

Anatomy of an OPTI: Part I. Form, function, and relationships

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In July 1995, the American Osteopathic Association (AOA) Board of Trustees passed new regulations for the accreditation of osteopathic graduate medical education (GME) programs by establishing the Osteopathic Postdoctoral Training Institutions (OPTI) system, to be implemented over 4 years. The resulting changes include requirements for college cosponsorship of GME programs and the establishment of standards for the minimum number of residency programs, interns, and residents. The OPTIs will be subject to AOA inspections at least every 5 years. Proponents of the OPTI system claim it will strengthen the profession by promoting educational collaboration, raising academic standards, and requiring appropriate resources to support osteopathic medical education. Opponents fear that it will be too resource intensive, create an additional layer of unnecessary bureaucracy, and have a negative impact on small colleges, hospitals, and states. Despite the controversy, a process for applying for OPTI status has been developed by the AOA, and a number of hospitals and colleges are already developing OPTIs. This article, the first in a two-part series, identifies issues and barriers to be considered in the formation of OPTIs and articulates principles underlying successful collaborations. In Part 2 these issues, principles, and barriers will be reinforced by describing the process used to form a large OPTI—the Ohio University College of Osteopathic Medicine (OU-COM) Centers for Osteopathic Regional Education (CORE) System.

(Key words: Osteopathic medical education, OPTI, undergraduate medical education, graduate medical education)

In July 1995, in one of its most controversial actions in recent years, the American Osteopathic Association (AOA) Board of Trustees passed new regulations for the accreditation of osteopathic graduate medical education (GME) by establishing the Osteopathic Postdoctoral Training Institutions (OPTI) system to be implemented over the next 4 years. The principal changes resulting from the

OPTI system include requirements for college participation in internships and residencies and the establishment of standards for the minimum number of residency programs, interns, and residents to be trained by an OPTI.

Until July 1999, either the colleges of osteopathic medicine (COMs) or AOA-accredited hospitals can sponsor osteopathic internships and residencies. By then, each osteopathic internship and residency must be cosponsored by a COM and at least one AOA-accredited hospital. Each OPTI must operate a rotating internship and at least two residencies, one of which must be in primary care. OPTIs will be subject to AOA inspection at least every 5 years.

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it will strengthen the profession by promoting collaboration, raising academic standards, and requiring appropriate threshold resources necessary to support osteopathic medical education. Opponents fear it will be too resource intensive, create an additional layer of unnecessary bureaucracy, and have a negative impact on small osteopathic colleges, hospitals, and states. Despite the controversy, a process for applying for OPTI status has been developed, and a number of institutions are already developing OPTIs. This article, the first in a two-part series, identifies strategic issues to be considered in the formation of OPTIs, articulates principles underlying successful collaborations, and reviews barriers encountered in developing OPTIs. Part 2 will be published in the November JAOA. It reinforces these issues, principles, and barriers by describing the process used to form a large OPTI—the Ohio University College of Osteopathic Medicine (OU-COM) Centers of Osteopathic Regional Education (CORE) System.

OPTI Rationale and requirements

Accreditation process

The AOA accredits hospitals and colleges as *institutions*, but accredits GME as internship and residency *programs*. The AOA accreditation of COMs and hospitals requires detailed self-study assessments, internal audits, and site visits by a panel of multidisciplinary experts. This global and comprehensive process is intended to take into account all the resources that an institution can focus on its mission. In contrast, for internships and residencies, self-study assessments and internal audits are not required, and site inspections focus on individual program requirements. As such, the broader assessment of the institution's resources available to support the educational mission may not emerge. The OPTI system for accreditation establishes institutional—as well as program—requirements, and provides a more comprehensive approach for assessing the resources that institutions will provide to support individual internships and residencies.

To qualify for accreditation, an OPTI

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must include at least one AOA-accredited hospital. This requirement is driven by the need for osteopathic identity and is viewed as essential to preserve the integrity of osteopathic training programs. There is no limit to the number of other hospitals that may be included, irrespective of accreditation status. The other major requirements for eligibility as an OPTI are related to structure, organization, and function. To qualify as an OPTI, the college and hospital(s) must demonstrate a mission statement, organizational structure, committee system, faculty development activities, and budget. The process that will be used to accredit OPTIs is only now evolving, and hospitals already sensitized to the costs of internship and residency inspections fear that additional OPTI inspections will now be imposed on them. To address these concerns, the AOA appointed a 12-member OPTI task force composed of equal representation from the AOA, the American Association of Colleges of Osteopathic Medicine (AACOM), the Association of Osteopathic Directors of Medical Education (AODME), and the specialty colleges. This task force will provide assistance to emerging OPTIs, offer advice regarding implementation of the requirements, and make recommendations for monitoring OPTIs. Finally, because the OPTI system is to be implemented in stages over the next several years, it is anticipated that osteopathic medical institutions could plan for an OPTI in Year 1, revise it in Year 2, and determine its final structure in Year 3.

Collaboration

The COMs and hospitals have not maximized their potential for collaboration during the past 30 years. In reality, most GME programs were controlled by hospitals with little involvement from COMs. Undergraduate and graduate medical education have been separate, compartmentalized processes, with COMs having near-exclusive control over predoctoral education, and the hospitals having near-exclusive control over postdoctoral training. Although most COMs (except those in Chicago, New Jersey, and Philadelphia) have little experience in GME, this inex-

perience should not preclude a more viable role for COMs in the future. The colleges possess expertise in curriculum and faculty development, evaluation, research, and scholarly activities that can strengthen osteopathic GME programs. Relationships established between hospitals and colleges provide a new opportunity for the profession by making it possible to bestow university/COM credentials on hospital training programs. Additionally, under new leadership, the AACOM has pledged greater commitment to GME. The COMs are demonstrating a willingness to reallocate resources to support the continuum of osteopathic medical education, and the American Osteopathic Hospital Association (AOHA) supports closer ties to the COMs. The OPTI system will facilitate these initiatives.

Program size

An OPTI must include a rotating internship and at least two residencies, one of which must be in primary care. The internship must have a minimum of four interns, and each residency must have a minimum of three residents. Thus, a fully developed OPTI will have a minimum of ten physicians in training at any given time; four interns and six residents. Although few studies that compare the outcomes of small GME programs with large ones are available, these requirements make common sense and are related to the necessity for a critical mass of resources to conduct effective GME programs. Although the number of trainees that constitutes a critical mass is arbitrary, little dispute exists that internships or residencies with one or two trainees are disadvantaged, compared with larger programs.

Some institutions cite geography as a barrier, in that potential OPTI partners may be thousands of miles away. However, geography is not an insurmountable obstacle in bringing institutions together in a collaborative organizational structure to pursue common missions and goals. Technology seems poised on the threshold of resolving traditional geographic barriers. Distance learning technologies (video-conferencing, computer linkages, and access to the Internet) will, in the future, allow COMs and hospitals

scattered around the country to work effectively within the same OPTI structure.

Representatives from small COMs, hospitals, and states opposed requirements regarding the number of programs and trainees. Their reasons were that these requirements could prevent them from qualifying as an OPTI. These institutions need not be excluded from osteopathic GME if they collaborate with larger institutions. Such an arrangement should provide smaller programs with additional support and resources. Residencies in different medical disciplines will contribute greatly to the academic environment of the OPTI; a critical mass of students, interns, and residents will fuel the educational process; and, bolstered by appropriate curriculum and faculty development, the GME conducted by the OPTI will be more credible and effective.

For small hospitals, the problem may lie in recruiting sufficient numbers of interns or residents to meet the OPTI requirements. Furthermore, small colleges may have difficulty restructuring and reallocating resources to support an OPTI. In regions of the country where osteopathic representation is not prominent and any AOA-training programs depend on allopathic institutions, there may be an unwillingness (or inability) of these allopathic institutions to conform with OPTI requirements (such as AOA accreditation or recruitment of a minimum of osteopathic interns and residents). But, with collaboration and careful planning, small size, like geography, represents a challenge rather than a barrier. Smaller hospitals can collaborate with larger ones and with COMs to form OPTIs. Similarly, small COMs, with little in the way of GME programs, will still have resources to offer hospitals that do have GME programs. Together, these institutions can also join with larger COMs to form OPTIs that meet their needs.

Strategic issues

The OPTI means different things to different people. On the one hand, it's an instrument to reform osteopathic GME accreditation. In that sense, it is a bureaucratic enhancement. But, in a very real

understood in the context of primary, secondary, and tertiary responsibilities and accountability.

The COMs bear primary responsibility and accountability for undergraduate medical education. Hospitals share secondary responsibility to the extent that they provide clinical training for third- and fourth-year students. Agreement must now be reached on the other responsibilities the colleges will bear for GME programs in the OPTI. Structural mechanisms can be developed to vest the COM with secondary responsibility for internships controlled by the directors of medical education (DMEs), and tertiary responsibility for residencies directed by departments and overseen by DMEs.

Reimbursement for GME follows the intern and resident and is paid to the hospital. Accordingly, hospitals bear primary responsibility for internships and residencies and should assume salaries, benefits, administrative costs, and faculty and curriculum development expenses related to the GME programs. Yet, over the years, osteopathic hospitals have accepted secondary responsibility for medical students. In so doing, they provide training facilities, as well as access to patients, supervision from voluntary faculty and, to some extent, assistance with the students' cost of living.

Conversely, it seems unreasonable for hospitals to bear financial responsibility for the administration, implementation, and evaluation of a COM curriculum, or faculty development programs geared toward students. Using this structure, COM deans remain primarily responsible for their third- and fourth-year students. Hospital DMEs bear secondary responsibility for students on site. Clinical departments and residency program directors play a tertiary role by accepting responsibility for clinical training of students in their disciplines. The OPTI document makes possible the establishment of a system that encompasses primary, secondary, and tertiary responsibilities by promoting collaboration between COMs and hospitals. Furthermore, OPTIs will promote a continuum of physician training, beginning with matriculation, and ending with completion of a formal residency. Those

COMs and hospitals that form OPTIs should clearly define the responsibilities of each party in the endeavor. They need to identify strategies to promote fairness, equity, and a reasonable division of labor in operating educational programs.

Finances

One way to handle financial issues and to achieve harmony and "buy-in" to an OPTI is to require that all participants in the OPTI make a financial contribution. After all, institutions value, prioritize, and commit for that which they pay. The ability of various partners to pay will vary and thus must be negotiated. The AACOM and its member colleges lobbied hard for a requirement to include them in OPTIs, so why absolve them from financial support? The AOHA and hospitals already understand that developing OPTIs will require greater hospital financial investments. Some COMs wrongfully conclude that hospitals in the OPTI intend to defray the costs of their GME programs (already reimbursed by the government) with financial contributions the COM makes to the OPTI. In reality, hospitals simply want COMs to bear the legitimate costs of developing, implementing, and evaluating the college curriculum in hospital training sites, while sharing the costs of faculty development programs that could benefit both undergraduate and graduate medical education.

Certain guidelines seem reasonable for determining the actual contributions colleges or hospitals make. As a rule, COMs possess greater capacity for in-kind contributions, because they have greater curriculum and faculty development resources than hospitals. For most hospitals, the financial contribution will exceed the in-kind contribution to the OPTI. They have fewer curriculum and faculty development resources. Therefore, COM financial contributions should be earmarked for programs to strengthen clinical clerkship training. Meanwhile, hospital financial contributions should be earmarked for programs to strengthen GME. Adherence to financial guidelines such as these will allow personnel and programs to develop within the OPTI that benefit both undergraduate and graduate education. For

example, OPTIs will need help from educational specialists to plan curriculum and faculty development programs. These costs can be shared, economies of scale can be achieved, and duplication of services avoided by hiring the same educational specialists to serve undergraduate and graduate educational goals.

Difficulties over financial issues can be the undoing of medical education consortia. Many hospitals feel that COM contributions limited to in-kind support don't represent a sufficient commitment. The COMs receive none of the reimbursement for GME and are concerned that monies they contribute would be channeled to support GME rather than clerkship training. Even when assured that college dollars will be earmarked to support clinical clerkships, many of the small, private institutions with limited funds are wary.

Hospitals—also feeling the pinch of difficult economic times—must be convinced that new investments in osteopathic medical education are justified. Chances of success will increase if COMs reallocate resources to meet hospital expectations regarding minimal financial and in-kind contributions and view their financial contribution as supporting Years 3 and 4. Similarly, the hospitals must recognize that their financial contributions will be earmarked to support Years 5, 6, and 7.

Autonomy issues

Issues related to the autonomy of each partner in the OPTI sometimes pose the greatest challenge to resolve. Decision makers representing hospitals or COMs and universities bring different organizational cultures to the negotiating table. Osteopathic hospitals and COMs functioned independently in the past, but the formation of an OPTI involves collaboration, the establishment of a common mission, and the setting of mutual goals. Each partner must relinquish some control so that management can progress more by consensus than by the mandate of any one partner. Above all, candor and honesty must prevail in negotiating strategic issues related to control.

Requiring a financial contribution from each OPTI partner will help resolve

sense, OPTIs will exist as distinct structural entities with form, function, and relationships. As a result, an OPTI may be viewed as a consortium. The consortium model promotes collaboration, perhaps the greatest strength of the OPTI system. Indeed, OPTI and consortium are nearly interchangeable in the sense that a consortium is simply two or more institutions linked by contract to pursue a common mission. In this context, OPTI is the osteopathic acronym for consortium. OPTIs are already being developed in Arizona, Michigan, Ohio, Pennsylvania, and other regions of the country. The nature of OPTIs (or consortia) is a departure from the past, and involves multiple institutions, and complex goals. Thus, the institutions forming them must negotiate numerous strategic issues. Although different osteopathic institutions and partners will face issues unique to their environment, developing OPTIs will often entail similar strategic issues, challenges, and barriers concerning the following:

- structure and organization;
- responsibilities and accountability;
- finances; and
- autonomy.

Structure and organization

Effective planning is the key ingredient in successful OPTI development; it requires a permanent organizational structure responsible for carrying out its mission, goals, and objectives. Planning an OPTI is a labor-intensive process. The goal at the end of Year 1 should be agreement on a structure, organization, and a blueprint to be implemented in Year 2. Achieving this goal will be contingent on a nucleus of COM/hospital decision makers assuming responsibility for drafting proposals and documents to keep the process moving. The first step in this stage of planning is the development of a mission statement for the OPTI that the partner institutions can support and promote. The mission statement should answer these questions:

- What or who is the OPTI?
- Who are the OPTI stakeholders?
- What issues, needs, or problems does the OPTI exist to address?

- How will the OPTI address its problems and meet its needs?
- What are the core values of the OPTI?
- What makes the OPTI unique?

As the partners reach agreement on the mission, they can begin negotiating the committee system and organizational structure. Collaboration and sharing of resources are major advantages of the OPTI system and consortium model, but they will be lost if an appropriate committee system is not developed, and if an organizational structure in which the committees can function is not clearly defined. To some extent, the organizational structure and committee system will depend on the mission of the OPTI and the types of services it provides.

Each OPTI will require a policy-making group or board and several subcommittees. An executive committee can provide leadership, monitor operations, make decisions on a month-to-month basis, and forward recommendations to the board. A bylaws committee will be needed to draft an organizational structure that specifies the responsibilities of individuals and committees, as well as governing parameters approved by the board. A finance committee will provide assistance in preparing and reviewing budgets and making fiscal recommendations.

The establishment of additional committees will depend on initiatives the OPTI undertakes, activities that it chooses to promote, and the size and scope of its internships and residencies. Wide distribution of agendas and minutes will help keep all members of the OPTI informed. Larger OPTIs will want to consider the use of emerging technologies in computers and distance learning to share information and to achieve common goals. As the size and number of participating institutions in the OPTI increase, the development of an effective communication system to coordinate and integrate committee activities and to disseminate information becomes more important.

Responsibilities and accountability

During the past few years, agreement has been reached (sometimes reluctantly) whereby COMs must expand the focus of

their relationship with hospitals from strictly focusing on undergraduate medical education to include graduate medical education. Doing so will involve a reordering of the traditional relationships between COMs and hospitals and will trigger discussions regarding expectations, responsibilities, and accountability.

For example, the AACOM argued that its member colleges—as academic leaders in the profession—should have a greater role in GME. As a result, a requirement for a COM in each OPTI was eventually negotiated. Accordingly, COM expectations that hospitals and specialty colleges recognize the potential of COM resources and contributions were acknowledged by the AOA and teaching hospitals. But, by fighting for—and achieving—a requirement for COM participation in OPTIs, colleges have also created expectations that they will provide their hospital partners and training programs with resources that would not otherwise be available.

Opponents of the COM requirement in the OPTI system argued that COMs would not actually contribute to the operations of the OPTI. This view was fueled by the long-standing failure of COMs to generally provide financial or appropriate in-kind support for clinical training given third- and fourth-year students at hospital sites. If COMs expect a viable role in OPTIs, they should first financially support their own undergraduate curriculum for students based in the OPTI's hospitals.

Doing so will send a powerful message, namely that the COMs are prepared to take a different approach to the education of osteopathic physicians. Such an approach will place accountability for undergraduate medical education where it belongs.

As a result of OPTI, all internships and residencies will be jointly sponsored by COMs and hospitals, which should mean nothing less than shared responsibilities and accountability for GME. However, *shared* responsibilities in conducting either undergraduate or graduate medical education does not imply *equal* responsibilities. This distinction is fundamental to successful OPTI building and can be

issues related to control. Financial investment assures each partner a voice in consortium operations. The amount of influence should be proportionate to the magnitude of the investment. For example, if the hospitals, the original sponsors of the GME programs, are contributing two thirds of the financial resources to the OPTI and the COM one third, then this influence should be reflected in the operations of the OPTI.

Nonetheless, influence in the OPTI should not be measured solely on the basis of financial contribution. Specifically, the COM can strengthen its stake by the types and levels of in-kind contributions it makes. For example, it is difficult to place a price tag on the university credentials a COM offers hospital training programs based in communities. Likewise, COMs can make invaluable contributions to curriculum and faculty development, administrative services, research, and scholarly activity.

A final, albeit sticky, issue in resolving autonomy concerns relates to the attitudes both COMs and hospitals bring to the negotiations. The COMs have a tendency to view their institutions as the authority on all matters academic, an attitude that rankles DMEs and residency directors. Hospitals have been responsible for osteopathic GME for four decades and have achieved a commendable track record. As such, they tend to view their institutions as the authority on graduate training, an attitude that rankles college deans and faculty. These attitudes are most likely to emerge when the discussions turn to control, influence, and autonomy. Fortunately, by allowing a full year for planning, the partners in an OPTI can assign ample time for resolution of these strategic issues.

Given that governing disputes often relate to finances, a system must be developed that provides the financial backers of the OPTI with reasonable assurance that they will retain fiduciary responsibility for their investments. One way to accomplish this is by delegating authority over financial issues to a finance committee or an executive subcommittee of the board. This committee would be composed only of representatives from institutions that are

providing the financial support for the OPTI. Negotiation over fiduciary issues should be conducted during the planning year so that conflicts can be resolved *before* establishing the budget and implementing consortium activities.

Disputes over governing may also be precipitated by the need for participating institutions to maintain autonomy over their own structure, organizations, and decision making. Having acknowledged this need, it must be said that some autonomy issues can never be negotiated. For example, the authority vested in the dean by the COM or university can never be subjugated to the authority of the OPTI board, any more than the authority vested in the hospital's board or CEO can be subjugated to the dean or medical school board. These issues need to be identified early. Agreements need to be reached so that constraints such as these will be honored in the course of conducting consortium business.

Conclusion

The OPTI system for accrediting osteopathic GME programs introduced in July 1995 is a step in the right direction for osteopathic medical education. The heretofore prevailing systems inhibited collaboration and underemphasized the power of shared resources for the profession. OPTI is a name for an accreditation reform, a synonym for a consortium; it is an acronym for the future providers of osteopathic GME and a plan for promoting collaboration and excellence in the osteopathic medical profession. The OPTI system requires that COMs and osteopathic hospitals work together. It outlines a framework for collaboration and sets minimal standards for the number of programs and trainees that are necessary to constitute an OPTI. The successful development of OPTIs or consortia will require that osteopathic hospitals and COMs restructure their relationships and reallocate their resources to support the activities of the OPTI.

The COMs and hospitals interested in OPTIs should develop their plan in Year 1, implement it in Year 2, and revise and establish the final structure in Year 3. The planning process will involve regular

meetings and the commitment of upper-level decision makers from all institutions. Numerous strategic issues must be negotiated. These issues are related to structure, organization, function, financing, and governing.

During the planning year, the COMs and hospitals must mesh their different organizational cultures; establish a common philosophy for osteopathic medical education; define clearly the role, responsibilities, and accountability of each party in the OPTI; and reach agreement on the mission statement, organizational structure, committee system, and budget. In developing OPTIs, COMs and hospitals face challenges and barriers related to poor planning, financial constraints, governing disputes, conflicting attitudes and perceptions, and autonomy concerns. A formidable process, OPTI development can, nonetheless, be accomplished in 1 year with commitment from decision makers, a careful plan, patient negotiation, a willingness to compromise, and modest financial investments from participants in the OPTI.

The OPTI system exemplifies a significant advancement for the osteopathic medical profession. It promotes collaboration between osteopathic postdoctoral training institutions, where for too long there had been little collaboration. It promotes the development of infrastructure (or some would say bureaucracy) where little infrastructure had existed to support osteopathic graduate medical education. The OPTI program takes a serious, comprehensive approach to the accreditation of osteopathic GME. As such, it may afford a significant transitional step to a saner, more credible accreditation process for osteopathic medical education, both undergraduate and graduate. Finally, OPTI sets new standards for excellence that may assist the profession in dealing with its GME challenges. It offers a vision for the future of osteopathic medical education that involves a collaborative approach by COMs and hospitals to sustain a continuum of osteopathic physician training that begins with matriculation in the COMs and ends with completion of a formal residency.