AMERICAN OSTEOPATHIC ASSOCIATION

BASIC STANDARDS FOR RESIDENCY TRAINING IN OSTEOPATHIC FAMILY PRACTICE AND MANIPULATIVE TREATMENT

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I. INTRODUCTION

A. Definition

1.1 Residency training programs in Osteopathic Family Practice and Manipulative Treatment are designed to provide the osteopathic physician with advanced and concentrated training in the specialty of osteopathic family practice. These programs must be designed to meet the needs of the osteopathic medical school graduate desiring to be certified in Osteopathic Family Medicine and Manipulative Treatment. The osteopathic concept of health care emphasizes that the human body is a unit in which structure and function are mutually and reciprocally interdependent; that the body, through a complex equilibrium system, tends to be self-regulatory and self healing; that adequate function of body systems depends upon the unimpeded flow of blood and nerve impulses; that the musculoskeletal elements comprise a body system, whose importance far exceeds that of providing framework support; and that there are somatic components of disease that are not only manifestations of, but are also important contributing and/or maintaining factors in the diseased area as well as areas distant from the diseased part. Disease prevention is the cornerstone of osteopathic family practice and shall be given major emphasis throughout the curriculum.

a. These basic standards are approved by the American Osteopathic Association (AOA), and the American College of Osteopathic Family Physicians (ACOFP).

1.2 Upon the successful completion of a residency in osteopathic family practice and manipulative treatment, the physician will be prepared to provide comprehensive osteopathic health care to diverse populations.

B. Scope of Training

1.3 **Programs will offer** the osteopathic family practice resident with properly organized training, in both cognitive and procedural domains that will provide progressive primary responsibility for patient care in both the inpatient and outpatient setting within the context of a family environment. This shall occur through continuity of didactic and clinical experiences. The training in the application of osteopathic principles and practice is an integral part of all programs.

C. Training Requirements

1.4 All programs must be designed to provide training that meets the needs of those graduates who intend to become osteopathic family physicians. The presence of other programs sponsored by the institution, i.e., geriatric medicine and/or sports medicine, must not result in dilution of the experience available to the osteopathic family practice residents.

1.5 Osteopathic family practice residency training programs must be three years in length.

1.6 Individuals successfully completing specified portions of their osteopathic family practice residency as per Basic Standards can proceed to subspecialty training at institutions approved to offer these programs in association with an approved osteopathic family practice residency.

1.7 A residency training program shall commence after it has received the approval of the AOA Program and Trainee Review Council (PTRC).

II. INSTITUTIONAL REQUIREMENTS

A. Sponsoring Institutions

2.1 To be approved by the American Osteopathic Association for residency training in osteopathic family practice and manipulative therapy, an institution must meet at a minimum the requirements as formulated in the AOA Accreditation Document for Osteopathic Postdoctoral Training Institutions (OPTI) and The Basic Document for Postdoctoral Training Programs.

2.2 The institution must provide sufficient patient volume to properly train a minimum of six residents (two (2) per year) in osteopathic family practice. The available patients must provide a broad spectrum of problems, as defined in this document, for the adequate training of residents.

2.3 There must be a minimum of two OGME-1 approved positions dedicated to Family Practice

2.4 The institution's department of family medicine or its equivalent shall be directly responsible for the resident's training through the Program Director.

2.5 The sponsoring institution must require participation in the AOA Clinical Assessment Program (CAP) **or its equivalent**.

2.6 The sponsoring institution must maintain a participation rate of 90% in the AOBFP certification examination within a five-year period after completion of training. The rate will be calculated from the time of the previous inspection.

2.7 The sponsoring institution must maintain a 90% pass rate (five year rolling average) of the AOBFP certifying examination.

C. Appointment of Residents

2.8 The program must provide a written policy and procedures for the selection of residents **that meets all requirements as described in the *AOA Basic Documents*. In addition all appointed residents must:**

a. Have passed COMLEX II, including the clinical skills portion of this exam.

b. Be or become a member of the AOA and ACOFP. These memberships must be maintained throughout the residency training.

2.9 For appointment to advanced standing and other special circumstances see Appendix III.

D. Administration of the Educational Program

2.10 A maximum of twenty business days (Monday through Friday) **and** minimum of ten working days per **training** year of vacation, professional, sick or other leave may be granted by the Program Director, unless such leave is designated by federal, state, or union regulations. In such cases, federal, state and/or union regulations shall supersede these policies. No more than twenty business days of leave per **training** year may be granted for any purpose without extending the residency. If a resident is given a leave of absence for reasons of maternity, physical or mental disabilities and returns to duty, he/she may continue the training to completion for the required 156 weeks of training. The program shall have a written statement of policies regarding leave in the resident manual.

2.11 There shall be a resident manual, which will include, but not be limited to the following:

a. Educational goals and objectives for all core and/or regularly assigned rotations.

b. A set of rules and regulations stating resident duties and responsibilities, including hospital floor procedures and general orders.

c. Leave policies.

d. All financial arrangements including housing, meals and other benefits, as determined by the institution and described in the resident contract.

e. An outline of the content of the orientation program.

f. Outside work for pay is prohibited during OGME-1.

g. Membership in the AOA and ACOFP is required.

h. Policies governing evaluation and appeal mechanisms.

E. Resident Schedules and Workload

2.12 **Written policies must be in place at each program that demonstrates compliance with the requirements concerning resident work hours and outside employment as described in the *AOA Basic Documents*.**

2.13 The Program Director, with the concurrence of the Director of Medical Education, has the prerogative, for educational purposes, of granting a total of ninety days family medical leave for any academic year. This time must be made up on a day for day basis. Taking such a leave will not penalize the resident. In the event that more than ninety days family medical leave is required in one year, a new contract must be negotiated.

2.14 The Program Director and Director of Medical Education shall provide for the proper supervision and clinical teaching of all training assignments.

2.15 **The program must have a written moonlighting policy that meets the requirements of the *AOA Basic Documents*.** Criteria shall include:

a. The resident must be in good standing within the residency program.

b. All residency requirements, institutional requirements, logs, evaluations, and medical records must be up-to-date.

III. FACULTY QUALIFICATIONS AND RESPONSIBILITIES

A. Program Director

3.1 **Each program must have a separate and distinct program director. By July 1 2012, a minimum of 1000 hours per program year must be dedicated time to the residency and compensated by the institution. This dedicated time may include time spent in teaching, precepting, administration, and scholarship activities.**

B. Qualifications

3.2 The Program Director must be licensed to practice medicine in the state in which the training site is located.

3.3 The Program Director must be certified in Osteopathic Family Practice and Manipulative Treatment by the American Osteopathic Board of Family Physicians.

3.4 The Program Director must be a member in good standing of the American College of Osteopathic Family Physicians

3.5 The Program Director must be an active member of the department of family medicine or its equivalent, and engaged in patient care.

3.6 The Program Director shall have no less than three years of family practice experience (not including time as a resident), prior to becoming a Program Director.

3.7 A new Program Director of a residency with more than twelve approved slots shall fulfill one of the following:

a. Have served as Program Director of another residency for no less than three years.

b. Have served as **full-time faculty member** of a residency for no less than three years.

3.8 A new Program Director must be approved by the ACOFP Committee on Education and Evaluation.

3.9 Exceptions to the requirements for Program Director may be approved by an Ad Hoc Committee of the ACOFP Committee on Education and Evaluation.

3.10 **Program directors may be approved on an interim basis in geographic areas where a fully qualified program director is not immediately available. In these instances, standards 3.3, 3.4, and 3.6 may be temporarily suspended to allow recruitment of a permanent program director. All other requirements must be met in addition to the following:**

a. **Program directors, appointed on an interim basis, must meet the following minimal qualifications:**

i. **Current board certification from American Osteopathic Board of Family Physicians (AOBFP) or the American Board of Family Medicine (ABFM).**

ii. **Member in good standing of the American College of Osteopathic Family Physicians (ACOFP) or American Academy of Family physicians (AAFP).**

iii. **Minimum of 2 years of post residency practice experience.**

b. **Program directors, appointed on an interim basis, must be approved by the executive committee of the CEE.**

c. **Program directors, appointed on an interim basis, may be approved for a maximum of 18 months. If extenuating circumstances develop, the CEE may approve the interim program director for an additional 6 months.**

C. Responsibilities

3.11 The Program Director or physician designee must attend a Residency Directors' Workshop sponsored by the American College of Osteopathic Family Physicians every year in order to qualify the residency program for approval. Each Program Director must personally attend **once** every two years. Directors of new programs or new directors of on-going programs are required to attend the next available workshop, not to exceed one year from their appointment.

3.12 The Program director must have sole responsibility and authority for the educational content and conduct of the residency. The Program director's authority in directing the residency program must be defined in the program documents of the institution. The Program Director must fully implement the Basic Standards for Residency Training in Osteopathic Family Practice and Manipulative Treatment as outlined in this document.

3.13 The Program Director **shall** report annually by August 1 to the ACOFP Committee on Education and Evaluation. This report shall contain documentation of all residents in the program along with other information as specified on a form furnished by ACOFP.

3.14 The Program Director must verify that the resident demonstrates competency in meeting or exceeding the minimum standards for quality patient care utilizing the competency-based evaluation.

3.15 The Program Director must report to the ACOFP Committee on Education and Evaluation deficiencies in the residency or internal problems in the parent institution that could adversely affect the educational component of the residency.

3.16 The Program Director must devote a minimum of **400** hours per year to teaching and administrative activities exclusive of patient care.

3.17 The Program Director **shall** attend **a procedural workshop** every two years.

3.18 The Program Director must assume leadership for the coordination of inspections as required by the AOA.

D. **Family Physician Faculty**

3.19 The training program shall have faculty and administrative staff who are qualified by training and experience to teach osteopathic graduates. These professionals shall not only be competent medical practitioners, but they shall also be dedicated to the science and art of education.

3.20 **By July 1, 2012 all programs regardless of the number of residents must have a minimum of two family physician faculty members one of whom must be the program director.**

3.21 **There shall be at least one full-time equivalent family physician faculty for each six residents in the program. A faculty is considered full time based on time devoted to residency related activities (teaching, precepting, administration, scholarship). Any of the following methods may be utilized to determine full time faculty status:**

a. **5 half days/week**

b. **1000 hours/year**

c. **80 hours/month**

E. Qualifications

3.22 All faculty members must be licensed to practice medicine in the state in which the training site is located.

3.23 All family physician faculty members must be certified in family practice. The ACOFP Committee on Education and Evaluation will determine the acceptability of alternate qualifications.

3.24 The Supervisor of the continuity of care site of the osteopathic Family Practice residency must:

a. Be a member of the ACOFP.

b. Be certified by the American Osteopathic Board of Family Physicians.

c. Have been in active osteopathic Family Practice for at least **three** years, or a graduate of an ACOFP-approved osteopathic Family Practice residency program.

d. Be able to teach procedures incorporated in the specific continuity of care site.

e. The Supervisor of the continuity of care training site must have a reporting relationship to the program director.

3.25 The faculty shall consist of teachers with diverse interests and expertise to ensure the training responsibilities of the program are met. There must be a critical mass of family physician faculty to assure sufficient continuity of teaching and supervision. When part-time faculty is used, continuity of teaching and supervision must be maintained.

3.26 There must be family physician faculty with admitting privileges in the hospital(s) where the residents' patients are hospitalized.

3.27 The family physician faculty shall, as a group, be qualified to teach all of the required procedures as listed in Part Five: Program Requirements, Procedures of this document.

3.28 The family physician faculty must continue to commit specific time to patient care, independent of supervision of the residents, so that they can maintain their clinical skills and serve as a role model.

F. Faculty Research and Scholarly Activity

3.29 Graduate medical education must take place in an atmosphere of scholarly inquiry. Faculty **shall** participate in the development of new knowledge, and develop habits of inquiry as a continuing professional responsibility. Scholarship implies an in-depth understanding of the basic mechanisms of normal and abnormal states, and the application of this knowledge to clinical practice.

3.30 The faculty as a **group** must demonstrate involvement in **research and** scholarly activity. This activity may include:

a. Participation in clinical discussions and conferences.

b. Participation in national and regional professional societies, particularly through presentations and publications.

c. Participation in research, especially projects that are funded following peer review.

d. Provision of guidance and support to residents involved in research.

G. Other Faculty

3.31 Physicians from other specialties are an essential component of the faculty. These faculty members must spend sufficient time in teaching and supervising the residents to ensure the accomplishment of the program goals in their specialty area. This may be accomplished through direct supervision or serving as a consultant in the care of the resident's patients.

3.32 Additional teaching faculty/staff are encouraged, especially in the areas of behavioral science, nutrition, addiction and pharmacology.

3.33 All faculty members must have appropriate credentials in their respective field. The sponsoring institution shall have the responsibility of determining the acceptability of qualifications for all faculties.

IV. FACILITIES

A. Synopsis

4.1 All programs must provide the facilities required for the education of residents. These facilities must be geographically close enough to the primary training facility to permit efficient functioning of the educational program, or have the capacity to link facilities via live interactive video conferencing. The institution must assume the financial, technical and educational support necessary to the program.

B. Hospitals

4.2 Multiple hospital facilities may be utilized, provided there is no compromise in the quality of the educational program.

4.3 Cooperative affiliations with facilities within the OPTI are encouraged, where this will enhance the education of the resident.

4.4 The medical staff **shall** be organized so that family physicians participate in the hospital governance on an equivalent level to that of other specialties. There must be a clinical department or section of osteopathic family practice.

C. Ambulatory Continuity of Care Training Site

4.5 The primary setting for training in the knowledge, skills, and attitudes of osteopathic family practice is the model ambulatory office (continuity of care training site). It is here that the resident will learn to provide continuing, comprehensive care. This will be accomplished by being responsible for a panel of patients over the course of the training period.

4.6 Each program shall provide a minimum of one osteopathic family practice training site. Multiple sites will be approved only if the program shows adherence to all standards set forth in this document. This facility will help insure that each osteopathic family practice resident will receive an adequate continuity of care experience with a panel of patients and families over a thirty-six month continuum.

4.7 Each **continuity of care site shall** include a waiting area, examination rooms, consultation room, resident's office, a laboratory appropriate to office practice, and **electronic resources for** data retrieval system.

4.8 Diagnostic laboratory and imaging facilities **shall** be available as appropriate to the location of the site.

4.9 Each continuity of care site must have the capability to perform the following procedures at the time of the patient visit: glucose, throat culture or rapid strep screen, urinalysis, wet mount, EKG, spirometry, screening audiometry, and microscopic evaluation of urine.

4.10 Each continuity of care site must have the availability of minor surgery on site.

4.11 The economic aspect of the osteopathic family practice training site must be self-contained and patterned after that of a private practice. This includes, but is not limited to, appointments, statements, insurance form filings, etc. Data, specific to each resident, is to be used in the economics section of the residency.

4.12 Faculty and support staff must be available in appropriate numbers. There shall be a ratio of one faculty for every six osteopathic family practice residents in the program. Residents must not provide for patient care in an unsupervised setting.

4.13 Allied health professionals **shall** be part of the site's health provider team when appropriate to both facilitate patient care and familiarize the resident to their function in the delivery of primary care.

4.14 A professional medical records system must be maintained that provides for a quality assurance, quality improvement process. Chronic medication lists, problem lists, and prevention protocols **shall** be prominent and used to assist in continuity of care. The medical record system can be maintained in any manner that easily provides recognition of each resident's patient panel.

4.15 An ambulatory setting, providing primarily episodic care, cannot be used as a continuity of care site. Patient care visits at the continuity of care facility must be predominantly by appointment.

4.16 The continuity of care training site may be located in proximity with a multi specialty site provided the operations are separate. The osteopathic family practice residency continuity of care patient panel appointments must be made through the osteopathic family practice section. An appropriate mechanism must be in place to assure that a proportionate number of new patients are assigned to the osteopathic family practice resident panel.

D. Library Services

4.17 Residents must have ready access to a major medical library.

a. Electronic retrieval of information from medical databases must be available to residents at all affiliated facilities.

b. After hours availability of library services is essential.

E. Patient Population

4.18 The patient population served by the residency program facilities shall be diverse. This implies gender, cultural, and age diversity. The ability to provide care to these populations in the hospital, at home, in the continuity of care training site, and long term care facilities must be demonstrated.

4.19 A sufficient number of inpatients must be available to provide adequate training in all the specific component parts of the curriculum.

4.20 The disease spectrum available for the resident's education must demonstrate a broad range of problems and mirror that which is common to the community in general.

V. PROGRAM REQUIREMENTS

A. Core Competencies

5.1 The following Core Competencies shall be required of all residents to successfully complete a residency in osteopathic family practice and manipulative treatment. The following core competencies shall be completed. Each program shall be responsible for implementation

and documentation. The Competency-Based Evaluation (CBE) document shall be the instrument used by all programs to document achievement of these core competencies.

5.2 Osteopathic Philosophy and Osteopathic Manipulative Medicine

Required Elements

a. Demonstrate competency in the understanding and application of OMT appropriate to the medical specialty.

b. Integrate osteopathic concepts and OMT into the medical care provided to patients as appropriate.

c. Understand and integrate osteopathic principles and philosophy into all clinical and patient care activities.

5.3 Medical Knowledge

Required Elements

a. Demonstrate competency in the understanding and application of clinical medicine to patient care.

b. Know and apply the foundations of clinical and behavioral medicine appropriate to their discipline.

5.4 Patient Care

Required Elements

a. Gather accurate, essential information for all sources, including medical interviews, physical examinations, medical records, and diagnostic/ therapeutic plans and treatments.

b. Validate competency in the performance of diagnosis, treatment and procedures appropriate to the medical specialty.

c. Provide health care services consistent with osteopathic philosophy, including preventative medicine and health promotion that are based on current scientific evidence.

5.5 Interpersonal & Communication Skills

Required Elements

a. Demonstrate effectiveness in developing appropriate doctor-patient relationships.

b. Exhibit effective listening, written and oral communication skills in professional interactions with patients, families and other health professionals.

5.6 Professionalism

Required Elements

a. Demonstrate respect for patients and families and advocate for the primacy of patient's welfare and autonomy.

b. Adhere to ethical principles in the practice of medicine.

c. Demonstrate awareness and proper attention to issues of culture, religion, age, gender, sexual orientation, and mental and physical disabilities.

5.7 Practice-Based Learning and Improvement

Required Elements

a. Treat patients in a manner consistent with the most up-to-date information on diagnostic and therapeutic effectiveness.

b. Perform self-evaluations of clinical practice patterns and practice-based improvement activities using a systematic methodology.

c. Understand research methods, medical informatics, and the application of technology as applied to medicine.

5.8 Systems-Based Practice

Required Elements

a. Understand national and local health care delivery systems and how they impact patient care and professional practice.

b. Advocate for quality health care on behalf of patients and assist them in their interactions with the complexities of the medical system.

B. Synopsis

5.9 The osteopathic family practice faculty shall develop all educational experiences, with the assistance of other specialties as needed.

5.10 All required resident rotations must be educational in nature and properly supervised. Residents shall not be removed from rotations to perform unrelated institutional services.

5.11 Each individual program must have the required core curriculum as contained in this document. Specific curricular components may vary to allow each program to utilize local strengths. Weekly educational conferences must be a part of all core curriculums.

5.12 Any major change to an osteopathic family practice residency program must be approved in writing by the ACOFP Committee on Education and Evaluation prior to implementation. Requests for changes must include the educational impact of any request and documentation that the educational process will not be compromised by said change. Changes must be approved in advance. Major changes are defined as: a new Program Director or changes not consistent with these basic standards.

5.13 There shall exist in every osteopathic family practice residency training program a required and structured curriculum. This shall incorporate the educational objectives listed in these basic standards. Each phase of the curriculum shall be properly allocated as to time, either longitudinally or as an intensive experience of shorter duration.

5.14 The following "core" curriculum is required. In addition to this portion of the training, each program is to define those areas of instruction that are unique to that specific program.

5.15 Specific methods of teaching and evaluation with written objectives and goals for each portion of the curriculum shall exist.

5.16 The residency training shall be three years or thirty-six months in duration and shall meet all of the minimum basic requirements. During the residency training program, emphasis SHALL be placed on ambulatory and longitudinal comprehensive patient care, with a strong didactic component as an integral part of the program. The program **shall** encourage flexibility in meeting the needs of each resident.

5.17 Pilot or experimental programs and/or projects will be considered. Proposals must demonstrate equivalent training to the basic program as outlined in this document. All such proposals must be approved in advance by the ACOFP Committee on Education and Evaluation.

5.18 From the start of the OGME-1, the physician will have up to six years to complete the program requirements.

5.19 Rotations will not be completed on a weekend-only basis. Residents whose training is less than full-time will be included in the approved number of positions for the training site.

C. Principles of Osteopathic Family Practice

5.20 Family-oriented comprehensive care with demonstrated emphasis on continuity shall be an integral part of each curricular component. Residents must be taught to demonstrate and articulate osteopathic family practice concepts to patients and colleagues.

D. Continuity of Care

5.21 Each program shall instruct residents of the importance of the interrelationship among the physician, the patient, the patient's family, the community, and the health care system.

5.22 Learning continuity of care is not limited to the continuity of care site and the hospital. For those patients unable to visit the continuity of care site, appropriate assignment to resident panels will be made in order to provide the resident with experience in home care and care in long-term care facilities.

5.23 Each resident is expected to maintain continuity of responsibility for his/her patients when such patients require hospitalization or consultation with other health care providers. The resident must maintain active participation in the decisions involving the health of the patient.

E. Osteopathic Comprehensive Health Care

5.24 Recognizing the validity of the principles of osteopathic medicine, especially that of treating the whole person, each program will provide the opportunity for the resident to gain a thorough understanding of the role social, cultural, behavioral, spiritual, and biologic dimensions play in the health of the individual.

5.25 Structure and function are integrally related. With this relationship intact, the body has the capacity to maintain health. The resident shall be provided the opportunity to achieve competence in health maintenance and disease prevention, utilizing the principles promoted in the osteopathic philosophy.

5.26 Health promotion and disease prevention is a major responsibility of the family physician. Teaching this to residents is an essential part of each component of the curriculum. This shall be done through stressing health assessment, health education, preventive care, behavioral counseling, genetic counseling, the role of the family in the care of the patient (especially end of life care), aging, nutrition, and epidemiology of illness, as well as acute and chronic disease management.

5.27 Methods of record keeping that facilitate longitudinal, comprehensive, preventive care shall be utilized. The resident will be taught the importance of this as it relates to health promotion and quality of care assessment.

F. Component Sections of Core Curriculum

General Information

5.28 Recognizing that family physicians do the majority of their patient care in an ambulatory setting, the major portion of the training time must be spent providing comprehensive primary care for patients in that setting.

5.29 Flexibility in curriculum is desirable and necessary. A basic core exists to provide a comparable educational experience for all graduates of the program. The expected goal of osteopathic family practice education is to train a physician to manage the majority of the patients presenting to his/her office and to provide the opportunity to acquire the knowledge and behavioral skills to render continuing and comprehensive health care to those patients. This curriculum is designed as a general guide to concepts and skills that **shall** be acquired while in a residency. The curriculum assumes a three year integrated program, inclusive of an AOA-approved OGME-1 year. Other sequences of educational experiences may result in deficiencies that would have to be corrected in order to attain the level of experience listed. Each of the topics listed on the following pages must be included in every residency program.

5.30 For each component section of the curriculum, a set of basic competencies has been identified. These **shall** set the standard for the performance skills of all residents. These competencies can be found in the competency-based evaluation document.

G. Continuity of Care Training Site

Synopsis

5.31 The continuity of care training is separate and distinct from any other ambulatory training in the osteopathic family practice residency program. The continuity of care training requirement cannot be fulfilled by any discipline other than osteopathic family practice. The test of continuity of care is whether or not the same resident has seen the same patient each time the patient presents to the continuity of care site. This **shall** occur a majority of the

time, except in emergencies. Schedules **shall** be adjusted to accommodate this phase of the residency. It is the continuity of care training that has a defined time element.

5.32 The osteopathic family practice training site shall be the central focus for the osteopathic family practice resident's continuity of care experience. Osteopathic family practice is a comprehensive specialty that encompasses the total health care of the individual and the family. Physiological, emotional, cultural, economic, psychological and environmental factors as they relate to the disease process are considered.

H. Facility

5.33 For a given resident the continuity of care experience may be at no more than two sites if the residency program elects to use two sites, the resident may be assigned to both sites simultaneously or each site for twelve consecutive months during OGME-2 and OGME-3. During OGME-1, the continuity experience must be at the same continuity site. Each site must meet all the requirements for the continuity of care experience as outlined in these basic standards. Each site must be self-contained as to the required elements of patient care and education. With multiple sites, the sponsoring institution must have in place mechanisms to insure the required educational experiences at each site. Assignment of a resident to a single continuity of care site for the entire residency is the preferred method.

5.34 Osteopathic manipulative treatment will be integrated into the continuity of care experience and documented on the charts.

I. Patient Pool for Continuity of Care

5.35 The patient population of the continuity of care facility **shall** mirror that of the community as far as age, gender, ethnicity, and payer mix.

5.36 Each resident will be assigned a panel of designated patients. This panel will consist of a sufficient number of patients to assure adequate training. Each resident panel **shall** reflect the age, gender, and ethnicity and payer mix of the community. The residents **shall** be clearly identified as the health care provider for the panel. The resident will be responsible, under supervision, for the health care needs of their assigned panel of patients. A designated patient may be assigned to only one resident at a time. Patients assigned as part of a designated patient panel must have documented multiple visits to the facility. Each panel must reflect a variety of diagnosis compatible with the educational objectives of the residency. This **shall** consist of at least seventy-five percent of all problems and diagnosis seen at the continuity of care site and **shall** include somatic dysfunction. Throughout the training, the resident is responsible, under supervision, for the care of his/her patient panel. In addition to the base of patients, each resident will acquire new patients as these patients present to the osteopathic family practice center. As the skill and proficiency of the resident improves, an increasing daily patient load is expected. By the end of the training, the resident **shall** be able to manage an adequate number of patients to be successful in practice. It is anticipated that the patient volume will average six patients per half day at the beginning of the residency and at least ten patients per half day at the completion of the residency. This is of course variable depending on the complexity of the patients' problems. Patients will be assigned exclusively to faculty only after the needs of the residents are met.

J. Scheduling of Continuity of Care

5.37 The continuity of care assignment is the most important single feature of the residency. No rotation or discipline or other duties are to interfere with the intent or implementation of the continuity of care experience portion of the residency.

5.38 The first year resident will spend one-half day per week for the entire year in the continuity of care training site. The patients seen during this longitudinal experience will be the nucleus of the resident's panel of patients that he/she will follow during the remaining months of the residency. This experience **shall** be scheduled on the same day, Monday through Friday, throughout the year. In programs that have more than one continuity of care training site, each resident must complete this experience in the same facility so as to assure continuity of care training with the same patient population.

5.39 During years two and three the resident shall spend an average of three half days per week at the osteopathic family practice training site. There must be documented a minimum of three hundred twelve half days in the continuity of care experience during the final twenty-four months of the residency. This continuity of care experience is separate from other ambulatory care experiences.

5.40 Fifty-one percent or one hundred fifty-nine half days of the continuity of care experience **shall** be completed at the institution granting the residency certificate.

5.41 The sequence of the required three hundred twelve half days may be adjusted to accommodate the need to utilize outside rotations. However, in no instance will the duration of the continuity of care experience be less than eighteen months or seventy-two weeks.

Goals

5.42 To provide didactic and clinical learning experiences in an ambulatory setting to assure competence in treating patients in this aspect of osteopathic family practice.

5.43 To provide the opportunity for progressive responsibility in longitudinal patient care.

5.44 To provide instruction in outpatient procedures and ambulatory care practice.

Objectives

The resident will demonstrate competence in his/her ability to:

5.45 Deliver osteopathic care to patients in an ambulatory setting.

5.46 Manage effectively a normal caseload during a scheduled day.

5.47 Develop medical practice management skills.

5.48 Increase his/her expertise in:

a. Methods of referring patients.

b. Methods of counseling.

c. Providing patient education.

d. Delivery of osteopathic manipulative treatment.

e. Diagnosis and treatment of patients in all age groups.

f. Providing preventative measures for a varied patient population.

g. Diagnosing and managing medical and surgical problems.

5.49 Develop a thorough understanding of family oriented care.

5.50 Become familiar with the evaluation of industrial injury and criteria for returning to work.

5.51 Become familiar with the basic guidelines for reporting communicable diseases.

5.52 Become familiar with the use of community resources in total patient care.

5.53 Learn how to be a part of a health care team.

5.54 Demonstrate team leadership skills.

K. Hospital Care

Synopsis

5.55 Inpatient osteopathic family practice must be incorporated into the residency program. Residents are expected to participate in the inpatient care of their patients from the osteopathic family practice continuity of care training site. In the case where a defined inpatient osteopathic family practice unit exists, this can be utilized for part of this requirement. The residents **shall** care for hospitalized patients from their panel. The osteopathic family practice residents, who will be supervised by the osteopathic family practice faculty, will manage all patients from the continuity of care osteopathic family practice training site.

Goal

5.56 To provide didactic and clinical learning experiences in a hospital setting to assure competence in this aspect of osteopathic family practice.

Objectives

The resident will demonstrate competence in his/her ability to:

5.57 Manage hospitalized patients.

5.58 Appropriately seek consultation and participate in patient care with the consultant.

L. Osteopathic Principles and Practice

Synopsis

5.59 This component of the curriculum shall be taught in a longitudinal fashion in all patient care settings. This may be accomplished through didactic lectures, one-on-one tutorial instruction, direct application of osteopathic manipulative treatment or other appropriate formats.

5.60 The continuity of care training site is key to the development of good skills in osteopathic manipulative treatment. Appropriate supervision shall be provided so that the resident will

integrate these skills into the daily care of his/her patients. This shall be documented in the medical record.

Goals

5.61 To teach the resident, through didactic as well as clinical settings, the application of osteopathic principles and osteopathic manipulative treatment in all patient care settings.

5.62 To expose the resident to multiple treatment techniques so he/she may choose the most appropriate method of treating any patient.

Objectives

The resident will demonstrate competence in his/her ability to:

5.63 Describe the philosophy behind osteopathic manipulative treatment.

5.64 Describe the role of the musculoskeletal system in disease, including somato/visceral reflexes, alterations in body framework, and trauma.

5.65 Describe contraindications to osteopathic manipulative treatment.

5.66 Utilize multiple methods of treatment including, but not limited to, High-Velocity/Low Amplitude (HVLA), strain/counter strain, and muscle energy.

5.67 Demonstrate, as documented in the medical record, his/her use of osteopathic principles and osteopathic manipulative treatment in the continuity of care training site in an integrated fashion. It is understood that integration implies the use of OMT in such conditions as, (but not limited to) respiratory, cardiac, and gastrointestinal disorders, as well as musculoskeletal disorders.

M. Behavioral Science

Synopsis

5.68 Knowledge and skills in this area is a critical element in osteopathic family practice. These elements **shall** be acquired through a program that integrates these concepts with all disciplines throughout the resident's total educational experience. The continuity of care training site **shall** serve as the primary location for training in this area. Family physicians and psychologists, as well as others, may be involved in the teaching of this curricular component.

Goals

5.69 To provide training so the resident will be able to diagnose and manage the psychological component of disease.

5.70 To provide training so the resident will understand the importance of his/her own well-being and the prevention of impairment.

Objectives

The resident will demonstrate competency in his/her ability to:

5.71 Understand psychological growth and development.

5.72 Utilize appropriate interviewing skills.

5.73 Utilize appropriate counseling skills.

5.74 Diagnose and manage substance abuse.

5.75 Diagnose and manage eating disorders.

5.76 Diagnose and manage common psychiatric disorders.

5.77 Manage the emotional aspects of non-psychiatric disorders.

5.78 Recognize signs of family violence including abuse, and neglect.

5.79 Recognize the role of ethics in patient care.

5.80 Understand the importance of being sensitive to gender, age, race, and cultural differences within his/her patient population.

5.81 Demonstrate knowledge of psychopharmacology.

5.82 Demonstrate an understanding of situations that have the potential of leading to his/her impairment.

N. Practice Management

Synopsis

5.83 Health care in our society is undergoing significant dynamic changes that will impact the resident on completion of his/her training. In order to adequately prepare the resident for entry into the health care environment, experiences shall be provided to assist him/her in assuming a productive role in this complex environment.

5.84 Data from the resident's own continuity of care training site experience will be used to illustrate the basic economic principles of medical practice. This data will include timely statements indicating the volume of patients seen revenue generated per patient visit, gross charges, contractual adjustments, balance billing, overhead costs and prorated economic data. The program shall have a structured curriculum in aspects of personal and practice financial management education. This must include modules on debt consolidation, student loan repayment, retirement planning, and financial planning. A minimum of twenty hours of instruction shall be devoted to this area of the curriculum.

Goal

5.85 To provide the resident with didactic and practical experiences designed to prepare him/her for the economic aspect of medical practice.

Objectives

The resident will demonstrate competency in his/her ability to:

5.86 Enter into contractual arrangements with health care systems.

5.87 Understand issues of medical jurisprudence.

5.88 Understand community systems and agencies that enter into aspects of health care.

5.89 Understand risk management.

5.90 Understand principles of office management.

5.91 Understand the principles of reimbursement, and coding, including coding for osteopathic manipulative treatment.

5.92 Understand the differences of Group Practice vs. Private Practice vs. Employment as part of a hospital system.

Core Areas of Specialty

O. Emergency Medicine

Synopsis

5.93 Training in emergency medicine shall be a minimum of two months duration, including at least one month in the OGME-1 year. The training shall include both didactic and clinical experiences.

Goal

5.94 To provide the resident, didactic and clinical experiences in that will expand his/her knowledge and skills in the management of emergency medical and surgical problems.

Objectives

The resident will demonstrate competency in his/her ability to:

5.95 Triage emergency patients of all ages.

5.96 Stabilize and provide initial treatment for medical and surgical emergencies.

5.97 Evaluate and treat lacerations.

5.98 Evaluate sprains, strains, and other soft tissue injuries.

5.99 Evaluate, immobilize, and refer skeletal fractures as appropriate.

5.100 Provide emergency management for toxic ingestions.

5.101 Provide emergency management for substance abuse.

5.102 Provide emergency management for chest pain.

5.103 Provide emergency management for anaphylaxis.

5.104 Maintain certification in ACLS.

P. Internal Medicine

Synopsis

5.105 The minimum duration of this portion of the curriculum shall be twenty-four (24) weeks. A mix of hospital based and ambulatory experiences is required. Procedures appropriate to osteopathic family practice shall be emphasized. During the OGME-1 year there must be at least eight (8) weeks of general internal medicine experiences. There must be at least four (4) weeks of training in critical care medicine during the residency. An emphasis will be placed on the specific subspecialty areas listed below.

Goal

5.106 To provide the resident, through didactic and clinical experiences in outpatient and inpatient settings, educational experiences that will expand his/her knowledge and skills in the management of adult, medical diseases.

Objectives

The resident will demonstrate competency in his/her ability to:

5.107 Recognize those patients who should be managed in a hospital setting.

5.108 Manage patients in the hospital setting.

5.109 Manage hospitalized patients after discharge.

5.110 Seek specialty consultation when appropriate, and maintain direct responsibility for the management of the patient.

5.111 Perform specific medical procedures as outlined in the procedure section of these basic standards.

5.112 Understand and utilize appropriate pharmacologic interventions.

Q. Allergy and Immunology

Objectives

The resident will demonstrate competency in his/her ability to:

5.113 Understand the physiology of the allergic response.

5.114 Understand immunosuppression.

5.115 Understand the mechanism of desensitization.

5.116 Care for the allergic patient.

5.117 Understand the role of somatic dysfunction and the relationship of osteopathic principles and treatment on the immune system.

R. Cardiology

Objectives

The resident will demonstrate competency in his/her ability to:

5.118 Understand the variety of management strategies for cardiac disease.

5.119 Recognize symptoms of cardiac disease.

5.120 Understand the cardiac effects of pulmonary disease.

5.121 Understand cardiac manifestations of systemic diseases.

5.122 Understand the indications for open-heart surgery.

5.123 Understand the role of somatic dysfunction in cardiac disease.

5.124 Integrate osteopathic manipulative treatment into the management of patients with cardiac disease.

5.125 Perform a preoperative cardiac assessment.

S. Dermatology

Objectives

The resident will demonstrate competency in his/her ability to:

5.126 Recognize and manage common dermatological conditions.

5.127 Identify allergic etiologies of dermatologic lesions.

5.128 Know the indications for dermal biopsy.

5.129 Recognize dermatologic manifestations of systemic disease.

T. Endocrinology

Objectives

The resident will demonstrate competency in his/her ability to:

5.130 Diagnose and manage uncomplicated endocrine disorders.

5.131 Understand the indications for surgery in the management of endocrine disorders.

U. Gastroenterology

Objectives

The resident will demonstrate competency in his/her ability to:

5.132 Screen appropriately for colorectal cancer.

5.133 Understand the role of osteopathic principals and treatment in the diagnosis and management of gastrointestinal disease.

5.134 Understand the indications for surgery in gastrointestinal disease.

5.135 Manage uncomplicated diseases of the gastrointestinal system.

V. Hematology

Objectives

The resident will demonstrate competency in his/her ability to:

5.136 Manage common hematologic disorders.

5.137 Understand hematopoiesis.

5.138 Understand the diagnosis and management of coagulopathies.

W. Infectious Diseases

Objectives

The resident will demonstrate competency in his/her ability to:

5.139 Diagnose and manage common infectious diseases.

5.140 Understand the epidemiology of infectious diseases.

5.141 Appreciate the role of the health care team in the control of infectious disease.

5.142 Understand the role of the immune system in health and disease.

5.143 Understand the role of antibacterial, anti-fungal, and anti-viral agents in the management of infectious disease.

X. Nephrology

Objectives

The resident will demonstrate competency in his/her ability to:

5.144 Understand electrolyte and acid-base disturbances.

5.145 Understand the etiology and diagnosis of nephrotic diseases.

5.146 Diagnose and manage common medical disorders of the kidney.

5.147 Utilize pharmacologic agents appropriately in patients with renal disease.

Y. Neurology

Objectives

The resident will demonstrate competency in his/her ability to:

5.148 Diagnose and manage common disorders of the nervous system.

5.149 Understand the role osteopathic manipulation plays in the management of neurologic disorders.

Z. Oncology

Objectives

The resident will demonstrate competency in his/her ability to:

5.150 Screen for and diagnose common cancers.

5.151 Participate with the oncologist in the care of cancer patients.

5.152 Utilize a team approach for the care of cancer patients.

5.153 Utilize Hospice in the management of the terminally ill patient.

AA. Pulmonology

Objectives

The resident will demonstrate competency in his/her ability to:

5.154 Perform a preoperative pulmonary assessment.

5.155 Diagnose and manage common pulmonary diseases.

5.156 Understand the role of osteopathic manipulation in the treatment of pulmonary disease.

BB. Rheumatology

Objectives

The resident will demonstrate competency in his/her ability to:

5.157 Diagnose and manage common disorders of the musculoskeletal system.

5.158 Diagnose diffuse connective tissue disease.

5.159 Understand the role osteopathic manipulation plays in the management of patients with rheumatologic disease.

CC. Obstetrics/Gynecology

Synopsis

5.160 The minimum duration of this portion of the curriculum shall be twelve (12) weeks. This will be in addition to the routine care of patients in the continuity of care training site. Four (4) weeks must be completed during OGME-1.

Goal

5.161 To provide the resident, through didactic and clinical experiences in outpatient and inpatient settings, with educational experiences that will prepare him/her to manage obstetrical and gynecological care in a manner consistent with local and regional standards of care.

DD. Gynecology

5.162 The gynecological portion of this training experience **shall** include both ambulatory and in-hospital patient care. Procedures appropriate to the family physician **shall** be taught.

The resident will demonstrate competency in his/her ability to:

5.163 Diagnose and manage vaginitis.

5.164 Counsel patients appropriately prescribe contraception.

5.165 Manage abnormalities of the Pap smear.

5.166 Diagnose and initiate management of abnormal uterine bleeding.

5.167 Diagnose and initiate management of pelvic pain.

5.168 Counsel and advise patients regarding use or non-use of post-menopausal hormonal therapy.

5.169 Participate in pre-operative and post-operative care of gynecological disorders.

5.170 Integrate the use of osteopathic principles in the management of gynecological disorders.

5.171 Obtain appropriate consultation for selected gynecological abnormalities.

EE. Obstetrics

5.172 All residents must have training in the management of obstetrical patients. This **shall** involve prenatal care, delivery, and post-natal care. The program **shall** make available advance training for residents who desire to participate in family practice obstetrics.

The resident will demonstrate competence in his/her ability to:

5.173 Participate in uncomplicated vaginal delivery.

5.174 Provide surgical assistance during cesarean section delivery.

5.175 Recognize early signs and symptoms of fetal and/or maternal distress.

5.176 Recognize and initiate management for common medical problems in the obstetrical patient.

5.177 Diagnose and initiate management for first trimester pregnancy loss.

5.178 Diagnose and initiate management for ectopic pregnancy.

5.179 Diagnose and initiate evaluation for infertility.

5.180 Integrate the use of osteopathic principles in the management of obstetrical patients.

5.181 Management of lactation issues.

FF. Pediatrics and Adolescent Medicine

Synopsis

5.182 There shall be a structured educational experience consisting of a minimum of sixteen (16 weeks). Four (4) weeks shall be completed during OGME-1. The training must include neonatal medicine, as well as the care of the ambulatory or hospitalized patient between 2 and 16 years of age.

Goal

5.183 To provide the resident, through didactic and clinical experiences in outpatient and inpatient settings, with educational experiences that will expand his/her knowledge and skills in the management of pediatric and adolescent patients.

Objectives

The resident will demonstrate competency in his/her ability to:

5.184 Diagnose and manage pediatric problems encountered in family practice.

5.185 Manage pediatric emergencies.

5.186 Provide general care of the newborn in the hospital and office setting.

5.187 Provide well childcare up to and including adolescence.

GG. Surgery

Synopsis

5.188 The minimum duration of this portion of the curriculum shall be twenty (20) weeks with four (4) weeks of general surgery training in OGME-1. Emphasis will be placed on the ambulatory management of surgical problems in the specific subspecialty areas listed below. Procedures appropriate to osteopathic family practice shall be emphasized. Pre and post operative diagnosis and management will be stressed.

Goal

5.189 To provide the resident, through didactic and clinical experiences in outpatient and inpatient settings, educational experiences that will expand his/her knowledge and skills in the management of surgical diseases.

Objectives

The resident will demonstrate competency in his/her ability to:

5.190 Diagnose and manage surgical disorders and surgical emergencies.

5.191 Refer patients with surgical problems, in a timely and appropriate fashion, to the appropriate surgical specialist.

5.192 Assist the surgeon in the operating room.

5.193 Perform those specific surgical procedures that family physicians may be called on to perform.

5.194 Manage, in conjunction with the surgeon, the surgical patient during the preoperative and postoperative period.

5.195 Understand basic surgical principles, of asepsis, handling of tissue, and assisting in the operating room.

HH. General Surgery

Objectives

The resident will demonstrate competency in his/her ability to:

5.196 Recognize and manage, with the surgeon, conditions requiring surgical care.

5.197 Provide pre-hospital preparation of the elective surgical patient.

5.198 Integrate osteopathic principles and manipulative treatment in the management of surgical patients.

5.199 Perform specific surgical procedures as outlined in these basic standards.

II. Ophthalmology

Objectives

The resident will demonstrate competency in his/her ability to:

5.200 Diagnose and manage common ophthalmologic conditions that may present to the family physician's office.

5.201 Diagnose and manage corneal lesions

5.202 Remove a foreign body from the eye.

JJ. Orthopedics

Objectives

The resident will demonstrate competency in his/her ability to:

5.203 Diagnose and manage common orthopedic conditions that patients may present to the family physician's office.

5.204 Integrate osteopathic manipulative treatment into the management of orthopedic disorders.

KK. Otolaryngology

Objectives

The resident will demonstrate competency in his/her ability to:

5.205 Diagnose and manage common otolaryngologic conditions that may present to the family physician's office.

5.206 Integrate osteopathic principles and manipulative treatment into the management of disorders of the ear, nose, and throat.

LL. Urology

Objectives

The resident will demonstrate competency in his/her ability to:

5.207 Diagnose and manage common urologic conditions that may present to the family physician's office.

5.208 Integrate osteopathic principles and manipulative treatment into the management of urologic disorders.

MM. Community Medicine

Goal

5.209 To provide the resident, through didactic and clinical experiences in outpatient and inpatient settings, with educational experiences that will enhance his/her knowledge and skills in health promotion disease prevention, including appropriate strategies such as immunizations, healthful lifestyle changes, and other community related programs.

Objectives

The resident will demonstrate competency in his/her ability to:

5.210 Utilize community resources to assist in the management of patients.

5.211 Understand the role of local health departments in the management of patients.

5.212 Utilize evidence-based principles to determine appropriate strategies for care.

5.213 Identify modifiable risk factors for the prevention of disease.

5.214 Understand how physicians' personal behavior affects the patient's perception of them as a role model for responsibility in their own health.

5.215 Understand the importance of patient education in the area of injury prevention, especially motor vehicle accidents, accidents in the home, sports injuries, and domestic violence.

5.216 Understand the role of and utilize Hospice in the care of the dying patient.

5.217 Understand the importance of recognizing cultural diversity among the patient population and within the community.

NN. Geriatrics

Synopsis

5.218 There must be a structured curriculum to train the resident in the care of geriatric patients. Training shall take place at the continuity of care training site, hospital, long-term care facility, patient's home, geriatric assessment unit, or in any other site appropriate for the care of elderly individuals.

Goal

5.219 To provide the resident with didactic and clinical exposure to the care of elderly patients.

Objectives

The resident will demonstrate competency in his/her ability to:

5.220 Understand the physiologic changes that occur with aging.

5.221 Differentiate between normal age-related changes and disease pathology.

5.222 Recognize atypical presentations of diseases in elderly individuals.

5.223 Utilize basic geriatric assessment tools in clinical practice.

5.224 Assess and assign appropriate levels of long-term care for elderly persons.

5.225 Understand the differences among the continuum of care for elders.

5.226 Manage the elderly patient in various levels of care.

5.227 Understand the role of the family in the care of the elderly.

5.228 Perform a functional assessment of elderly.

5.229 Understand the role of a multidisciplinary team in the care of the elderly.

5.230 Access available community resources to care for frail and/or homebound elderly patients.

5.231 Utilize osteopathic manipulative treatment (with special attention to myofascial release, strain counter strain, and muscle energy) in the treatment of the elderly patient.

5.232 Understand the role of and utilize hospice in the care of the dying patient.

5.233 Understand the use of appropriate immunizations in the elderly patient

5.234 Understand the issue of self-determination including advanced directives.

5.235 Understand strategies to optimize quality of life.

5.236 Understand appropriate pain management in the elderly.

5.237 Understand pharmacokinetics in the elderly.

5.238 Recognize the importance of being an advocate for accessibility to health care for all elderly patients.

OO. Sports Medicine

Synopsis

5.239 Training in sports medicine shall include clinical and didactic experiences in pre-participation assessment, injury prevention, evaluation, management and rehabilitation related to athletic and recreational injuries.

Goal

5.240 To provide the resident, through didactic and clinical experiences in outpatient and inpatient settings, with educational experiences that will expand his/her knowledge and skills in the management of athletic and recreational injuries.

Objectives

The resident will demonstrate competency in his/her ability to:

5.241 Evaluate individuals for athletic participation clearance.

5.242 Manage uncomplicated injuries sustained in sports related activities.

PP. Diagnostic Imaging

Goal

5.243 To provide the resident, through didactic and clinical experiences, with an educational experience that will expand his/her knowledge and skills in the utilization and interpretation of appropriate imaging techniques.

Objective

The resident will demonstrate competency in his/her ability to:

5.244 Utilize appropriate studies to appropriately diagnose and manage common medical and surgical diseases.

QQ. Electives

Synopsis

5.245 There shall be a minimum of twenty (20) weeks and a maximum of twenty-eight (28) weeks of supervised electives available to all residents during the course of the residency. At least four (4) weeks must be completed during OGME-1, at least eight (8) weeks in OGME-2, and at least eight (8) weeks in OGME-3.

5.246 All electives must be approved by the Program Director in advance of the start of the rotation.

Goal

5.247 To provide the resident, through didactic and clinical experiences in outpatient and inpatient settings, with additional educational experiences that will enhance his/her training with experiences relevant to his/her plans for future practice.

Objectives

The resident will demonstrate competency in his/her ability to:

5.248 Complete elective rotations that will allow the resident to increase his/her competency in areas of special interest, which may include but not be limited to, administrative medicine, critical care, geriatrics, or sports medicine.

RR. Procedures

Synopsis

5.249 The residency program must ensure that each graduating resident competent in the performance of appropriate procedures.

Goal

5.250 To provide the resident, through observed clinical training, educational experiences that will prepare him/her to perform procedures that are necessary to provide comprehensive patient care.

Objectives

5.251 Mandatory Procedural Competence (Required Procedures)

The program must develop training and evaluation methodologies to document that each graduate is competent to perform the following procedures:

a. Incision and drainage of abscess
b. Biopsy of skin
c. Excision of subcutaneous lesions
d. Cryosurgery of skin
e. Curettage of skin lesion
f. Laceration repair
g. Injection of shoulder joint
h. Injection/aspiration of knee joint
i. Injection of sacroiliac joint
j. Endometrial biopsy
k. Office microscopy
l. Casting
m. EKG interpretation
n. Office spirometry
o. Toenail removal
p. Defibrillation
q. Removal of cerumen from ear canal
r. Insertion of urethral catheter
s. Endotraceal intubation

5.252 Optional Procedures

The program must offer residents exposure to the following procedures:

a. Vasectomy
b. Central line placement
c. Vaginal delivery
d. Episiotomy repair
e. Flexible sigmoidoscopy
f. Colonoscopy
g. Lumbar puncture
h. IUD insertion
i. Breast cyst aspiration
j. Epistaxis management (nasal packing/anterior cautery)
k. Trigger point injections
l. Allergy testing
m. Neonatal circumcision
n. Colposcopy with biopsy

SS. Research and Scholarly Activity Requirements

Synopsis

5.253 Each program shall provide opportunities for residents to participate in research or other scholarly activity. Instruction in critical evaluation of medical literature, including assessing study validity, must be provided.

5.254 The participation of each resident in an active research activity is required. Such research can be accomplished by participation in or completion of any of the following:

a. Resident research projects within the department of family medicine.

b. Institutional research programs in which the department of family medicine is actively involved.

c. Area-wide or multi-centered research projects involving the teaching institution and its department of family medicine.

d. Original paper on health care related topic.

e. Presentation at a state, regional, or national meeting.

f. Authoring a grant

Goal

5.255 To provide the resident with research opportunities that will provide an awareness of the basic principles of study design, performance, analysis, and reporting, as well as of the relevance of research to patient care.

Objectives

The resident will demonstrate competency in his/her ability to:

5.256 Understand the concepts of and principles behind evidence based medicine.

5.257 Critically evaluate medical literature and its applicability to clinical practice.

5.258 Participate in scholarly activities and convey findings to his/her peers.

VI. EVALUATION

A. Evaluation of Residents

6.1 There shall be ongoing evaluation of the knowledge and skills of each resident. This shall consist of evaluation of each resident at the time of application as well as in-service testing and periodic assessment of the resident's performance.

6.2 During the training program, the resident must:

a. Follow the schedule set forth by the Program Director and completes all assignments in a timely fashion.

b. Keep a log of each procedure performed.

c. Participate in the annual ACOFP In-Service Exam.

d. Residents must attend a minimum of one national ACOFP Scientific Seminar during OGME-2/OGME-3. This requirement can be met by the resident attending either the ACOFP Spring Scientific Seminar or the AOA/ACOFP Fall Scientific Seminar. If they

attend the Fall AOA Meeting the resident must register as an ACOFP member for the Fall Meeting to count towards this requirement.

6.3 At the completion of each rotation the resident shall be evaluated by the appropriate faculty. These evaluations shall be signed by the responsible faculty and the resident and reviewed by the Program Director. A copy of these evaluations shall be maintained on file at the program office.

6.4 The Program Director will meet with and review the performance of each resident quarterly to insure that educational objectives are being met.

6.5 Residents **shall** be advanced to positions of higher responsibility only on the basis of evidence of their satisfactory progressive professional growth.

6.6 All residents must have successfully completed COMLEX Part III in order to be advanced to OGME-3.

6.7 The program must maintain a permanent record of evaluation for each resident. This must be available to the resident, the ACOFP Committee on Education and Evaluation, the assigned inspector, and other authorized personnel.

6.8 The Program Director is responsible for a final evaluation for each resident who completes the program. This evaluation must include a review of the resident's performance during the final period of training and **shall** verify that the resident has demonstrated sufficient professional ability to practice competently and independently. This final evaluation shall be a part of the resident's permanent record maintained by the program. The Competency-Based Evaluation (CBE) document must be a part of this final evaluation. A copy of this final evaluation shall be placed on file at the central office of the ACOFP.

6.9 In cases of early termination of a resident contract, the Program Director shall provide the resident with documentation regarding which rotations, if any, were completed satisfactorily. The AOA Postdoctoral Division must be promptly notified and the terminated contract submitted to the AOA. A copy of this documentation shall be forwarded to and kept on file at the central office of the ACOFP.

B. Academic and Disciplinary Dismissals

6.10 The hospital and department must have clearly defined procedures for academic and disciplinary action. Academic dismissals result from failure to attain a proper level of scholarship or non-cognitive skills, including clinical abilities, interpersonal relations, and/or personal and professional characteristics. Institutional standards of conduct include such issues as cheating, plagiarism, falsifying records, stealing, alcohol and/or substance abuse, or any other inappropriate actions or activities.

6.11 In cases of academic dismissal, the hospital and department will inform residents, orally and in writing, of inadequacies and their effects on academic standing. The resident will be provided a specified period in which to implement specified actions required to resolve academic deficiencies. Following this period, if academic deficiencies persist, the resident may be placed on probation for a period of three to six months. The resident may be

dismissed following this period, if deficiencies remain and are judged to be irremediable. In accordance with institutional policy, the resident will be provided an opportunity to meet with appropriate program supervisors to appeal decisions regarding probation or dismissal. Legal counsel at hearings concerning academic issues will not be allowed to participate.

6.12 In cases of disciplinary infractions that are judged irremediable, the hospital and department will provide the resident with adequate notice, in writing, of specific ground(s) and the nature of the evidence on which the disciplinary action is based. The resident will be given an opportunity for a hearing in which the disciplinary authority will provide a fair opportunity for the resident's position, explanations and evidence. Finally, no disciplinary action will be taken on grounds, which are not supported by substantial evidence. The department and/or hospital intern training committee, or house staff education committee, or other appropriate committees will act as the disciplinary authority. Residents may be allowed counsel at hearings concerning disciplinary issues. Pending procedures on such disciplinary action, the hospital in its sole discretion may suspend the resident, when it is believed that such suspension is in the best interests of the hospital or of patient care.

6.13 Immediate dismissal without hearing will be allowed where patient or staff safety is judged by the Program Director to be at imminent risk.

C. Evaluation of Faculty

6.14 All teaching faculty must be evaluated annually. This **shall** include evaluation of teaching ability, clinical knowledge, attitudes, and communication skills. There **shall** be a mechanism for anonymous input by the residents.

D. Evaluation of Program

6.15 Each program must incorporate all elements of these basic standards. The educational effectiveness of a program must be evaluated in a systemic manner. This shall include regular self-evaluation within the context of the educational goals and objectives of the needs of the residents, teaching responsibilities of the faculty, the availability of administrative and financial support, and of the availability of health care resources within the community. This evaluation must examine the balance between education, research, and service. The teaching faculty must hold regular meetings to accomplish these reviews. At least one resident representative **shall** participate in these reviews, and written resident evaluations **shall** be utilized.

6.16 At the completion of each rotation, the resident shall evaluate the rotation. These evaluations shall be reviewed by the Program Director and remain on file at the institution.

6.17 The Program Director, in conjunction with the institution's department of osteopathic family practice or its equivalent shall evaluate the residency program annually.

E. Evaluation of Patient Care

6.18 There must be in place a mechanism to evaluate the care provided by the residents in both the inpatient and outpatient settings. There **shall** be evidence that this information is used to improve education and patient care.

F. Evaluation of Graduates

6.19 Each program shall maintain a system of evaluation of its graduates. Feedback on demographic and practice profiles, licensure and board certification, the graduates' perceptions of the relevancy of training to practice and ideas for improved training and new areas of interest shall be obtained. A suggested format is a survey after one year and every five years thereafter.

VII. EVALUATION OF PROGRAM BY THE ACOFP COMMITTEE ON EDUCATION AND EVALUATION

A. Synopsis

7.1 The ACOFP Committee on Education and Evaluation will evaluate each program at regular intervals. At the time of this evaluation, it will be determined the degree of compliance with these basic standards. One measure of quality shall be the performance of residents on the certifying examination of the American Board of Osteopathic Family Physicians.

7.2 The ACOFP Committee on Education and Evaluation will notify all residents in a program that receives a one year continuing approval. This does not include new programs or provisional approval.

B. Probationary Status

7.3 All probationary continuing program approvals and all programs denial actions by AOA PTRC must be copied to all program residents, the Program Director, the Director of Medical Education at the institution, the training institution, the sponsoring institution, and to the OPTI governing board. Programs are required to inform applicants and residents of probationary status.

7.4 A training program disapproval action occurring at AOA PTRC shall be effective on June 30, one year from the end of the academic year in which the AOA PTRC action occurs. AOA PTRC reserves the right to establish an earlier date of termination as appropriate.

7.5 All one year continuing program approvals shall be considered probationary status.

C. Withdrawal of Program Approval

7.6 Approval of a training program may be withdrawn if the program or the sponsoring institution fails to meet the following criteria:

7.7 Non-compliance with the approval requirements:

a. Refusal to undergo on-site inspection for program review.

b. Failure to supply requested documentation within thirty days of notification of deferral of action by the AOA PTRC.

c. Failure to follow directives associated with the approval process.

D. Delinquency of Payment

7.8 Programs judged to be delinquent in the payment of fees ninety days after the invoice date shall not be eligible for review, shall not be eligible to accept residents, and shall be notified by certified mail of the effective date of withdrawal of approval.

E. Program Lapse

7.9 Any residency that has been inactive for three successive years shall be declared lapsed by the AOA Department of Education and closed during the third year of inactivity. In the event that a program is declared lapsed, the institution will have to apply to the AOA, through its division of Postdoctoral Training, as a new program.

F. Failure to Participate in Match

7.10 Acceptance of osteopathic residents without participation in the AOA match:

a. Any institution with an AOA-approved osteopathic family practice residency program that selects residents but has not participated in that year's AOA match program will be placed on probation for one year and may not recruit potential residents during that probationary time

7.11 Substantive or continuing variance from these basic standards.

APPENDIX I

Guidelines for Retraining Non-Family Physician Specialists in Osteopathic Family Practice and Manipulative Treatment

A. There will be an opportunity for these physicians to receive more than the four (4) months of advanced standing, but not to exceed twelve (12) months. This would constitute one year of credit toward the three (3) year osteopathic family practice residency program. The request for advanced standing credit will be made by the resident, in conjunction with the Program Director to the ACOFP Committee on Education and Evaluation, which will take final action on the request.

B. A board certified specialist may receive credit for four (4) months in a primary discipline, two (2) months of ER, four (4) months of elective, etc., not to exceed twelve (12) months. The credit will be given if the physician has worked in these areas of expertise and has demonstrated enough evidence of meeting the Basic Standards.

C. The continuity of care portion of training is required. The physician may participate in the program on a part-time basis; however, the program must be completed within a four year time period.

D. For the allotment of residency slots, the program will provide slots according to the time spent by the physician. For example, a ½ time program will constitute ½ a resident slot, a ¼ time program will constitute ¼ resident slot, and a full-time program will constitute one resident slot. These residents must be included within the approved number of training positions for the training site.

E. These programs must take place in an already approved and fully accredited osteopathic family practice residency program. They must be equivalent to residency training as stated in the basic standards for residency training in osteopathic family practice and manipulative treatment.

F. The program may not be completed as a weekend-only rotation and it must be done in a continuous period.

APPENDIX II

Guidelines for Residency Completion Programs for AOA-Certified Family Physicians

A. These physicians may complete a third or second and third years of training on a flexible or alternative basis. The program must meet the requirements of the AOA/ACOFP Basic Standards for Residency Training in Osteopathic Family Practice and Manipulative Treatment. The physician will have up to four (4) years to complete the program. The program will take place at an institution within an approved and fully accredited residency in osteopathic family practice and manipulative treatment.

B. There will be an opportunity for these physicians to receive more than the four (4) months of advanced standing, but not to exceed twelve (12) months. The request for advanced standing credit will be made by the Program Director to the ACOFP Committee on Education and Evaluation, which will take final action on the request.

C. The training must qualify as residency training. The continuity of care portion will be required and the rotations will not be completed on a weekend-only basis. The program will be on at least ¼ time. The training site will allot either ¼ or ½ or one resident slot for the training physicians according to the amount of time spent in the program. These residents must be included within the approved number of positions for the training site.

D. It is recommended that all part-time programs be affiliated with a College of Osteopathic Medicine. Affiliation is an on-going academic interaction between the program and the college as it relates to organization and academic support of the program. The affiliation agreement must be in writing and approved by the ACOFP Committee on Education and Evaluation, and indicate specific responsibilities assigned to the college as included in the affiliation agreement.

E. The program will not be open to any physicians who have graduated from an osteopathic college after 1994.

F. Initial review of all flexible or alternative training program applications will be made by the ACOFP Committee on Education and Evaluation, which will make recommendation for final approval to the AOA PTRC. This approval by AOA PTRC must occur prior to the start of the program.

APPENDIX III
Guidelines for Advanced Placement

A. **Residents entering osteopathic family practice residency programs who have taken previous residency training in accredited osteopathic or allopathic residency programs may request advanced placement. The Program Director of the accepting program is responsible for reviewing previous training and comparing it to the training standards of this document. In no instance is the Program Director compelled to recommend advanced standing.**

B. **The Program Director shall forward requests for advanced standing to the ACOFP Committee on Education and Evaluation (CEE). The CEE shall report to the AOA PTRC all approvals for advanced placement WITHIN 60 DAYS OF RECEIPT.**

C. **The CEE will review all requests for advanced standing and will grant credit based on the following criteria:**

1. **A maximum of twelve (12) months (52 weeks) of advanced standing may be granted for AOA approved OGME-1 training.**

2. **For prior training in Osteopathic Family Practice, month-for-month credit for previous training may be awarded.**

3. **For prior training in any discipline other than Osteopathic Family Practice, the program director will evaluate completed rotations to determine if any are applicable to Osteopathic Family Practice. A maximum of six (6) months (24 weeks) of advanced standing, beyond an AOA-approved OGME-1 year, may be recommended for approval.**

4. **For prior training completed in Allopathic Family Medicine, AOA approval of the OGME-1 year is required. A maximum of twelve (12) months (52 weeks) may be granted beyond the OGME-1 year.**

D. **All transferring residents must complete the ambulatory continuity training requirements described in standards 5.40 and 5.41. The CEE may modify this requirement when a resident transfers due to a program closure.**

APPENDIX IV
ACOFP Requirements Under Which a Resident Can Achieve Program Completion

A. For residents completing or terminating an AOA-approved internship, ACOFP OGME-1 Special Emphasis Internship, or an approved equivalent in which the five core rotation requirements have been met:

1. The Program Director must submit the Final Resident's Report on the form provided by the ACOFP within thirty (30) days of the resident's program completion, or within thirty (30) days of the resident's termination from the program.

B. For residents completing an ACGME-approved internship and an AOA-approved family practice residency:

1. Approval of the ACGME internship must be obtained from the AOA PTRC.

2. Subsequent to that approval, the resident will be considered complete upon submission of the documents defined above for residents completing an AOA-approved internship.

C. If training requirements change during an individual resident's training program, the program director will require the resident to complete either:

1. All requirements in place at the beginning of residency training, or

2. All requirements in place at the time of residency graduation.