Preliminary Recommendations: Improving Rates of Osteopathic Membership in STFM

The STFM Membership Committee and Group on Osteopathic Education have several preliminary recommendations:

1. Continue to explore the missions and goals held by STFM and allopathic and osteopathic family medicine organizations. Be aware of and acknowledge where these goals converge and differ.

2. Create better lines of communication among STFM, osteopathic and allopathic organizational leaders, and family medicine faculty. National conferences and special events should be posted at a site supported by or linked to STFM.

3. Explore and build opportunities for joint training. Conference planning should continue to include themes of interest to osteopathic family medicine education, such as highlighting special areas of clinical teaching and dual accreditation. Establish that full CME credits will be available for both allopathic and osteopathic physicians and appropriate STFM-sponsored conferences.

4. Although osteopathic organizations such as the AOA and ACOFP already recognize outstanding students and colleges within their own organizations, it would a very positive step to see STFM also recognize the success of osteopathic schools and report publicly on achievements and events that have mutual interest.

5. Promote appreciation for cultural and historical differences between osteopathic and allopathic medicine by clarifying shared visions and goals, especially for family medicine educators, research, and community and patient outcomes.

Conclusion

As members of the STFM Membership Committee and Group on Osteopathic Family Medicine, we admit to a bias in favor of a strong and vibrant STFM membership. But beyond our biases, we believe that all teachers of family medicine will benefit from greater alignment of mutual interests across osteopathic and allopathic schools, programs, and faculty. Given the fact that there are more osteopathic residents in allopathic programs, it is incumbent on all of us to work together. Additionally, the faculty development activities provided by STFM can be beneficial to osteopathic education. By working together in a collaborative fashion, we can have a stronger impact on the health of our patients. In fact, STFM leaders met with ACOFP leadership last year to begin discussions of collaborative efforts for the future.

We invite your input on the topic of increasing osteopathic physician faculty membership in STFM. We also invite you to share the themes of this paper with your colleagues. If there is to be a common culture for all teachers of family medicine that will grow regionally, nationally, and beyond, it will be because small communities of academic colleagues have examined and advanced the good they find within these ideas.

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KEEPING OUR EYE ON THE BALL: MANAGING THE EVOLUTION OF ELECTRONIC HEALTH RECORDS

The AAFP's leadership regarding Electronic Health Records (EHRs) has been impressive. As the Future of Family Medicine report underscored, EHRs include not only clinical information systems but also scheduling, billing and other functionalities, and these broader functionalities are critical for the fiscal viability of the New Model of Family Medicine. The AAFP initiative has created a market in small-office EHRs, resulting in development of common technical standards and better understanding of the costs of EHR adoption, greatly speeding the process. The Academy's leadership has also led other professional organizations and the federal government to address the fundamental structure of health records, including the Continuity of Care Record (CCR), pay-for-performance measures, and EHR certification.

ADFM believes, however, that these successes represent only a first step. As important as small-office EHRs are, they represent a by-station on the road

towards the information systems we will need for primary care. If we allow the small-office EHR to represent the sole vision of family medicine, then family medicine will be forever confined to an office, largely unconnected to the other settings in which our patients receive care. We believe that family medicine must keep its eye on the goal—a patient-centered electronic health record which will allow the family physician to manage care across the spectrum of care, combining office with hospital, insurer and public health data to allow continuous improvement of access, costs and outcomes.

To achieve this vision, we will need to confront substantial organizational, financial and intellectual challenges. These include:

1. Interconnectivity. Many hospital systems have developed hybrid systems that are partly homegrown and partly commercial. Given the complexity of the tasks, limited number of vendors and huge investments, health systems are often conservative. Interconnectivity with outpatient EHRs often seems a low priority for hospital based systems; yet, in order to create the information system primary care needs, we must bridge this gap. The evolving certification process will help.

2. Financing. In small offices, EHRs offer hope of improving cash flow through pay-for-performance and reduction of dictation and staffing costs. However, as a recent ADFM survey has shown, most family medicine units incur the costs of implementation without the benefits of the associated savings.

3. Ease of Data Entry. Structured data entry facilitates chronic disease management. Direct entry by clinicians, however, is often cumbersome, making transition to EHRs challenging and often lowering productivity. Resolving this is a priority. Some EHRs work better than others, of course, and the ultimate solution may be technical—voice recognition technology that also enables coding and disease management prompts. Patient-entered data through personal health records and interfaces to immunization, laboratory, or radiology databases will also help.

4. Underdeveloped Office Systems. Realizing the full potential of EHRs requires office system reengineering and customizations in software. Yet EHR conversion can prove so exhausting that clinical system redesign is not done immediately. Specifics will vary with site and EHR.

5. Addressing Comorbidity. Family physicians bring to health care the potential to manage multiple chronic diseases simultaneously. Yet, the architecture of most available EHRs allow disease management 1 disease template at a time. A priority for family medicine must be facilitating management of multiple diseases at a single visit.

6. RHIOs (Regional Health Information Organizations). The full potential of EHRs will be realized only when a patient's health information becomes accessible to her family physician regardless of geography or insurer. Compatibility among systems will be slow to progress, competitive systems will be reluctant to share information, and regulation will complicate the process.

Individually, each of these areas represents a substantial organizational, intellectual and financial challenge. Together, the list is daunting. As with any journey, however, the first steps are the most important—and we need to start by understanding what is important. Departments of family medicine have a major role to play. The market has produced large systems like Epic and others that are increasingly capable of addressing both the needs of complex medical centers and small office practices. Users' groups for each of these systems and direct linkages with developers can drive system development. Departments also have many faculty who play leadership roles in their institutions' informatics groups, as well as connections to broader Academic Health Center and University IS resources. How can we as a discipline organize this strategic resource? Finally, increasing numbers of family medicine researchers have substantial expertise in disease/population management or the management of particular clinical problems. How can the discipline leverage their expertise to manage the evolution of electronic health records?

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