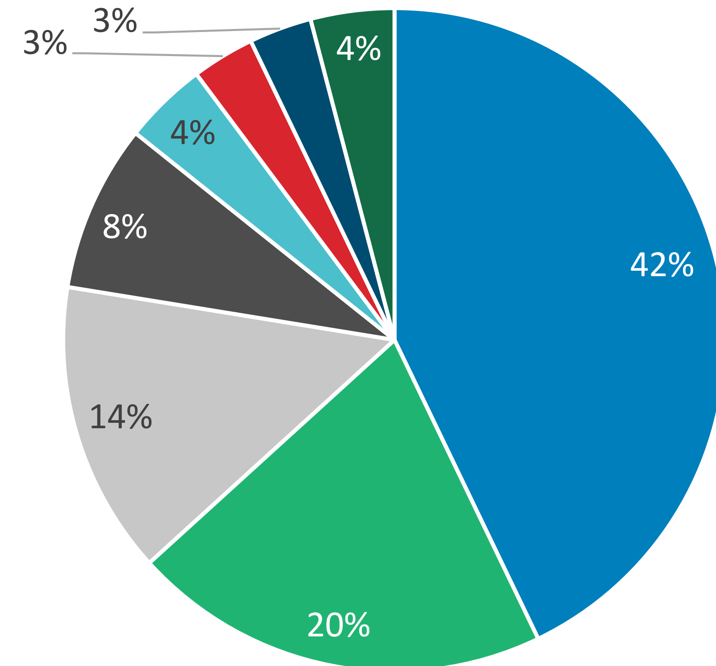
Osteopathic Medical School Revenue Sources, FY20



Tuition and Fees
Government Appropriations
Grants and Contracts
Medical Practice Plans
Other

Source: https://archive.aacom.org/reports-programs-initiatives/aacom-reports/revenues-and-expenditures

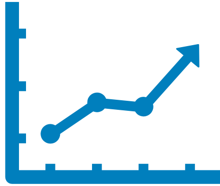
Allopathic Medical School Revenue Sources, FY21



Practice Plan
Hospital
Federal Grants and Contracts
Other Grants and Contracts
Government and Parent Support
Gifts and Endowment
Tuition and fees
Miscellaneous

Source: https://www.aamc.org/data-reports/data/i-revenue-us-medical-schools-source-fiscal-year-2021

Market consolidation to continue



Healthcare M&A activity in 2022 hit an all-time high of 2,395 transactions, an 8% increase from 2021.

Consolidation continues, with 67% of hospitals being part of a healthcare system, a 10% increase from five years prior.

The number of smaller health systems that consolidated into larger health systems nearly doubled between 2020 and 2021.

What we have seen → **What we are seeing more of**

- Vertical integration (physicians affiliated with hospitals)
- Increased geographic footprint, including across state lines
- Horizontal integration (hospitals into health systems)
- Defensive acquisition strategy
- Strategic partnerships
- Increased financial pressures
- Market differentiation
- Transforming care delivery
- Expanding into new models of care

Sources: Record-Breaking Health Care M&A Activity Recorded in 2022, According to Acquisition Data from LevinPro HC, Levin Associates; American Hospital Association (AHA) Hospital Statistics, Fast Facts on US Hospitals, 2017; AHA Hospital Statistics, Fast Facts on US Hospitals, 2022; Large Hospital Mergers Signal New Phase of Healthcare Deals, *RevCycle Intelligence*.

Top Health Systems/US Hospitals (by rank) Are All Academic

1. Mayo Clinic–Rochester
2. Massachusetts General Hospital
3. Johns Hopkins Hospital
4. Cleveland Clinic
5. New York-Presbyterian Hospital–Columbia and Cornell
6. UCLA Medical Center
7. UCSF Medical Center
8. Cedars-Sinai Medical Center
9. NYU Langone Hospitals
10. Northwestern Memorial Hospital
11. University of Michigan Hospitals–Michigan Medicine
12. Stanford Health Care–Stanford Hospital
13. Brigham and Women's Hospital
14. Mount Sinai Hospital
15. UPMC Presbyterian Shadyside
16. Keck Hospital of USC
17. University of Wisconsin Hospitals

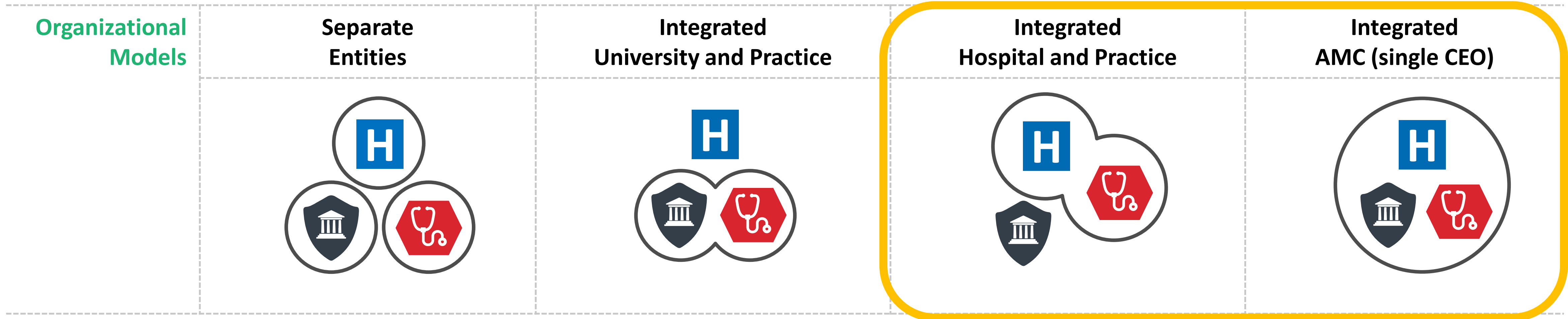
18\. (tie) Hospitals of the University of Pennsylvania–Penn Presbyterian

18\. (tie) Mayo Clinic–Phoenix

20\. (tie) Houston Methodist Hospital

20\. (tie) Yale New Haven Hospital

Existing and Emerging Academic Health Systems Are Further Integrating



Note: A fifth organizational model whereby the health system and SOM are corporately integrated and the FGP exists as a separate entity is not pictured here. ECG is aware of only one AMC with this structure.

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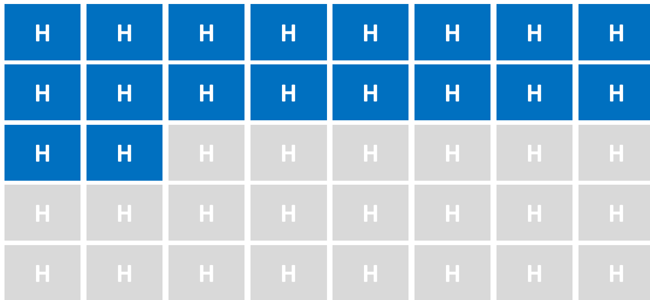
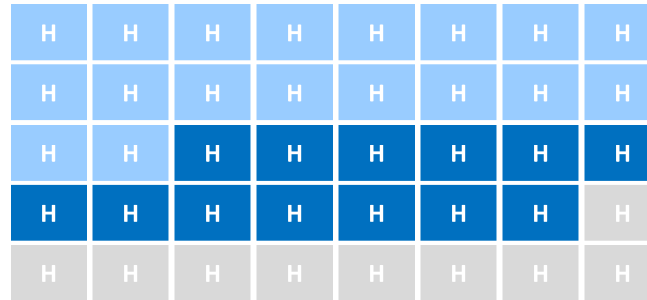
Where does “independent” fit in a market that favors consolidation, scale, and tighter integration?

The majority of top (by size) health systems have or are pursuing major academic affiliations.



Of the 40 largest health systems in the country, **18** have long-standing academic affiliations, either as part of a university system or as a principal academic partner.



In only the past decade, an additional **13** of the 40 largest systems have entered into a major academic affiliation or developed their own medical schools.

Of the 9 systems with no academic affiliation, **1** is currently on the move, and several others are pursuing GME as a workforce strategy which is commonly an entry point to becoming more academic.

H Each icon represents one of the 40 largest health systems in the United States that are currently part of an AMC or pursuing an academic affiliation.

Source: ECG analysis and classification of the top-40 US health systems by bed count and number of hospitals as defined by *Becker’s Hospital Review* in 2021, https://www.beckershospitalreview.com/100-of-the-largest-hospitals-and-health-systems-in-america-2021.html.

Market forces are driving convergence, what is the defining characteristics of these organizations? Independence?

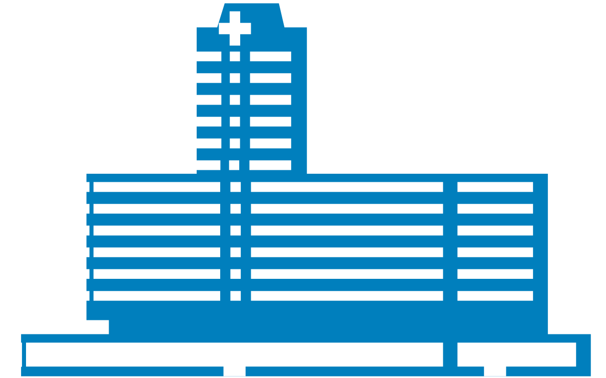
Community Health System/Independent AMC/AHS

Drivers (examples)

- Workforce development
- Innovation
- Specialization and COEs
- Market differentiations

Academic Health Systems

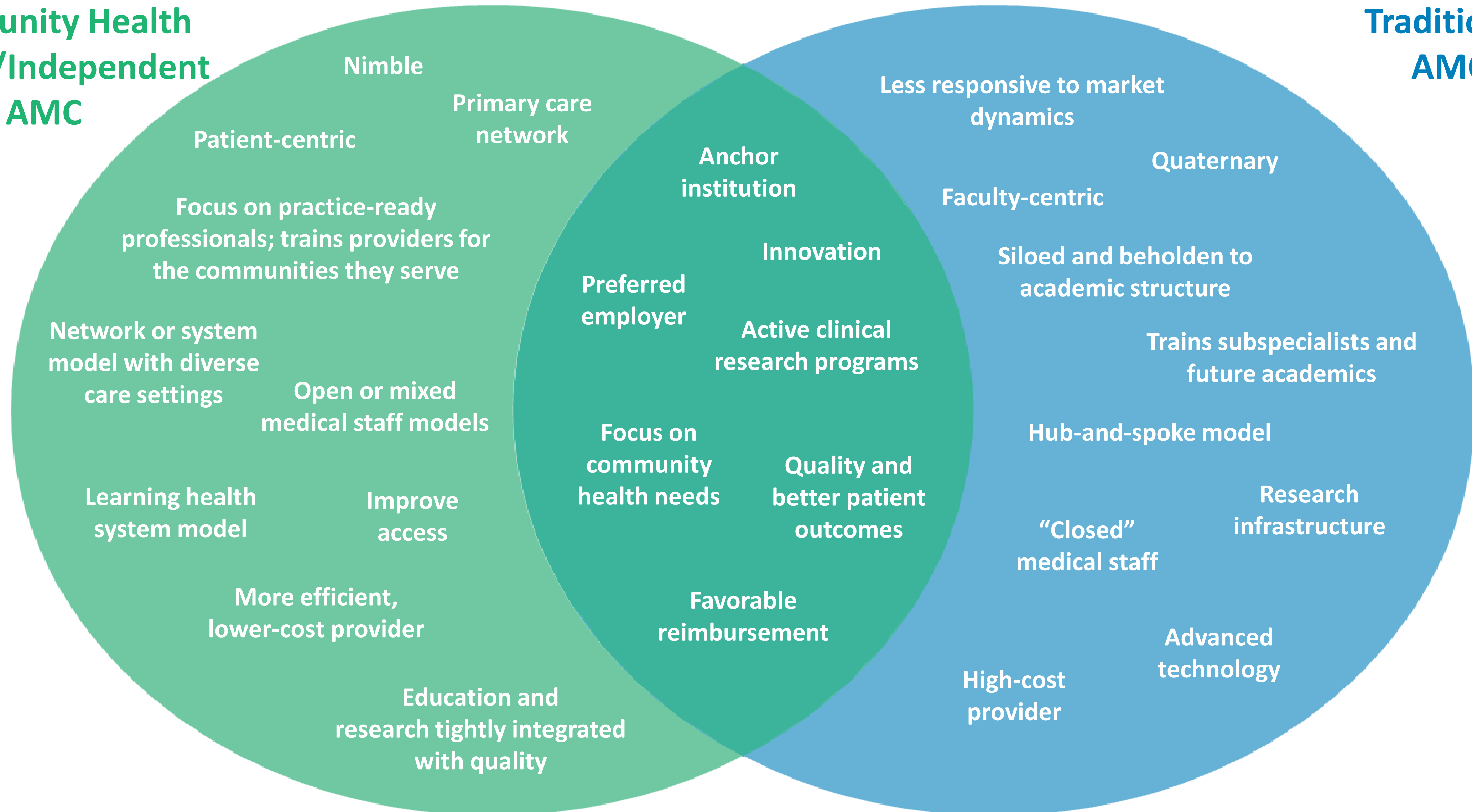
Traditional AMC/AHS



Drivers (examples)

- M&A: community hospitals
- Primary care strategy
- Demand for outpatient care
- Financial pressures

Organizational Models that Emphasize the Best of Both Will Succeed



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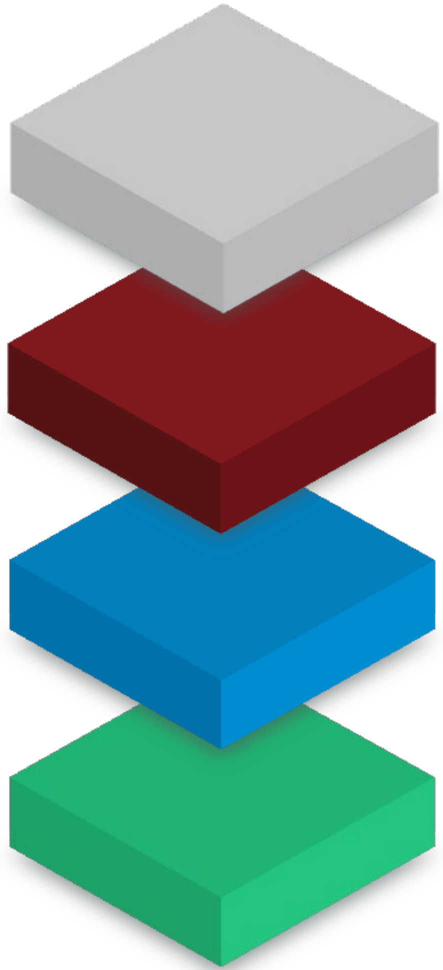
Trends



- Medical Schools are Proliferating While Health Systems Are Consolidating and Carefully Considering their Academic Investments
- Effective Affiliations are Critical for Accreditation
- Interprofessional Education and Non-Traditional Competencies
- Research and Innovation Competencies are Valuable to Clinical Delivery Partners

What is Community-Based Education?

Community-Based Medical Schools Definition

Community-Based School

There are three components of the AAMC's analytic definition of a "community-based" medical school: A community-based medical school

(1) does not have an integrated teaching hospital,

(2) received full accreditation in 1972 or later, and

(3) is non-federal.

This definition is used by the AAMC for analytic purposes; medical schools may refer to themselves as "community-based" using different definitions.

Source: https://www.aamc.org/data/ocd/field_definitions/

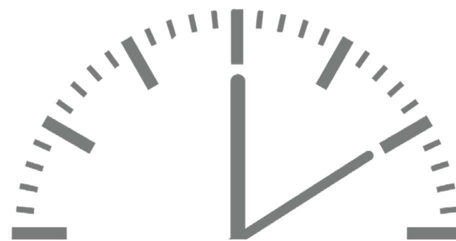
Community-Based Medical Education Definition

Breakout Activity:
Shared Experiences and New Opportunities

Breakout Activity: Shared Experiences and New Opportunities

- A **facilitator** has been assigned to each break-out room to **manage time, invite participation**, **document highlights** of the discussion and **answer questions** about the exercise.
- Nominate a reporter who will be the group's spokesperson.
- Each group has been assigned a different discussion topic/question.
- For 5 minutes consider the question on your own, quietly. Jot down your initial responses / ideas.
- For 22 minutes discuss your different perspectives, ask questions of your colleagues.
- For 3 minutes wrap up, summarize and final comments, and prepare for the report-out
- **After 30 minutes** we will take a 10-minute break and then regroup for a report-out at 2:55 p.m. ET.

30 minutes for discussion



Questions / Discussion Topics

Group 1	Reflect on your experience with community-integrated/based/anchored education • What are the greatest advantages? Can they be amplified? • What are the drawbacks and challenges? How can they be solved or mitigated?
Group 2	What are the observable differences between “traditional” medical education delivered in a community setting and educational programming that is designed to fully integrate within the community setting?
Group 3	How can partnerships and collaborations be used to improve and/or expand community-based medical education (traditional: schools and hospitals, others: community organizations, etc.). What pitfalls have you encountered?
Group 4	Discuss and share best practices for assuring consistency and comparability within a community-based educational model. Balance structure and consistency with the benefits of diverse learning environments and multiple settings.

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Report Out

Report-out: Shared Experiences and New Opportunities

Group 1	Reflect on your experience with community-integrated/based/anchored education • What are the greatest advantages? Can they be amplified? • What are the drawbacks and challenges? How can they be solved or mitigated?
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A: Reflect on your experience with community-integrated/based/ anchored education

- What are the greatest advantages? Can they be amplified?
- What are the drawbacks and challenges? How can they be solved or mitigated?

- Advantages:
  - Train in the same or similar environment as their future practice setting; holding rotations where learners are likely to remain in practice
  - Ratio of students to opportunities is small (e.g., close to 1:1 supervision, other teaching opportunities) and enhances clinical experience
  - People who are teaching, really love to teach
  - Residents more readily able to care for patients independently and providing much needed services/access to care
  - Residents exposed to social determinants of health, different/more models of care, different ways to become involved in teaching
- Challenges:
  - Practitioners and others keeping an open mind on different learning environments than the “traditional” educational settings (i.e., large academic center)
  - Having systems co-/near-located to affiliate or partner with, but dealing with a more competitive culture that may not be conducive to facilitate learning
  - Ever-changing landscape and uncertainty of what academic systems in the market may be pursuing
  - Finding interested faculty depending on geography or bias from previous teaching environments/systems
  - Review committee representation leans toward “traditional” systems (this may be addressed in future)
  - Faculty development can be difficult – allocating time for either group or individual development
  - Compensation systems for physicians (regardless of employment status) – productivity incentives
  - Preconceived notions/assumptions about community-based education

Report-out: Shared Experiences and New Opportunities

Group 1	Reflect on your experience with community-integrated/based/anchored education • What are the greatest advantages? Can they be amplified? • What are the drawbacks and challenges? How can they be solved or mitigated?
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B: What are the observable differences between "traditional" medical education delivered in a community setting and educational programming that is designed to fully integrate within the community setting?

- Initial "traditional med ed delivery" – the university had the overarching authority and community environment afforded residents more autonomy in their clinical training experiences (less direct supervision, more clinical exposure)
  - Transition to equal representation; more recognition from universities/academic partners that community training environments are important for resident training due to complexity, acuity, etc.
  - There is more equal respect on how each entity contributes to the training of physicians (supporting their ability to practice independently)
  - Balance of power between university/academic partner and community partner (and recognition that both experiences are needed)
- Difference between designing curriculum with intent to incorporate community settings throughout the training programs (organizations, not just hospitals) and designing curriculum for community settings to fill gaps (there are more than inpatient settings; other outlets allow for residents to focus on health equity, disparities within the community, etc.)
- Fully integrated design takes into account community needs and cross-matching the competencies required by program to create a unique experience tailored to the community.
- Examples of where community settings highlight/focus and academics typically do not: Correctional health, telemedicine
- With the fully integrated model, there is contribution to the program feedback.
  - Community settings are looking for practice ready individual.
  - Academic/traditional model focuses on meeting the minimum requirements/components.
- Variance in resources provided to organizations to help contextualize the differences in rural and urban settings
- Challenges to engaging community partners when designing programs in a traditional setting.

Report-out: Shared Experiences and New Opportunities

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C: How can partnerships and collaborations be used to improve and/or expand community-based medical education (traditional: schools and hospitals, others: community organizations, etc.). What pitfalls have you encountered?

- Partnerships can help expand educational offerings
- Provide different perspectives to medical centers that may not have otherwise had outside influences; consider healthcare in a different light
- Opportunity to leverage resources and scale across multiple organizations who may not be able to do so on their own
- Increased focus on partnerships with community organizations (Fresh start, food banks, free clinics)
  - Pitfall: reimbursement
  - Positives significantly outweigh the negatives
  - Preparing our students for the real world; build more compassion around health equity
- Partnering with community health departments and other hospitals (teaching hospitals within short distance) and leveraging resources
- Partner with FQHC so students can have this public health experience
- Partnering with some wholistic medical partners
  - Pitfall: reimbursement, competing priorities
- Partner with military institutions (AF base), other universities, FQHCs – offering diverse opportunities
  - Pitfall: "territorial" over community resources
- Collaborating within your community and how to approach collaborative discussions with community organizations
  - Creating more ties to community
  - Partnering with organizations that may not be "traditional partnerships"
  - Importance of building trust when trying to address issues of health equity
- Seen faculty "enjoy" collaborations with medical schools –access to increased resources
- Involvement in community organizations goes beyond academic benefits and helps students/residents feel connected to their communities and indirectly, helped with retention
- How do we overcome the hurdles with finance?
- How do we support our GME leaders? What might the partnership look like? What resources might be available to help organizations get started?

Report-out: Shared Experiences and New Opportunities

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D: Discuss and share best practices for assuring consistency and comparability within a community-based educational model. Balance structure and consistency with the benefits of diverse learning environments and multiple settings.

- Data sharing is key to pulling best practices across community-based models.
- There is potential for consistency if community programs are asked to provide data regarding health outcomes.
- Different sites may serve different populations. While they may employ different strategies and have different resources, they can be compared based on how well they are serving their populations .
- Consistency may be created by having a set curriculum from the school, with input and opportunities for amendments by programs.
- Sites may be compared using scores from students at various campuses. Investigating where and why differences may exist can help share best practices across different sites.
- Determine what the local opportunities or barriers may be, and employ creative solutioning to bring equity to different program sites.
  - For example, tap in subspecialties when generalists are not available
  - Leverage resources across sites

Elevator Pitch – The Value Proposition of Community-Based Education

Creating Talk Tracks – The Building Blocks of your Elevator Pitch

What are talk tracks?

- Commonly used by salespeople
- Modular approach to building a pitch

Tips and Hints

- Limit each talk track to one idea
- Don't use jargon, can be understood by the uninitiated
- Share results but limit how many statistics/numbers you layer on
- A real-life story/example can be relatable and memorable
- End with a clear call to action

SCENARIO:
You unexpectedly find yourself with 30 seconds to share the work that you're passionate about with an important executive or community member.

Are you ready?

Practice using your talk tracks and then modify them based on what you learn…

Closing Remarks

Alegneta Long
Vice President, Graduate Medical Education Initiatives

Kimberly Pierce Burke
Executive Director

Accreditation, Designation, and Disclosure

- Accreditation

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education through the joint providership of Ochsner Clinic Foundation and the AIAMC. The Ochsner Clinic Foundation is accredited by the ACCME to provide continuing medical education for physicians.

- Designation

The Ochsner Clinic Foundation designates this live activity for a maximum of 2.75 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

- Disclosure

The Ochsner Clinic Foundation relies upon everyone in control of content at all sponsored continuing medical education activities to provide information objectively and free from bias. In accordance with ACCME and institutional guidelines, the faculty for this continuing medical education activity has been asked to complete the CME Disclosure of Relevant Financial Relationships form. If anyone involved in control of content for the activity does disclose a relationship with an ineligible company, their materials have been peer reviewed to mitigate any potential bias.

Evaluation Survey

https://www.surveymonkey.com/r/AACOMAIAMC

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1. Visit ***www.ochsner.org/cme***
2. Select *"Go to the CME Conference Portal"*
3. Enter your e-mail address and select *"Log In"*
4. Select *"Click Here to show a list of conferences for self-registration"*
5. Scroll down to "Evolving Landscape of Medical Education: Where do IAMCs and Community-Based Teaching Hospitals Fit in this Ever-Changing Space? " and hit select on the left.
6. Select *"Log in to claim credits for conference"*
7. Confirm your personal information, then hit *"Save Data and Continue"*
8. Enter the number of credits, check the box to confirm the credits, then select "Enter credits"
9. Click print certificate

The conference will show up under the list of conferences you have attended. You can select it to print your certificate. Conferences you have attended previously will also show on this screen.

You can visit this site to print your certificate(s) at any time for your records.

If you have any questions, please contact Katie Guillot at katie.guillot@ochsner.org

thank you!