A Qualitative, Interview-Based Study of the Health Policy Fellowship's Osteopathic Identity

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Disclosures: Dr Skinner periodically lectures as part of the Health Policy Fellowship sessions. However, he does not receive any compensation for these presentations beyond travel costs. Dr Franz has no financial disclosure or conflict of interest to report.

Support: None reported.

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Submitted September 29, 2016; final revision received November 29, 2016; accepted December 13, 2016.

Context: Since 1993, the Health Policy Fellowship (HPF) has trained osteopathic professionals in health policy and leadership. Although almost 250 fellows have graduated from the program, many of whom have assumed leadership roles within the osteopathic medical profession, the HPF has, to the authors' knowledge, never been subjected to scholarly analysis.

Objective: To understand the HPF's professional significance as a health policy and leadership training program that has enrolled mostly osteopathic physicians.

Methods: Semistructured interviews were conducted with graduates supplemented by interviews with other professionals involved with the HPF. Using an inductive grounded theory approach, we coded interviews for major themes.

Results: Forty-three interviews were conducted, 38 of which were with graduates of the program and 5 of which were with HPF staff. The data suggest that although the content of the HPF is applicable to all medical professionals, the program's language and structure are designed to accommodate specific needs of osteopathic professionals. Specifically, the language of the fellowship emphasizes the "high ground" (considering multiple perspectives on an issue), and the structure of the fellowship allows fellows to continue in their jobs but travel to several COMs and to Washington, DC, throughout the year.

Conclusion: Closer examination of the HPF helped convey the relevance of this program, and perhaps programs like it, for a minority medical profession still finding its voice within the policy climate of US health care.

J Am Osteopath Assoc. 2017;117(3):184-190
doi:10.7556/jaoa.2017.032

Keywords: fellowship, health policy, osteopathic identity

Since 1993, the Health Policy Fellowship (HPF) has trained osteopathic physicians (ie, DOs) and other osteopathic professionals (ie, those with graduate or other doctorate degrees and strong links to the osteopathic medical profession[1]) in health policy. The program is "a year-long leadership training program designed to give osteopathic physicians the skills they need to analyze, formulate, and implement health policy on the local, state, and national levels with the purpose of increasing access to affordable, quality health care.[2] After her experience in the prestigious Robert Wood Johnson (RWJ) Health Policy Fellowship program, Barbara Ross-Lee, DO, who was the first DO to complete the RWJ program,[3] came to believe that the osteopathic medical profession lacked a presence on Capitol Hill. She believed a similar training program was needed to increase DO representation and thus founded the HPF.[4] With the 2016 class, the HPF has graduated 241 fellows.

Despite the HPF's more than 20 years of engagement with the osteopathic medical profession, the program has never been subjected to scholarly analysis. Specifically, the HPF's place within the profession, how fellows have benefited professionally from the HPF, and how the needs of the profession have been met within the broader context of US health care have not been examined. The objective of the present study was to understand the contribution of the HPF to the osteopathic medical profession and the role this training plays in the professional careers of graduates.

Methods

From May to July 2016, we conducted interviews with HPF graduates and personnel associated in various manners with the program. The study was approved by the Ohio University Institutional Review Board in May 2016. Interviewees were recruited via e-mail using the full list of living HPF graduates. Those who responded that they were interested were contacted via telephone, and verbal consent to participate in the study was obtained.

Interviews were in-depth and semi-structured in nature and averaged 30 minutes. In accordance with the principles of grounded theory, the study began with the following guiding research questions:

- What were the motivating factors of fellows to enroll in the HPF?
- What role did the HPF play in fellows' professional trajectories?
- What do fellows see as the relationship between the HPF and the osteopathic medical profession?

Extensive notes taken by both researchers (D.S. and B.F.) were uploaded to Dedoose, a qualitative data analysis software package, and coded by both researchers after each interview was completed. In grounded theory, interviewing continues until thematic redundancy appears, a phase known as *theoretical saturation*.[5] To reach this state, researchers engage in "theoretical sampling," which is purposely seeking out participants whose views might introduce new information.[6] Using a snowball sampling approach, we followed up with fellows whose names were suggested by participants and who we believed would offer a perspective not yet captured. In the interest of broad geographical representation, we sent follow-up e-mails to fellows located in unrepresented states and to graduates from years that were not yet represented.

Following grounded theory procedures, coding encompassed 3 distinct phases: open coding, axial coding, and theoretical coding. After several interviews were coded, we met to evaluate intercoder reliability before proceeding to code the additional interviews. This process involved memo writing, cross-coding, and the collaborative questioning of code choices.[7] At the conclusion of coding, we met to assess redundancies, merge codes, and evaluate key findings.

The names provided in the following paragraphs, with the exception of Ross-Lee, were changed to ensure participant anonymity.

Results

Twenty-two fellows responded to our initial request, and 19 additional fellows responded after follow-up e-mails. In 3 cases, we were unable to schedule interviews or the fellow stopped responding. Thus, we interviewed 38 HPF graduates (*Table 1*) and 5 affiliates of the program (the director [Ross-Lee], faculty, and staff). Two recurring themes from the interviews provide insight into one of our guiding questions—namely, the HPF's relationship to osteopathic medicine. The first theme was that fellows and affiliates use language to discuss health policy that reflects their position as a minority within the broader medical profession, which reflects how they think about health policy. The second

Table 1.
Health Policy Fellowship (HPF) Interviews: Characteristics of Participants Who Were Fellows (n=38)

Characteristic	No. (%)
Degree Held	
DO only	21 (49)
DO with graduate degree	6 (14)
PhD	4 (9)
Other[a]	7 (16)
Leadership Position Held	
Dean/associate dean	11 (29)
AOA president	2 (5)
States Represented[b]	18 (36)
HPF Cohorts Represented[c]	21 (95)

[a] Includes participants who held MD, MBA, RN, MPP, and MS degrees.
[b] Percentage calculated from 50 states.
[c] Percentage calculated from a total of 22 HPF cohorts.

theme reflected the fellows' emphasis on the structure of the program, which was developed in response to the context within which many DOs practice.

Learning a Language for Involvement in Policy

Several fellows described participating in the program as "learning a language." In a profession that despite recent expansion remains a minority, with DOs comprising only 8% of actively licensed physicians in the United States,[8] "learning a language" was akin to "finding a voice." Zeke noted, for example, that the fellowship "helped me communicate in an entirely different way and allowed me to change health systems," which in turn altered the direction of his career. One HPF affiliate identified the language of the fellowship as a "scaffold" upon which subsequent expertise and professional development could be built. Another HPF affiliate noted that the HPF focused on "not just thinking outside the box, but conveying one's message," which he or she believed was critical because many physicians focus their studies on science and thus lack "public speaking skills." Although most fellows seemed to feel that the language that one learns from the HPF is substantive, there is also a degree to which this language provides access to certain circles. Stanley, for example, noted that he learned a new vocabulary that enables fellows "to sound like they are talking intelligently about those topics." Dawn concurred, noting that it is "key to be able to use the language of the legislature, the law, and health policy."

The HPF also advances a vernacular of its own that was evident in interviews. Most importantly, the language of "taking the high ground" appeared in almost every interview. The "high ground," or considering multiple perspectives on an issue, was particularly important in understanding health policy debates and allowed fellows to "see the big picture." Ginny saw the attainment of this perspective as a key outcome of the HPF, noting that "we learned to take the high ground…to be more open-minded." Oftentimes, fellows saw this perspective as part of a transformation. Elizabeth saw her cohort as initially interested in protecting the rights of physicians but thought that the HPF "forced me to take the high ground." Steven characterized the high ground as a "higher level of contemplating ideas." Some participants acknowledged that, as Jack put it, "Some fellows were more adept at taking the high ground than others," in part because those fellows struggled to relinquish their stakeholder positions.

Beyond noticing others' shortcomings, a number of fellows displayed a high degree of self-critique. Elizabeth noted that the program helped her reach "a whole new level." For her this level meant listening to multiple perspectives on health policy and dislodging her previous position as a "fierce defender" of physicians. Paul recollected that "the biggest component was gaining a broad understanding...of what went into the policy and politics of health at the state and national levels." He believed he "got a broader scope of that," in part through being "exposed to different ideas across the country." But the program's aim is less absolutist than developmental because, for Jack, "If you try to get

to the high ground, you're going to go a lot further than if you hadn't tried." The high ground, according to several fellows, connected quite logically to health policy. After all, as Tom noted, "good policy isn't particularly stakeholder driven."

Although acting as a stakeholder was discouraged, through this new language many participants recognized that an outcome of the training would be to increase the presence of the osteopathic medical profession in health policy debates. Fellows described this emphasis on leadership in various ways. Brian noted, "It's been an important program to help develop leaders in the profession," while Deanna, a non-DO fellow, added, "It's important for DOs to be front and center in the health policy arena because MDs are a powerful lobbying group. I'm not so sure that [DOs are] always so productive." An affiliate expressed concern that "osteopathic medicine had been in the background" of the health policy environment until the announcement of the single accreditation system for graduate medical education, but "now there is a concern that [the single accreditation system] will lead to the end of the profession." Ross-Lee maintains that because "we can't compete with our allopathic brethren" in health policy advocacy, we compensate with "moxie."

Lanny added historical perspective to the sentiment:

> In the 1980s, we were not taught to be the ones who were out in the forefront of medicine, working with the government. The [American Medical Association] was dog, we were tail. In my generation, we were taught that we would be the grunts.... But the world has changed.

Livia added that DOs "see themselves as underdogs, so they fight like underdogs." Jack agreed, adding that it is "important for a minority profession to be trained in health policy. We don't have the numbers, so we have to take a different tactic." Alana added, "Every [health care] profession needs at least a subgroup of individuals who are very well versed in health policy," a point that she thought to be particularly important at the state level. For these fellows, the language of the HPF provided a direct link to engagement with health policy as osteopathic professionals, both in their states and nationally.

Structure of the HPF

For many participants, the HPF's osteopathic identity is rooted not in the program's content but in its structure and design. The RWJ program emphasizes its…

> exclusive, hands-on policy experience with the most influential congressional and executive offices in the nation's capital to exceptional midcareer health professionals and behavioral and social scientists with an interest in health and health care.[9]

and requires, at minimum, "a 12-month residential experience in Washington, DC."[10] Another program, the Dartmouth Institute's Health Policy Fellows Program, matches fellows with projects in the area of health policy over the course of 18 months to 2 years.[11]

The HPF, however, was designed to accommodate the needs of osteopathic professionals at institutions with limited finances. "All of the allopathic programs" according to Ross-Lee, "are like a sabbatical." They require a year or more off from work and require programs to pay fellows' salaries. She added that because of limited funding available at osteopathic institutions and difficulties in obtaining coverage, "we can't do that in the osteopathic medical profession, so we had to come up with a different strategy," structuring the program so that DOs don't have to leave their positions to learn health policy. In this way, the HPF's design reflects several aspects that accommodate needs that interviewees regarded as specific to the osteopathic medical profession, even as the content of particular discussions and the foci of presentations may remain general. Duane, who had considered the RWJ fellowship, noted that the HPF "was easier to get and was less time and money" and "only weekends." His political aspirations within the profession led him to identify the HPF as a good fit.

Ross-Lee noted that a second goal of the program was to afford host institutions "visibility at the community level and the opportunity to invite policy makers from their community to interact," which underscores the HPF's unique emphasis on travel. While many health policy training programs have partici-

pants work in a particular city—especially Washington, DC—or are online, the HPF requires travel throughout the United States to 8 monthly 3-day seminars (6 at osteopathic medical schools and 1 each at the American Osteopathic Association's and American Association of Colleges of Osteopathic Medicine's Washington, DC, offices).[1] Ross-Lee stated that "physicians who are actively in practice or in faculty positions just do it as a weekend program." She believes that unlike many of their MD counterparts, DOs find it comparatively difficult to take an entire year off, or many weeks off at a time, to engage in a health policy curriculum.

Sometimes, of course, the HPF structure presents challenges to fellows. Amy noted, "The way the fellowship is constructed right now is a big commitment," adding, "If it could be offered in smaller bits along the line, it might open it up to more people." According to Jill, "Time was the challenge." In a sentiment echoed by other fellows, Timothy noted, "Without institutional support, [I] wouldn't have been able to participate." The most common source of support evoked by fellows was that of state associations and their academic institutions.

Despite the challenges, most fellows saw the HPF's on-site visit design as beneficial. For Herschel, "Presentations provided immediate feedback from people in politics" and "gave insight that would not have been available" had the sessions not been held in person. For Alex, the frequency of sessions "was a vehicle," without which "you might as well just send the fellows a book on policy. You might as well not have it." For Emily, "The group dynamic was extremely beneficial"; she specifically noted that it "would not have worked online—face-to-face sessions are critical." For many fellows, travel played an important role in helping them feel connected to the osteopathic profession itself. Clive echoed: "traveling and seeing different osteopathic colleges was important." Alana placed particular value in meeting folks from rural schools. Many fellows, therefore, emphasized ways in which the fellowship's design and structure reflected particular needs that they regarded as unique to the osteopathic medical profession.

Discussion

Our interviews reveal that HPF-specific language—especially the language of the high ground—is best understood not only as the development of a new skill and perspective, but something that many fellows regard as directly related to the HPF's osteopathic identity, shaped by structural features of the osteopathic medical profession itself. Our analysis also demonstrates that the HPF's importance to the profession lies in its design and culture, not academic content or particular points of advocacy. What makes the HPF osteopathic is less its content and more its design. In fact, our interviews suggest that the HPF's lack of a particular focus on the osteopathic medical profession, or even philosophy, may be a sign of the times, as DOs are increasingly recognized in the broader terrain of US medicine.[12]

Although travel can be expensive and sometimes logistically complex, it reflects the HPF's accommodation of osteopathic professionals' availability and financial constraints. The focus on short, intensive sessions in locations around the country has emphasized intensity and interaction over the comprehensiveness of a full-time program. Fellows seemed appreciative of the ability to process what they learn from month to month and prepare for the next session while never being forced to cease their work as osteopathic professionals. In this way, HPF fellows can remain immersed in their work while developing new skill sets. In line with the longstanding osteopathic commitment to working in less traveled parts of rural America,[13,14] some fellows specifically mentioned that the HPF afforded them an opportunity to see osteopathic medical schools in regions that they had not before visited.

As fellows and affiliates eagerly noted, many of the HPF's 241 fellows have assumed leadership roles within the profession (*Table 2*), and they currently work in 34 states and Washington, DC (*Figure*). Despite this success, considerable vagueness remains regarding the fellowship's name and place within the osteopathic medical profession. At the same time, the ambiguity regarding the fellowship's name is no oversight. Many fellows offered that the HPF is not—and should not

be—an advocacy program. Nor is it a tool of its sponsors—the New York Institute of Technology, which has long funded and directed it; the Ohio University Heritage College of Osteopathic Medicine, which has coordinated it; or the American Osteopathic Association, which recognizes it as a certificate program.

Beyond institutional ties, many fellows and affiliates emphasized that there is no such thing as "osteopathic health policy." Rather, health policy should be an evidence-based activity undertaken by professionals assuming the high ground. To this extent, given that most fellows are DOs or affiliates of the profession, the HPF's osteopathic identity is evident in the selection of fellows and the osteopathic circles in which they work, the language they speak, and the HPF's design and structure. As a minority profession within medicine in the United States, osteopathic physicians seek recognition for their approach to practice. The HPF's name reminds us that the ultimate goal of the profession is not to celebrate osteopathic medicine but to bring a certain perspective to bear on patient care, which in turn requires full participation in policymaking. To this end, the HPF's central contribution appears to be preparing leaders who can play critical roles in national policy debates while bringing visibility to the osteopathic medical profession.

As with any study, there are limitations to our data. Fellows who responded to our invitation may have done so in part because they were enthusiastic about the HPF. Despite being promised anonymity, none of the 38 fellows we interviewed seemed particularly interested in criticizing the program. Another potentially complicating factor is that at the time we undertook our interviews, we learned that there were discussions circulating among many fellows about potential changes to the HPF. Although we did not seek input about these discussions, they did come out in interviews. Consideration about the future of the HPF was not a goal of the study. Similarly, just as considerations about the future of the HPF may have shaped some of the outcomes, recall bias is certainly a concern, as one would expect it to be in interview-based research in which participants were being asked to recall impressions that in some cases spanned more than 20 years.

Table 2.
Leadership Positions Held by Health Policy Fellowship Graduates Since 2005 (N=241)

Position	No.
AOA president	3
AOA vice president	6
AOA Board of Trustee member	8
COM president	3
COM dean	28
State osteopathic association president	37

[a] No. is based on self-reported data compiled by the HPF since 2005.

Abbreviations: AOA, American Osteopathic Association; COM, college of osteopathic medicine.

Conclusion

Within the broader realm of US medicine, it is important to understand how osteopathic professionals are positioning themselves to influence policy developments and establish the voice necessary to participate productively in debates. This understanding is especially important at this time of health care reform as DOs become an increasingly prominent and ubiquitous force in health care. Despite the HPF's unique design and broad goals, our data suggest that the program has afforded fellows an opportunity to cultivate skill sets that are important not only in the development of US health policy, but also in ways that specifically reflect particular features and dynamics of the osteopathic medical profession.

Acknowledgments

We thank Ann K. Peton, MPH, director of the National Center for the Analysis of Healthcare Data, for providing us with the map of HPF fellow locations. We also thank Nancy Cooper, Health Policy Fellowship coordinator at Ohio University Heritage College of Osteopathic Medicine, for providing access to the HPF archives and tracking data, and Merry Biechler, who provided help in compiling and organizing the HPF archives for this study.

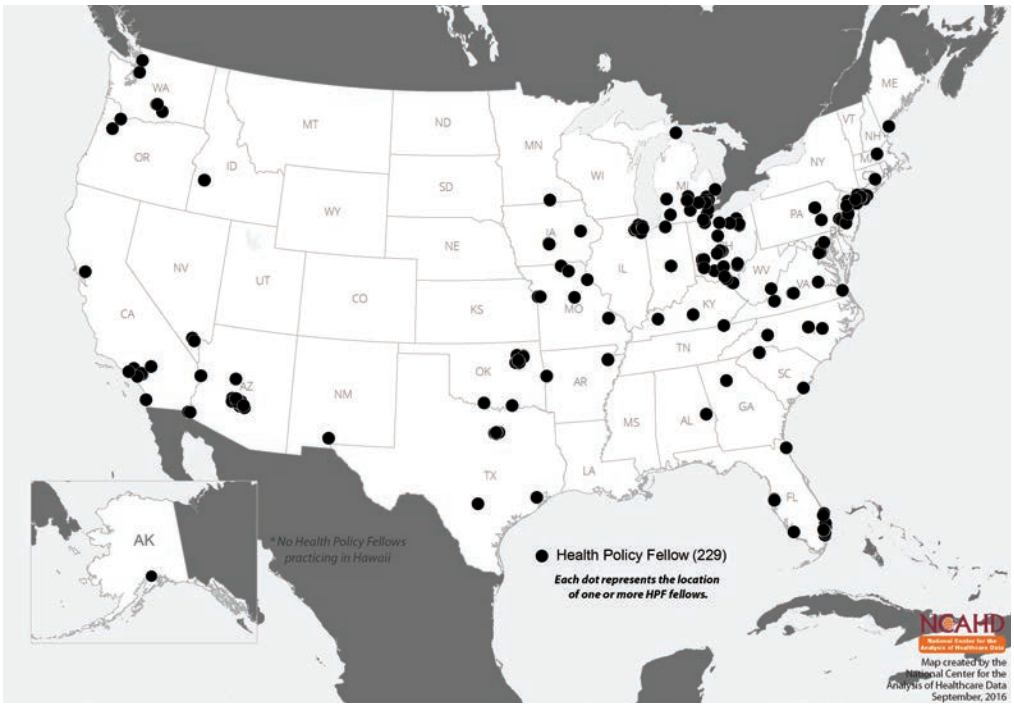

Figure.
National distribution of the current location of health policy fellows as of May 2016. Health Policy Fellowship (HPF) graduates currently work in 34 states and Washington, DC. This map was created by Ann K. Peton, PhD, from the National Center for the Analysis of Healthcare Data using data provided by Nancy Cooper, coordinator of the HPF.

Author Contributions

Both authors provided substantial contributions to conception and design, acquisition of data, and analysis and interpretation of data; both authors drafted the article or revised it critically for important intellectual content; both authors gave final approval of the version of the article to be published; and both authors agree to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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