



AMERICAN OSTEOPATHIC ASSOCIATION

**BASIC STANDARDS FOR RESIDENCY
TRAINING IN INTEGRATED
OSTEOPATHIC FAMILY
PRACTICE/NEUROMUSCULOSKELETAL
MEDICINE**

**American Osteopathic Association
American College of Osteopathic Family Physicians
American Academy of Osteopathy**

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PART ONE: INTRODUCTION

Definition

- 1.1 These are the Basic Standards for Residency Training in Integrated Osteopathic Family Practice/Neuromusculoskeletal Medicine as approved by the American Osteopathic Association (AOA), the American College of Osteopathic Family Physicians (ACOFPP) and the American Academy of Osteopathy (AAO). These standards are designed to provide the qualified resident with advanced and concentrated training in Integrated Osteopathic Family Practice/Neuromusculoskeletal Medicine and to prepare the resident for examination for certification by the American Osteopathic Board of Family Practice (AOBFP) and the American Osteopathic Board of Neuromusculoskeletal Medicine (AOBNMM).
- 1.2 Residency training in Integrated Osteopathic Family Practice/Neuromusculoskeletal Medicine is designed to provide the osteopathic medical school graduate with advanced training in family practice with special attention to the structural aspects of body function and their role in all disease processes, along with those strategies prescribed or administered to enhance homeostasis within the body unit.
- 1.3 The osteopathic concept of health care emphasizes that the human body is a unit in which structure and function are mutually and reciprocally interrelated; 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 having effects in areas distant from the diseased part. Disease prevention is the cornerstone of Osteopathic Family Practice and shall be given major emphasis throughout the curriculum.
- 1.4 The integration of the knowledge and skills of Osteopathic Family Practice training, with the discipline of Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine, allows the Osteopathic physician to direct additional attention to the neuromusculoskeletal system and its interaction with the other body systems. Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine expands the knowledge and understanding of osteopathic principles and practice, and heightens osteopathic manipulative medicine skills, and integrates these into the management of pediatric, adolescent, adult and geriatric patients.
- 1.5 This Integrated Osteopathic Family Practice/Neuromusculoskeletal Medicine residency training **emphasizes** knowledge of anatomy, physiology, and pathology as they relate to all body systems in health and disease. Development of skills of visual, palpatory, and biomechanical evaluation techniques is used to improve physical assessment of body disturbances expressed in the neuromusculoskeletal and other fundamentally related systems. The residency integrates proficiency in neuromusculoskeletal diagnosis and

treatment into the full field of Osteopathic Family Practice including all patients with acute and chronic pain, and diseases in both inpatient and outpatient settings.

- 1.6 Throughout this document, the requirement for supervision by a physician board certified in Neuromusculoskeletal Medicine can be met by either a physician holding a certificate from the American Osteopathic Board of Neuromusculoskeletal Medicine (AOBNMM) or its predecessor, the American Osteopathic Board of Specialty Proficiency in Osteopathic Manipulative Medicine (AOBSPOMM).**

Purpose

- 1.6 To provide the resident an organized training program with progressive primary patient care responsibilities in a family practice environment through didactics and clinical experiences. This ensures the resident meets the requirements leading to certification in both Osteopathic Family Practice and Neuromusculoskeletal Medicine **and Osteopathic Manipulative Medicine.**
- 1.7 To provide the resident with a large diverse patient population with a broad variety of pathology in acute, longitudinal, inpatient and outpatient settings.
- 1.8 To develop the Family Practice knowledge base for diagnostic, management and procedural skills and the knowledge base and skills to recognize structural changes, and traumatic effects.
- 1.9 To develop the Neuromusculoskeletal Medicine knowledge base for diagnostic, management and procedural skills, and the understanding and skills to integrate osteopathic manipulative treatment into total osteopathic medical management of all disease processes.
- 1.10 Develop physicians qualified to teach basic osteopathic principles and their clinical applications, to implement these concepts and to integrate them into undergraduate and postgraduate clinical programs.

Training Requirements

- 1.11 Integrated Osteopathic Family Practice/Neuromusculoskeletal Medicine residency training program must be four years in length, with the first year consisting of an AOA-approved OGME-1 year. Refer to AOA Accreditation Document for Osteopathic Postdoctoral Training Institutions (OPTI) and the Basic Document for Postdoctoral Training Programs.**
- 1.12 A minimum of four NMM rotations shall occur in each of the OGME 2, 3 and 4 years.

Scope of Training

- 1.13 All programs must be designed to provide training that meets the needs of those graduates who intend to become osteopathic physicians trained in Integrated Osteopathic Family Practice/Neuromusculoskeletal Medicine. The presence of other programs sponsored by the residency, i.e. geriatric medicine and/or sports medicine, must not result in dilution of the experience available to Integrated Osteopathic Family Practice/Neuromusculoskeletal Medicine residents.

PART TWO: INSTITUTIONAL REQUIREMENTS

Sponsoring Institution

- 2.1 To be approved by the AOA for a residency in Integrated Osteopathic Family Practice/Neuromusculoskeletal Medicine, an institution must meet all 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 three (3) residents in Integrated Osteopathic Family Practice/Neuromusculoskeletal Medicine. The available patients must provide a broad spectrum of problems, as defined in this document, for the adequate training of residents.
- 2.3 The sponsoring institution must require participation in the AOA Clinical Assessment Program (CAP).
- 2.4 The sponsoring institution must maintain a participation rate in the AOBFP of 100% of its graduating residents.
- 2.5 The sponsoring institution must maintain an 85% pass rate of the AOBFP and AOBNMM three year rolling average.
- 2.6 Upon satisfactory completion of the training program, the institution **together with the OPTI** shall award the resident an appropriate certificate. The certificate shall confirm the fulfillment of the program requirements, starting and ending dates of the program and the name(s) of the training institution(s) and the program director(s).

Participating Institutions

- 2.7 To assure that all programs in Integrated Osteopathic Family Practice/Neuromusculoskeletal Medicine is committed to and capable of delivering uniquely osteopathic postdoctoral training, each program must be affiliated with an Osteopathic Postgraduate Training Institute (OPTI).

- 2.8 For specific details of OPTI standards, refer to the **AOA Accreditation Document for Osteopathic Postdoctoral Training Institutions (OPTI) and the Basic Document for Postdoctoral Training Programs.**
- 2.9 In addition to the Integrated Osteopathic Family Practice/Neuromusculoskeletal Medicine program, each institution will also have individual residency training programs in Osteopathic Family Practice and Neuromusculoskeletal Medicine. Specific exceptions to this requirement maybe granted by the ACOFP Committee on Education & Evaluation and the AAO Postdoctoral Standards and Evaluation Committee upon documentation of appropriate institutional structure to support this program.
- 2.10 Any institution participating in the training of residents must have a written affiliation agreement with the base institution.
- 2.11 The residency-training program shall commence only after it has received the recommendation of the **AOA Program and Trainee Review Council (PTRC).**

Appointment of Residents

- 2.12 The program must provide a written policy and procedures for the selection of residents.
- 2.13 In order to be accepted into an Integrated Osteopathic Family Practice/Neuromuscukoskeletal Medicine residency program, an applicant must:
- a. Have graduated from an AOA accredited college of osteopathic medicine.
 - b. Be or become a member of the AOA, ACOFP, and AAO. These memberships must be maintained throughout the residency training.
 - c. Be appropriately licensed in the state in which the training is conducted.
- 2.14 The institution shall execute a contract with each resident in accordance with the **AOA Accreditation Document for Osteopathic Postdoctoral Training Institutions (OPTI) and the Basic Document for Postdoctoral Training Programs.**
- 2.15 Each first year resident, shall receive a medical evaluation, as well as any routine laboratory studies as required by the institution. All required immunizations must be current.

Administration of the Educational Program

- 2.16 A **maximum** of twenty (20) working days per year of vacation, professional, sick or other leave maybe granted by the Program Director, unless such leave is designated by federal, state, or union regulation. In such cases, federal, state and/or union regulations shall supersede these policies. 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 208 weeks of training. The program shall have a written statement of policies regarding leave in the resident manual.

- 2.17 At the beginning of the residency-training program, there shall be a period devoted to the formal orientation of the resident to the administrative and professional organization of the program facilities available including laboratories, nursing, social services, risk management, quality assessment, dietetics, medical records, and pharmacy. Residents will be advised regarding the duties, professional ethics and conduct towards other members of the health care team.
- 2.18 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. Policies governing evaluation and appeal mechanisms.

Resident Schedules and Workload

- 2.19 Since scheduling, hours on duty, and physical stamina impact resident education and the quality of care delivered to patients by residents in training, the following standards are established to be compatible with a quality educational experience. Written policies must be in place at each program that demonstrates compliance with the requirements concerning resident workload and outside employment. Each program will follow the AOA Resident Work Hours and Supervision Policies (Appendix V). There shall be a faculty member assigned as back up to the resident during each on-call day.
- 2.20 The Program Director, with the concurrence of the Director of Medical Education (DME), 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.
- 2.21 The Program Director and DME shall provide for the proper supervision and clinical teaching of all training assignments.
- 2.22 Outside employment will not be allowed during OGME-1.
- 2.23 OGME-1 residents may participate in private, professional or clinical practice as it relates to the structured educational experience to which they are assigned. They shall not receive compensation for such activities.

- 2.24 Outside employment (moonlighting) by residents maybe done only with approval of the DME and Program Director(s) who shall assure no conflicts exist with the program requirements, 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.
 - c. Evidence of malpractice insurance provided to the program.
 - d. Any other criteria established by the institution, program, DME, Program Director or OPTI.
 - e. **Moonlighting hours must not cause the resident to violate the AOA trainee duty hours policy (Appendix 5).**

PART THREE: FACULTY QUALIFICATIONS AND RESPONSIBILITIES

Program Director(s)

Synopsis

- 3.1 Each Integrated Osteopathic Family Practice/Neuromusculoskeletal Medicine residency program must have a single Program Director certified by both the AOBFP and AOBNMM or AOBSPOMM, or two separate co-directors, one certified by each of the above certifying boards.
- 3.2 The Program Director(s) of the Integrated Osteopathic Family Practice/Neuromusculoskeletal Medicine residency program must be a compensated position(s).

Qualifications

- 3.3 The Program Director(s) must be licensed to practice medicine in the state in which the training site is located.
- 3.4 The Program Director(s) must be a member in good standing of the American College of Osteopathic Family Physicians and the American Academy of Osteopathy. Alternatively, co-directors **must** be members of their respective colleges.
- 3.5 The Program Director(s) must be an active member of a hospital's Department of Family Practice or its equivalent, **and a** Department of NMM or its equivalent, if available, and engaged in patient care.
- 3.6 The Program Director(s) must demonstrate experience and/or interest in the field of medical education as well as administrative ability and sufficient expertise to implement educational programs.

- 3.7 The Program Director(s) must meet the standards of the position as formulated in the **AOA Accreditation Document for Osteopathic Postdoctoral Training Institutions (OPTI) and the Basic Document for Postdoctoral Training Programs.**
- 3.8 The Program Director(s) shall have no less than three (3) years of family practice experience and/or NMM experience as appropriate (not including time as a resident), prior to becoming a Program Director.
- 3.9 A new Osteopathic Program Director of an integrated residency with more than eighteen (18) approved **positions** shall fulfill one of the following:
- a. Have served as Program Director of another residency for no less than three (3) years.
 - b. Have served as associate Program Director of a residency for no less than three (3) years.
 - c. A change in Family Practice Program Director must be reported to the ACOFP Committee on Education & Evaluation, **the AOA and the OPTI.**
 - d. A change in NMM Program Director must be reported to the AAO Postdoctoral Standards and Evaluation Committee, **the AOA and the OPTI.**
 - e. Exceptions to the requirements for Program Director maybe approved by an ad hoc committee of the ACOFP Committee on Education & Evaluation and/or the AAO Postdoctoral Standards and Evaluation Committee as appropriate.

Responsibilities

- 3.10 The Family Practice Program Director or physician designee must attend a residency director's 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 at least every two (2) 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.
- 3.11 The NMM director shall attend a residency director's workshop or an equivalent educational program sponsored by the American Academy of Osteopathy.
- 3.12 The Program Director(s) 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(s) must fully implement the basic standards for residency training in Integrated Osteopathic Family Practice/Neuromusculoskeletal Medicine as outlined in this document.

- 3.13 The Program Director(s) shall provide for the proper supervision and clinical teaching of all training assignments in the continuity of care clinic. Supervision presupposes interactive dialogue with the resident concerning the patient's symptoms, examination, differential diagnosis, testing needed, and treatment plan. Continuity of the faculty is to be encouraged.
- 3.14 The Program Director(s)/DME shall arrange for residency training within the institution in cooperation with allied departments and assure the arrangement of affiliations and/or outside rotations necessary to meet the program objectives.
- 3.15 The Program Director(s) will maintain the ratio of qualified FTE supervisors to the total number of residents in the program at a minimum of 1:6.
- 3.16 The Program Director(s) shall, in cooperation with the AOA Department of Education, prepare required materials for inspection in advance of each inspection, and be available for the scheduled review. The Program Director(s) must assume leadership for coordinator of inspections as required by the AOA.
- 3.17 The Program Director(s) shall provide each resident with a resident manual, which shall contain all documents pertaining to the training program as well as the requirements for the satisfactory completion of the program.
- 3.18 The Program Director(s) must report annually to the ACOFP Committee on Education & Evaluation. This report shall contain documentation of all residents in the program along with other information as specified on a form furnished by ACOFP. The Program Director(s) will also submit quarterly reports to the **DME** of the institution.
- 3.19 The Program Director(s) must report annually to the Postdoctoral Standards Committee of the American Academy of Osteopathy. This report shall contain documentation of all residents in the program along with other information as specified on a form furnished by the AAO. The Program Director(s) will also submit quarterly reports to the director of medical education of the institution.
- 3.20 The Program Director(s) will insure all residents take the certification exam of both AOBFP and AOBNMM.
- 3.21 The Program Director(s) must verify that the resident demonstrates proficiency in meeting or exceeding the minimum standards for quality patient care utilizing the competency based evaluations and other required forms and patient logs. The Program Director(s), with the director of medical education, must verify the accuracy of the resident competency based evaluations forms and/or logs.
- 3.22 The Program Director(s) must report to the ACOFP Committee on Education & Evaluation and to the AAO Postdoctoral Standards and Evaluation Committee, deficiencies in the residency or internal problems in the parent institution that could adversely affect the educational component of the residency.

- 3.23 The Program Director(s) must devote a minimum of four hundred hours per year to teaching and administrative activities exclusive of patient care.

Director of Medical Education (DME)

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

- 3.25 There shall be an osteopathic DME appointed at each institution. Refer to Section 2.17-2.21 of the AOA “Accreditation Document for Osteopathic Postdoctoral Training Institutions” (OPTI) and the “Basic Document for Postdoctoral Training.”**

Faculty

Synopsis

- 3.26 There must be at least one full-time equivalent (FTE) family practice faculty for each six residents in the program. All programs regardless of the number of residents must have a minimum of two family practice faculties including the Program Director.
- 3.27 There must be at least one FTE NMM faculty for each six residents in the program. All programs regardless of the number of residents must have a minimum of two NMM faculties including the Program Director.

Qualifications

- 3.28 All faculty **members** must be licensed to practice medicine in the state in which the training site is located.
- 3.29 All family practice faculty **members** must be certified in family practice. The Committee on Education & Evaluation will determine the acceptability of alternate qualifications.
- 3.30 All NMM faculty **members** must be certified by the AOBNMM or AOBSPOMM. The AAO Postdoctoral Standards and Evaluation Committee will determine the acceptability of alternate qualifications.
- 3.31 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 six 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.
- 3.32 The supervisor of the NMM continuity of care portion of the residency must:
- a. Be a member of the AOA and AAO.
 - b. Have been in active NMM practice for at least three (3) years, or a graduate of one of the AAO-approved Neuromusculoskeletal Medicine residency programs.
 - c. Be certified by the AOBNMM or AOBSPOMM.
 - d. Be able to teach procedures incorporated in the specific continuity of care site.
- 3.33 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 faculty to assure sufficient continuity of teaching and supervision. When part-time faculty are used, continuity of teaching and supervision must be maintained.
- 3.34 There must be family practice faculty with admitting privileges in the hospital(s) where the residents' patients are hospitalized.
- 3.35 There must be NMM faculty with hospital privileges available to supervise inpatient NMM care.

Responsibility

- 3.36 The 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.

Faculty Research and Scholarly Activity

- 3.37 Graduate medical education must take place in an atmosphere of scholarly inquiry. Faculty should 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 state, and the application of this knowledge to clinical practice.
- 3.38 All members of the teaching faculty need not participate in clinical research, or other investigative activities. The faculty as a whole must demonstrate involvement in 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.

Other Faculty

- 3.39 Physicians from other specialties are an essential component of the faculty. These faculty **members** must spend sufficient time in teaching and supervising their 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.
- 3.40 Additional teaching faculty/staff are encouraged, especially in the areas of behavioral science, nutrition, addiction and pharmacology.
- 3.41 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 faculty **members**.

Institutional Educational Officer

- 3.42 The sponsoring institution may appoint an **Institutional Educational Officer** who is the institutional representative responsible for the coordination of all programs, and must notify the AOA on such appointment. The sponsoring institution must inform the AOA's Division of Postdoctoral Training **and the OPTI** of any changes in this position.
- 3.43 This person shall report to the DME of the sponsoring institution.
- 3.44 In no instance shall this person have any direct responsibility in the supervision of the educational aspects of the program.

PART FOUR: FACILITIES

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.

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 There must be a clinical department or section, which includes Osteopathic Family Practice and NMM physicians.

Ambulatory Continuity of Care Training Site

- 4.5 The primary setting for training in the knowledge, skills, and attitudes of Integrated Osteopathic Family Practice/Neuromusculoskeletal Medicine is the model ambulatory office (continuity of care training site). Here the resident will learn to provide continuing comprehensive care by being responsible for a panel of patients over the training period.
- 4.6 Each program shall provide a minimum of one Osteopathic Family Practice training site. All sites shall adhere to all standards set forth in this document. This facility will insure each FP/NMM resident receives adequate continuity of care experience through a panel of patients over a forty-eight (48) month continuum. During OGME-1 year, the continuity of care requirement may be satisfied through the Family Practice **continuity** component.
- 4.7 Each facility should include a waiting area, examination rooms, consultation room, resident's work area, a laboratory appropriate to office practice, and an adequate library with an electronic data retrieval system.
- 4.8 Diagnostic laboratory and imaging facilities should be located as appropriate for the site.
- 4.9 Clinic facilities should have access to imaging studies and appropriate viewing equipment.
- 4.10 Adequate treatment table(s) appropriate for teaching and practicing osteopathic manipulative **treatment** will be available.
- 4.11 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, hanging drop, EKG, spirometry, screening audiometry, and microscopic evaluation of urine.
- 4.12 **Each continuity of care site must have the availability of minor surgery on site.**
- 4.13 The economic aspect of the training site must be self contained and patterned after 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 training of the residency.

- 4.14 Faculty shall be available who are competent in the application and integration of **osteopathic Family Practice and NMM** in ambulatory care. Residents should not provide patient care in an unsupervised setting.
- 4.15 Allied health professionals should be part of the site's health provider team when appropriate to facilitate patient care and familiarize the resident to their function in the delivery of primary care.
- 4.16 A professional medical records system must be maintained which allows for quality assurance and quality improvement activities. Chronic medication lists, problem lists, and prevention protocols should be prominent and used to assist in continuity of care. The medical record system shall easily provide recognition of each resident's patient panel.
- 4.17 **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.
- 4.18 The continuity of care training site **may be** located in proximity to a multi-specialty site provided the operations are separate. An appropriate mechanism must be in place to assure a proportionate number of new patients are assigned to the Osteopathic Family Practice resident panel **and the Neuromusculoskeletal Medicine resident panel.**
- 4.19 Residents must have access to physical therapy equipment during that portion of the program addressing physical medicine and rehabilitation activities and integration into a treatment program.

Library Services

- 4.20 The institution shall maintain a medical library containing texts, the latest medical journals and other publications pertaining to Family Practice, and Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine. Internet access and a virtual library may meet this requirement.
- 4.21 The library shall be in the charge of a qualified person who shall act as custodian of its contents, arrange for cataloging and indexing and facilitate literature searches by the resident.
- 4.22 Electronic retrieval of information from medical databases must be available to residents at all affiliated facilities.
- 4.23 After hours, availability of library services is essential.

PART FIVE: PROGRAM REQUIREMENTS

Core Competencies

5.1 The following core competencies shall be required of all residents to successfully complete a residency integrated osteopathic family practice/ neuromusculoskeletal medicine. The following core competencies should 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.

Synopsis

- 5.9 The Integrated Osteopathic Family Practice/Neuromusculoskeletal Medicine 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 **The ACOFP Committee on Education & Evaluation and the AAO Postdoctoral Standards and Evaluation Committee must approve any major change to an osteopathic Integrated Family Practice/Neuromusculoskeletal Medicine residency program in writing 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 Integrated Osteopathic Family Practice/Neuromusculoskeletal Medicine 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 Specific methods of teaching and evaluation with written objectives and goals for each portion of the curriculum shall exist.
- 5.15 The residency training shall be four (4) years or forty-eight (48) months in duration and shall meet all of the minimum basic requirements. During the residency training program, emphasis should be placed on ambulatory and longitudinal comprehensive patient care, with a strong didactic component as an integral part of the program. The program should encourage flexibility in meeting the needs of each resident. Twelve (12) months (13 four-week blocks) of training specific to Neuromusculoskeletal Medicine must be completed. A minimum of four NMM rotations shall occur in each of the OGME-2, OGME-3 and OGME-4 years. In addition to **three** consultative NMM services, three NMM selectives are required. Any remaining NMM rotations may be selectives determined by the Program Director(s) or electives approved by the Program Director(s).
- 5.16 Pilot or experimental programs and/or projects may be considered. Proposals must demonstrate equivalent training to the basic program as outlined in this document. **The ACOFP Committee on Education & Evaluation and the AAO Postdoctoral Standards and Evaluation Committee must approve all such proposals in advance.**

Continuity of Care Clinics

- 5.17 Continuity of care clinics shall take place with both Family Practice and Neuromusculoskeletal Medicine and shall be **supervised** by appropriately certified faculty. Osteopathic principles shall be integrated within the care of the residents family practice panel of patients and consideration of all aspects of the patients health will be include in the care of the patients seen on a consultative basis in NMM.
- 5.18 Ideally, clinics would combine family practice and neuromusculoskeletal medicine with **supervisors** who are board certified in both disciplines. Each program may use separate or combined family practice and neuromusculoskeletal medicine clinics in a way that optimizes the use of its faculty and resident experience.
- 5.19 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.
- 5.20 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.
- 5.21 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.
- 5.22 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.
- 5.23 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.
- 5.24 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.

Component Sections of Core Curriculum

General Information

- 5.25 Recognizing that physicians certified in Family Practice and NMM practice in a variety of settings, including ambulatory, hospital care and consultation, and/or academic, the resident should spend time in a variety of clinical settings. While 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 this residency program 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, which should be acquired while in a residency. It provides an in-depth understanding of Neuromusculoskeletal Medicine's integration in to the diagnosis and treatment of all medical and surgical problems. The curriculum assumes a four (4) 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. For some component sections of the curriculum, a set of basic competencies has been identified. These should set the standard for the performance skills of all residents. These competencies can be found in the Competency-Based Evaluation (CBE) document.

Continuity of Care Training

Synopsis

- 5.26 The "core" of the residency program curriculum is its longitudinal or continuity of care component. The continuity of care training is separate and distinct from any other ambulatory training in the residency program. The continuity of care training requirement cannot be fulfilled by any disciplines other than Osteopathic Family Practice and Neuromusculoskeletal Medicine. 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 should occur a majority of the time, except in emergencies. Rotation schedules shall be adjusted to accommodate this component of the residency. The continuity of care training has the defined time element.
- 5.27 The residency program training site(s) shall be the central focus for the resident's continuity of care experience. Integrated Osteopathic Family Practice/Neuromusculoskeletal Medicine is a comprehensive specialty-training program 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.

Facilities

- 5.28 For a given resident, the Family Practice 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 **at least twelve** consecutive months during OGME-2, OGME-3 and OGME-4. During OGME-1, the continuity experience must be at the same continuity site.
- 5.29 Osteopathic manipulative treatment will be integrated into all continuity of care experience and documented on the charts.
- 5.30 Each FP and NMM 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.
- 5.31 The NMM continuity of care experience may be completed at no more than two sites. If multiple sites are utilized, each site would be utilized for at least twelve consecutive months.

Patient Pool for Continuity of Care

- 5.32 The patient population of the continuity of care facilities should mirror that of the community as far as age, gender, ethnicity, and payer mix.
- 5.33 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 should reflect the age; gender, ethnicity and payer mix of the community. The residents should 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 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 should consist of at least seventy-five percent of all problems and diagnosis seen at the continuity of care site and should 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 should be able to manage an adequate number of patients to be successful in practice. It is anticipated that the patient volume will average 6 patients per half day at the beginning of the residency and at least 10 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.

- 5.34 Residents will have a separate and identifiable patient panel in NMM that met the same requirements as detailed above. In all cases, the continuity of care training shall provide the resident with:
- a. Progressive responsibility in longitudinal patient care.
 - b. Conceptual and practical development of diagnostic and treatment skills in Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine.
 - c. An introduction to and progressive responsibility for preventive health care delivery.
 - d. Knowledge of community and rehabilitative resources in total patient care.
 - e. May follow NMM patients into Family Practice continuity of care clinic.
 - f. Patient volume should gradually increase to be consistent with a typical practice by the completion of the residency.

Scheduling of Continuity of Care

- 5.35 The continuity of care assignments is the most important 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.
- 5.36 The first year resident will spend one-half day per week for the entire year in the Family Practice 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. 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.
- 5.37 During years two, three and four, the resident shall spend an average of three half days per week at the residency program's Family Practice training site. For these years the resident will spend a minimum one half day per week in the residency program's NMM training site. **There must be documented a minimum of 468 half days in the total continuity of care experience, approximately 312 being in osteopathic Family Practice and 156 in Neuromusculoskeletal Medicine during the final 36 months of the residency.** This continuity of care experience is separate from other ambulatory care experiences.
- 5.38 Fifty one percent of the continuity of care experience should be completed at the institution granting the residency certificate (FP 159 days and NMM 80 days).
- 5.39 The sequence of the required half days maybe 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 27 months or 118 weeks.

Goals

- 5.40 To provide didactic and clinical learning experiences in an ambulatory setting to assure competence in treating patients in this aspect of Integrated Osteopathic Family Practice and Neuromusculoskeletal Medicine.
- 5.41 To provide the opportunity for progressive responsibility in longitudinal patient care.
- 5.42 To provide instruction in outpatient procedures, ambulatory care practice and NMM.

Objectives

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

- 5.43 Deliver osteopathic care to patients in an ambulatory setting.
- 5.44 Manage effectively a normal caseload during a scheduled day.
- 5.45 Develop medical practice management skills.
- 5.46 Increase his/her expertise in:
 - a. Methods of referring patients and collaborating with physicians who are referring for NMM specialty care.
 - 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.
- 5.47 Develop a thorough understanding of family oriented care.
- 5.48 Become familiar with the evaluation of industrial injury and criteria for returning to work.
- 5.49 Become familiar with the basic guidelines for reporting communicable diseases.
- 5.50 Become familiar with the use of community resources in total patient care, including social work, physical and occupational therapy, psychological counseling, and make appropriate referrals.
- 5.51 Learn how to be a part of a health care team.
- 5.52 Demonstrate team leadership skills.

Hospital Care

Synopsis

- 5.53 Residency training must include inpatient training in both Osteopathic Family Practice and NMM at a consultation level of care. The 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 should care for hospitalized patients from their panel. **The 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.**
- 5.54 The residents will participate in an inpatient NMM consultation service. This requirement maybe met by a minimum of three dedicated months on an NMM inpatient consultation service or the participation in a minimum of one hundred NMM consults on medical, surgical, pediatrics and Ob/Gyn patients.
- 5.55 Follow-up hospital care should be given to those patients on whom consultations are performed. Inpatient osteopathic manipulative treatment must be given under the supervision of a physician board certified in Neuromusculoskeletal Medicine. There must be direct interaction with the attending physician who is providing primary care to the patient, and who will supervise discussion of the physical exam, differential diagnosis, and medical or surgical management of the patient. Consultation and inpatient care should be performed on patients with a broad variety of diagnoses compatible with the educational objectives of the program. The osteopathic manipulative treatment provided must be designed to produce a physiological change in the patient that will impact the course of the illness. It is insufficient to treat only the musculoskeletal complaints in medically ill patients. The resident should participate in all phases of the consultation, including patient evaluation, management including the delivery of osteopathic manipulative treatment, and writing of the consultation and follow-up notes.

Goals and Objectives

- 5.56 To provide didactic and clinical learning experiences in a hospital setting to assure competence in this aspect of Osteopathic Family Practice and Neuromusculoskeletal Medicine.
- 5.57 Learn how to interact as both a primary care physician and a consultant with the hospital staff.
- 5.58 Develop the knowledge base to design osteopathic manipulative treatment plans to produce a physiological change in the hospitalized patient with a broad variety of medical and surgical problems.
- 5.59 Develop the diagnostic and palpatory skills necessary to contribute to the overall work-up of the patient with difficult diagnoses.

- 5.60 The consulting aspect of the program, refines the skill of physical diagnosis and differential diagnosis in patients on whom consultation is performed, understand the appropriate medical and surgical management of patients on whom consultation is performed, and learn to write a clear consultation report describing the findings and treatment recommendations.
- 5.61 By the end of the program, the resident should have developed the skills necessary to provide comprehensive osteopathic care to the hospitalized patient, as both an admitting/managing physician as well as a consultant in Neuromusculoskeletal Medicine.

Academic Training

Synopsis

- 5.62 An important goal of residency training in Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine is to train physicians who are qualified to be faculty at undergraduate and post-graduate teaching institutions. The residents must receive training in both lecturing and hands-on training. This training may occur at osteopathic colleges in undergraduate OPP and NMM departments, or in hospitals training osteopathic interns, residents, and third and fourth year medical students. Ideally, this aspect of training will include teaching experience in both large and small group settings.

Educational Goals

- 5.63 Learn lecturing skills to be able to prepare and deliver lectures on osteopathic concepts to undergraduate and postgraduate osteopathic medical students in large and small group settings.
- 5.64 Develop skills in multiple forms of lecture media (e.g., slides, PowerPoint, etc.).
- 5.65 Develop palpatory skills to provide hands-on training in osteopathic diagnosis and treatment.
- 5.66 Develop communication skills necessary to interact effectively with undergraduate and postgraduate students.
- 5.67 Develop the skills necessary to participate in research in the science of osteopathic medicine.

Plan

- 5.68 The resident will work with faculty in osteopathic colleges and osteopathic hospitals to learn lecturing skills. They will begin as assistant laboratory trainers learning the art and developing the palpatory and teaching skills necessary for hands-on teaching. As the knowledge and skills of the resident progress, they will deliver lectures and work independently as a trainer under the supervision of faculty members. By the completion

of the residency program, the resident will be qualified to serve as faculty at an osteopathic college or hospital.

Osteopathic Philosophy, Principles and Practice

Synopsis

- 5.69 **The resident must study osteopathic philosophy in depth in an** Integrated Osteopathic Family Practice/Neuromusculoskeletal Medicine residency. Central to this is in depth study of the writings of A.T. Still and other osteopathic physicians who were leaders in the field of Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine. Although this maybe accomplished by reading assignment, it is best done with the incorporation of group discussion on a regular basis. A minimum of two texts by A.T. Still must be read during the residency period. This philosophy will then be incorporated into the basic science and clinical study to produce physicians with a deep appreciation for the clinical application of the philosophy of osteopathy. In addition, the reading list recommended for the NMM boards should be included in the didactics.

Goals

- 5.70 To teach the resident, through didactic and clinical settings, the application of osteopathic principles and osteopathic manipulative treatment in all patient care settings.
- 5.71 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:

- 5.72 Describe the philosophy behind osteopathic manipulative treatment.
- 5.73 Describe the role of the neuromusculoskeletal system in disease, including somato/visceral reflexes, alterations in body framework, and trauma.
- 5.74 Describe contraindications to osteopathic manipulative treatment.
- 5.75 Utilize multiple methods of treatment including, but not limited to, High-Velocity/Low Amplitude (HVLA), strain/counter strain, muscle energy, osteopathy in the cranial field and myofascial release techniques and understand their indications, contraindications and appropriateness inpatient care including all myofascial, soft tissue, direct and indirect techniques currently taught in osteopathic colleges.
- 5.76 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.

Behavioral Science

Synopsis

5.77 Knowledge and skills in this area is a critical element in both Family Practice and Neuromusculoskeletal, as osteopathic philosophy recognizes the interrelationship of body, mind, and spirit in health and disease. Identifying emotional, psychological, and cultural issues and the role they play in the disease processes of the patient is essential to the residents' training. Learning medical and community resources available and developing appropriate referral skills should be part of this aspect of the residents training. The continuity of care training site should serve as the primary location for training in these areas of behavior that relate to stress and trauma induced disease and musculoskeletal dysfunction. Family physicians and psychologists, as well as others, maybe involved in the teaching of this curricular component. The behavioral science component of the curriculum should include the promotion of the physician's well being and prevention of impairment.

Goals

- 5.78 To provide training so the resident will be able to diagnose and manage the psychological component of disease.
- 5.79 In all cases, the longitudinal care shall address the physical, physiological, psychological, cultural, economic, and environmental factors as they relate to the disease process and the patient's wellness.
- 5.80 Instruct residents on the importance of the interrelationship of the physician, patient, patient's family, the community, and the health care system.

Objectives

- 5.81 Chronic pain and its impact on patient and family.
- 5.82 Identify areas of secondary gain.
- 5.83 Past physical and sexual abuse and chronic pain.
- 5.84 Fibromyalgia.
- 5.85 Post Traumatic Stress Disorder**
- 5.86 Depression/anxiety, other psychiatric issues.
- 5.87 Addiction including: Alcohol, drug, gambling, and compulsive eating.
- 5.88 Litigation and health.

- 5.89 Understand normal and abnormal psychological growth and development.
- 5.90 Utilize appropriate interviewing skills.
- 5.91 Utilize appropriate counseling skills.
- 5.92 Diagnose and manage substance abuse.
- 5.93 Diagnose and manage eating disorders.
- 5.94 Diagnose and manage common psychiatric disorders.
- 5.95 Manage the emotional aspects of non-psychiatric disorders.
- 5.96 Recognize signs of family violence including abuse, and neglect.
- 5.97 Recognize the role of ethics in patient care.
- 5.98 Understand the importance of being sensitive to gender, age, race, and cultural differences within his/her patient population.
- 5.99 Demonstrate knowledge of psychopharmacology.
- 5.100 Demonstrate an understanding of situations that have the potential of leading to his/her impairment.
- 5.101 Understand and recognize appropriate and inappropriate Doctor-patient relationships.
- 5.102 Recognize social issues as they contribute to and impact the illness.
- 5.103 Develop effective and appropriate referral skills.

Practice Management

Synopsis

- 5.104 Health care in our society is undergoing significant dynamic changes, which 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. 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 gross charges, contractual adjustments, balance billing, and reimbursement data.

Goal

- 5.105 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:

- 5.106 Enter into contractual arrangements with health care systems.
- 5.107 Demonstrate an understanding of the issues of bio-ethics and medical jurisprudence.
- 5.108 Demonstrate an understanding of community systems and agencies that enter into aspects of health care.
- 5.109 Demonstrate an understanding of risk management.
- 5.110 Demonstrate an understanding of office management, principles of reimbursement, and coding, including the AOA position paper on billing and coding using 25 modifiers.

Core Areas of Specialty

Emergency Medicine

Synopsis

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

Goal

- 5.112 To provide the resident didactic and clinical experiences 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:

- 5.113 Triage emergency patients of all ages.
- 5.114 Stabilize and provide initial treatment for medical and surgical emergencies.
- 5.115 Evaluate and treat lacerations.
- 5.116 Evaluate sprains, strains, and other soft tissue injuries.
- 5.117 Evaluate, immobilize, and refer skeletal fractures as appropriate.
- 5.118 Provide emergency management for toxic ingestions.

- 5.119 Provide emergency management for substance abuse.
- 5.120 Provide emergency management for chest pain.
- 5.121 Provide emergency management for anaphylaxis.
- 5.122 Maintain certification in ACLS.
- 5.123 Integrate NMM into the acute management of sprains, strains, headaches and other appropriate cases.

Internal Medicine

Synopsis

- 5.124 Understanding the interaction of osteopathic concepts with both the diagnosis and management of medical disease process including manipulative treatment is essential to residency training in Integrated Osteopathic Family Practice/Neuromusculoskeletal Medicine. This aspect of the residents training should be both didactic and clinical, and involve training from specialists in Osteopathic Family Practice, Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine and **internal medicine specialists**. It should occur in both the inpatient and outpatient setting.
- 5.125 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. During OGME-2 and OGME-3, emphasis will be placed on the specific subspecialty areas listed below.**
- 5.126 In addition to these Internal Medicine requirements, **three (3) months NMM consultant service or a longitudinal experience treating patients on the Internal Medicine service** under supervision of NMM faculty is required.
- 5.127 **A specialist in Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine must supervise the osteopathic evaluation and manipulative treatment.** There must also be direct interaction with the internist or generalist providing medical care to the patient, and supervised discussion of the physical exam, differential diagnosis, and medical management of the patient. **Both the Family Practice or Internal Medicine physician and the specialist in Neuromusculoskeletal Medicine and osteopathic manipulative medicine will evaluate the resident's performance in Internal Medicine.**
- 5.128 The manipulative treatment plan must address the pathophysiology of the disease process. It is insufficient to treat only the musculoskeletal complaints of patients with

medical problems. The diversity of diagnoses to meet this core requirement will be described in the subspecialty area of this section.

Goal

- 5.129 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 and the osteopathic physiology of medical diseases.

Objectives

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

- 5.130 Recognize those patients who should be managed in a hospital setting.
- 5.131 Manage patients in the hospital setting.
- 5.132 Manage hospitalized patients after discharge.
- 5.133 See specialty consultation when appropriate, and maintain direct responsibility for the management of the patient.
- 5.134 Perform specific medical procedures as outlined in the procedure section of these basic standards.
- 5.135 Understand and utilize appropriate pharmacologic interventions.
- 5.136 Understand the structural and reflex changes that accompany medical illnesses.
- 5.137 Understand the role these findings have in the pathophysiology of the disease process.
- 5.138 Understand how structural findings are incorporated into the overall work-up of the patient with other aspects of physical exam and diagnostic tests and procedures.
- 5.139 Incorporate the understanding of anatomy; physiology, and pathophysiology into the development of a manipulative treatment plan to directly assist the recovery from the medical problem.
- 5.140 Understand the impact of chronic pain on the body's hormonal/metabolic systems and how to identify these deficiencies.
- 5.141 Develop the palpatory skills necessary to recognize the structural changes that accompany medical illness, to the degree that these findings may assist in the process of differential diagnosis.
- 5.142 Reinforce the skills of physical diagnosis and differential diagnosis of the medical patient.

- 5.143 Develop skills necessary to apply osteopathic manipulative treatment to the entire spectrum of patients with medical illnesses, including bed bound and critically ill patients.
- 5.144 Develop skills to provide preventive medical management and health enhancement to the medical patient.

Allergy and Immunology

Objectives

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

- 5.145 Understand the physiology of the allergic response.
- 5.146 Understand immunosuppression.
- 5.147 Understand the mechanism of desensitization.
- 5.148 Care for the allergic patient.
- 5.149 Understand the role of somatic dysfunction and the relationship of osteopathic principles and treatment of the immune system.
- 5.150 Understand the role of neuroimmune endocrine system and how stress and chronic pain affect autoimmune and immunosuppressed states.
- 5.151 Understand the role of lymphatic drainage in stimulating T and B cell responses to infectious agents, and in the resolution of an inflammatory response, and the role of lymphatic and/or splenic pumps on this process.

Cardiovascular Medicine

Objectives

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

- 5.152 Understand the variety of management strategies for cardiac disease.
- 5.153 Recognize symptoms of cardiac disease.
- 5.154 Understand the cardiac effects of pulmonary disease.
- 5.155 Understand cardiac manifestations of systemic diseases.
- 5.156 Understand the indications for open-heart surgery.

- 5.157 Understand the role somatic dysfunction in cardiac disease.
- 5.158 Understand the diagnostic procedures and osteopathic medical management of the cardiovascular patient.
- 5.159 Perform a preoperative cardiac assessment.
- 5.160 Integrate osteopathic manipulative treatment into the management of patients with cardiac disease.
- 5.161 Learn the structure of the heart and pericardium, including fascial connections with the diaphragm, sternum, and anterior cervical fascia, and how cardiac function maybe altered by dysfunction of these tissues.
- 5.162 Learn the innervations and autonomic influence of the heart and vascular system, as well as how the innervation maybe altered by somatic dysfunction.
- 5.163 Learn the circulation to and from the heart and vascular system, including the lymphatic drainage, and how it maybe altered by structural problems and somatic dysfunction.
- 5.164 Understand the role of the above in cardiovascular diseases including, but not limited to:
 - a. Hypertension.
 - b. Angina.
 - c. Arrhythmias.
 - d. Congestive heart failure.
 - e. Valvular diseases.
 - f. Acute myocardial infarction.
 - g. Peripheral vascular disease.
- 5.165 Design a manipulative treatment program to address the structural considerations in the patient with cardiovascular disease as part of an overall treatment plan.
- 5.166 Develop palpatory skills necessary to recognize the structural and reflex changes associated with cardiovascular diseases.
- 5.167 Develop the skill level necessary to adapt osteopathic manipulative technique to be effective and appropriate for the patient with cardiovascular disease, regardless of age, severity of the disease, or the overall condition of the patient.

Dermatology

Objectives

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

- 5.168 Recognize and manage common dermatological conditions.
- 5.169 Identify allergic etiologies of dermatologic lesions.
- 5.170 Know the indications for dermal biopsy.
- 5.171 Recognize dermatologic manifestations of systemic disease.
- 5.172 Recognize the autonomic systems etiology for dermatologic problems and treat them with NMM in conjunction with medical care.

Endocrinology

Objectives

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

- 5.173 Diagnose and manage uncomplicated endocrine disorders.
- 5.174 Understand the indications for surgery in the management of endocrine disorders.
- 5.175 Identify palpatory findings of endocrine disease.
- 5.176 Understand relation of **neuro-endocrine immune (NEI) system**.
- 5.177 Treatment post op endocrine surgical patients using NMM.
- 5.178 Understand neuro- and cranial anatomy and its relation to the endocrine system.
- 5.179 Know anatomy and physiology of endocrine system.

Gastrointestinal Medicine

Objectives

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

- 5.180 Screen appropriately for colorectal cancer.
- 5.181 Understand the indications for surgery in gastrointestinal disease.
- 5.182 Manage uncomplicated diseases of the gastrointestinal system.
- 5.183 Understand the role of osteopathic principals and treatment in the diagnosis and management of gastrointestinal disease.

- 5.184 Learn the anatomy of the GI system including the mesenteries and their attachments to the viscera and the diaphragm, the mesenteric and fascial connections between abdominal viscera, and their role in supporting the visceral structures.
- 5.185 Learn the role of the diaphragm, the posterior abdominal wall, the pelvic diaphragm, the lumbar spine and the bony pelvis play in supporting the abdominal viscera, and how GI function may be altered by ineffective support from these structures.
- 5.186 Learn the innervations of the abdominal viscera, its role in peristalsis, abdominal blood flow, secretions, and sphincter function, and how it may be affected by somatic dysfunction.
- 5.187 Learn the anatomy of the abdominal vasculature, including the lymphatic drainage, and how it may be altered by structural problems and somatic dysfunction.
- 5.188 Understand the role of diaphragm excursion on abdominal venous flow, especially its role in portal circulation.
- 5.189 Understand the role of respiration and peristalsis on abdominal lymph flow.
- 5.190 Understand the role of the above in Gastrointestinal disorders, including but not limited to:
- a. Peptic ulcer disease.
 - b. Gastric motility disorders.
 - c. Irritable bowel disease.
 - d. Cholecystitis.
 - e. Pancreatitis.
 - f. Appendicitis.
 - g. Hepatitis and liver disease.
 - h. Esophageal reflux and hiatal hernia.
 - i. Ascites.
 - j. Inflammatory bowel disease.
 - k. Diarrhea and constipation.
- 5.191 Design a manipulative treatment program to address the structural considerations in the patient with gastrointestinal disease as part of the overall treatment plan.
- 5.192 Understand the diagnostic procedures and medical management of the GI patient.
- 5.193 Develop palpatory skills necessary to recognize the structural and reflex changes associated with gastrointestinal disease, to the degree that these findings may assist in the differential diagnosis.
- 5.194 Develop the skills necessary to adapt osteopathic manipulative treatment to the patient with gastrointestinal disease, regardless of age, severity of the disease, or the overall condition of the patient.

Hematology

Objectives

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

- 5.195 Manage common hematologic disorders.
- 5.196 Understand hematopoiesis.
- 5.197 Understand the diagnosis and management of coagulopathies.

Infectious Diseases

Objectives

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

- 5.198 Diagnose and manage common infectious diseases.
- 5.199 Understand the epidemiology of infectious diseases.
- 5.200 Appreciate the role of the health care team in the control of infectious disease.
- 5.201 Understand the role of antibacterial, anti-fungal, and anti-viral agents in the management of infectious disease.
- 5.202 Understand the anatomical/physiological considerations of the immune system and the interrelatedness of all body systems in combating infectious disease.
- 5.203 Understand the role of lymphatic drainage in stimulating T and B cell responses to infectious agents, and in the resolution of an inflammatory response, and the role of lymphatic and/or splenic pumps on this process.
- 5.204 Understand the role of body and fluid mechanics in the overall movement of lymph, and the effect of somatic dysfunction on lymph movement.
- 5.205 Understand the role of the diaphragm and respiration on central lymph drainage.
- 5.206 Learn the local anatomy, physiology, and mechanics of the lymphatic system for any region of the body, and the effect of somatic dysfunction on local lymphatic drainage.
- 5.207 Understand the role of the circulatory system in delivering antibiotics, immune cells, and their products to combat infectious processes, and the effect of somatic dysfunction on this process.

- 5.208 Understand the role of the primary respiratory mechanism on fluid movement throughout the body.
- 5.209 Learn the location and effect of local reflex patterns in an infectious process.
- 5.210 Understand the role of somatic dysfunction in predisposing a region, tissue, or organ system to infection.
- 5.211 Understand the role the above plays in infectious diseases including, but not limited to:
- a. Upper respiratory infections.
 - b. Urinary tract infections.
 - c. Cellulitis.
 - d. Pharyngitis.
 - e. Pneumonia.
 - f. Soft tissue infections.
 - g. Herpes Zoster/Hepatic neuralgia.
 - h. Meningitis.
 - i. OT media.
 - j. Tonsillitis.
 - k. Sinusitis.
 - l. Prostatitis.
- 5.212 Design a manipulative treatment program to address the structural considerations and stimulate the movement of lymph in the patient with infectious disease as a part of the overall treatment plan.
- 5.213 Understand the diagnostic procedures and medical management of infectious diseases.

Nephrology

Objectives

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

- 5.214 Understand electrolyte and acid-base disturbances.
- 5.215 Understand the etiology and diagnosis of nephritic diseases.
- 5.216 Diagnose and manage common medical disorders of the kidney.
- 5.217 Utilize pharmacologic agents appropriately in patients with renal disease.
- 5.218 Learn the anatomy of the kidney, ureters, bladder, and urethra, and the anatomical/physiological relationship of the kidney to the psoas muscle and its fascia, the ureter to the pelvic brim, and the bladder to the symphysis pubis.

- 5.219 Learn the innervations of the genitourinary system, its role in GU function and how it maybe affected by somatic dysfunction.
- 5.220 Learn the arterial, venous and lymphatic circulation to the kidney, ureters, and bladder, including its lymphatic drainage, and how it maybe affected by structural problems and somatic dysfunction.
- 5.221 Understand the role of the above in genitourinary diseases, including but not limited to:
 - a. Nephrolithiasis.
 - b. Pyelonephritis.
 - c. Urinary tract infection.
 - d. Prostatodynia/prostatitis.
 - e. Infertility/impotence.
 - f. Urinary incontinence.
- 5.222 Understand the structural reflex findings that are manifest by different genitourinary pathologies.
- 5.223 Design a manipulative treatment plan to address the structural considerations in the patient with genitourinary disease, as a part of the overall treatment plan.
- 5.224 Understand the diagnostic and osteopathic medical management of the genitourinary patient.
- 5.225 Develop palpatory skills to recognize the structural and reflex changes associated with genitourinary disease.
- 5.226 Develop the skill level necessary to adapt osteopathic manipulative technique to be safe, effective, and appropriate in the patient with genitourinary disease, regardless of their age, the severity of the disease, or their overall condition.

Oncology

Objectives

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

- 5.227 Screen for and diagnose common cancers.
- 5.228 Participate with the oncologist in the care of cancer patients.
- 5.229 Utilize a team approach for the care of cancer patients.
- 5.230 Utilize Hospice in the management of the terminally ill patient.
- 5.231 Understand indications and contraindications to Osteopathic Manipulative Treatment in oncology patients.

Pulmonary Medicine

Objectives

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

- 5.232 Perform a preoperative pulmonary assessment.
- 5.233 Diagnose and manage common pulmonary diseases.
- 5.234 Understand the role of osteopathic manipulation in the treatment of pulmonary disease.
- 5.235 Learn the anatomy and innervation of the respiratory musculature, including the diaphragm.
- 5.236 Understand the role of respiratory muscle fatigue and dysfunction in ventilatory problems.
- 5.237 Learn the anatomy of the bony thorax with its contents, including the spine, rib cage, clavicles and sternum. Understand its role, as well as that of the bony pelvis, the pelvic diaphragm, and cranium in normal respiration.
- 5.238 Understand the relationship between compliance of the thorax and the work of breathing, and the effect of increased work of breathing on the patient with pulmonary diseases.
- 5.239 Learn the innervations of the pulmonary parenchyma, as well as how the innervation may be altered by somatic dysfunction.
- 5.240 Learn the anatomy of the pulmonary vasculature, including the lymphatic drainage. Understand the role of normal respiratory excursion on venous and lymphatic drainage, visceral and parietal, pleura and related **visceral** and somatic reflexes.
- 5.241 Understand the role of the above in pulmonary diseases including, but not limited to:
 - a. Asthma.
 - b. COPD.
 - c. Pneumonia.
 - d. Bronchitis.
 - e. Restrictive lung diseases.
 - f. Pleural effusion.
 - g. Cancer.
 - h. Respiratory failure.
- 5.242 Design a treatment program to address the structural considerations in pulmonary diseases as part of an overall treatment plan.

- 5.243 Understand the diagnostic procedures and osteopathic medical management of the pulmonary patient.
- 5.244 Develop palpatory skills to recognize the structural and reflex changes associated with pulmonary diseases.
- 5.245 Develop the skill level necessary to adapt osteopathic manipulative technique to be effective, safe, and appropriate in the patient with pulmonary disease regardless of their age, the severity of their disease, or their overall condition.
- 5.246 Understand NMM and its application to **mechanically ventilated** patients.

Neuromusculoskeletal Medicine

Synopsis

- 5.247 The evaluation and treatment of Neuromusculoskeletal diseases is a central part of training in Integrated Osteopathic Family Practice/Neuromusculoskeletal Medicine. This section will include divisions of Neurology, Rheumatology, Orthopedics, Occupational Medicine, Radiology, Anesthesiology and Rehabilitation Medicine, to cover the diversity of diagnoses needed to meet this requirement. The resident must learn to use their palpatory skills to identify clues for the differential diagnosis of neuromusculoskeletal problems, and design osteopathic manipulative treatment plans and rehabilitation to improve the function of the neuromusculoskeletal system. The specialist in Integrated Osteopathic Family Practice/Neuromusculoskeletal Medicine will, by the nature of the specialty, often be the primary care provider for the patient with diseases of the Neuromusculoskeletal system. They should therefore be trained in the overall evaluation and management of these patients, as well as how to appropriately refer patients for specialty consultation when indicated. Over the course of three years of training, the resident should evaluate and treat with a broad variety of the following diagnoses. The quality and diversity of cases is more important than the number itself. This requirement can be met through the longitudinal and hospital care portions of the program. A minimum of two (2) months of intensive NMM rotations must be done with physicians specializing in outpatient OMT practice. Three (3) NMM selective rotations must be completed in the identified specialty areas (**Neurology, Rheumatology, Orthopedics and Physical Medicine and Rehabilitation**).

Objectives

- 5.248 Understand the physiology of acute and chronic pain.
- 5.249 Understand the structural consequences of trauma in addition to fracture, enthesopathy, sprain and joint instability.
- 5.250 Understand somatic referral patterns as in sclerotomal, myotomal, and dermatomal distributions as well as that specific to myofascial trigger points, ligamentous strains and discogenic injuries.

- 5.251 Understand the role of somatic dysfunction in diseases of the neuromusculoskeletal system.
- 5.252 Learn to diagnose and manage neuromusculoskeletal diseases including the utilization of diagnostic tests and all aspects of conservative management.
- 5.253 Expand expertise in the dosage, drug interactions, indications, and contraindications of pharmacologic agents used in the management of acute and chronic pain, including but not limited to:
 - a. Anti-inflammatory medications.
 - b. Skeletal muscle relaxants.
 - c. Antidepressants.
 - d. Analgesics.
 - e. Pain medication.
- 5.254 Learn to seek specialty consultation from all subspecialties listed below for the overall evaluation of neuromusculoskeletal diseases.
- 5.255 Understand the role of osteopathic manipulative treatment, joint stabilization and rehabilitation in the overall management of neuromusculoskeletal disease.
- 5.256 Perform a neuromusculoskeletal physical exam.
- 5.257 Initiate treatment programs for neuromusculoskeletal patients.
- 5.258 Develop appropriate referral patterns.
- 5.259 Know the appropriate use of braces, splints and strapping.

Neurology

Objectives

- 5.260 Understand the pathophysiology of common neurological problems amenable to conservative care.
- 5.261 Recognize complex neurological problems and obtain appropriate consultation.
- 5.262 Understand the anatomical and physiological considerations of the nervous system and the relationship of the central nervous system and peripheral nervous system to the body as a whole.
- 5.263 Understand the relationship between the primary respiratory mechanism and the functioning of the central nervous system.
- 5.264 Understand the blood supply, venous drainage, and CSF fluctuation in the central nervous system, and its cranial nerves.

- 5.265 Understand the role of structural and reflex changes in neurological dysfunction.
- 5.266 Diagnose and manage, not limited to:
- a. Cervical, thoracic and lumbosacral radiculitis.
 - b. Chronic pain syndromes.
 - c. Entrapment neuropathies.
 - d. Headache.
 - e. Trigeminal neuralgia cranial nerve intrapment.
 - f. Discogenic pain.
 - g. Myofascial pain.
 - h. Minor head trauma.
 - i. Greater occipital neuralgia.
 - j. Cerebral palsy.
 - k. Parkinson's disease.
 - l. Para and quadraplegia.
- 5.267 Diagnose and appropriately refer:
- a. Radiculopathy with nerve deficit.
 - b. CVA.
 - c. Peripheral neuropathy.
- 5.268 Incorporate osteopathic manipulative treatment into the overall design of the treatment program of the neurological patient.
- 5.269 Perform a neurological exam.
- 5.270 Perform a structural exam on the neurological patient.
- 5.271 Perform osteopathic manipulative treatment on the patient with neurological disease as part of the overall treatment program.
- 5.272 Develop the skill level necessary to adapt osteopathic manipulative technique to be effective, safe, and appropriate in the patient with pulmonary disease regardless of their age, the severity of their disease, or their overall condition.

Rheumatology

Objectives

- 5.273 Understand the anatomy and physiology of synovial joints.
- 5.274 Understand the role of the articulated human skeleton in the overall function of the body.

- 5.275 Understand the pathophysiology of common rheumatic diseases amenable to conservative care.
- 5.276 Recognize complex and severe rheumatic diseases and make appropriate referrals.
- 5.277 Understand the physiology and pathophysiology of the immune system.
- 5.278 Understand the pathophysiology of chronic inflammatory processes and chronic pain.
- 5.279 Understand and recognize the systemic effects of immune and inflammatory diseases.
- 5.280 Understand the role of the lymphatic system in immune function and the resolution of the inflammatory process.
- 5.281 Diagnose and manage, or participate in the management of:
 - a. Rheumatoid arthritis.
 - b. Gouty arthritis.
 - c. SLE.
 - d. Osteoarthritis.
 - e. Spondyloarthropathies.
 - f. Polymyalgia rheumatica.
 - g. Lyme disease.
 - h. Complex regional pain syndromes.
- 5.282 Design an overall treatment program that incorporates the use of osteopathic manipulative treatment in the rheumatological patient.
- 5.283 Perform an examination of the joints of the body.
- 5.284 Perform osteopathic manipulative treatment as part of the overall treatment program for the patient with rheumatological disease.
- 5.285 Develop the skill level necessary to adapt osteopathic manipulative technique to be effective, safe, and appropriate in the patient with pulmonary disease regardless of their age, the severity of their disease, or their overall condition.

Orthopedics

Objectives

- 5.286 Understand the anatomy, physiology and healing processes of living bone, and muscles, joint capsules, ligamentous and related soft tissue structures.
- 5.287 Understand the relationship between the skeletal system and the physiologic functioning of the body as a whole.

- 5.288 Understand the blood supply, innervation and venous and lymphatic drainage of bone, periosteum, ligament, tendon, muscle and related soft tissues.
- 5.289 Recognize the presence of somatic dysfunction in the skeletal and associated tissues, and the role it plays in the function of those tissues, and its disease processes.
- 5.290 Understand the pathophysiology of non-surgical orthopedic problems amenable to conservative care.
- 5.291 Recognize fractures and surgical orthopedic diseases and make appropriate referrals.
- 5.292 Understand principles and indications for prolotherapy.
- 5.293 Understand principles and indications for intraarticular injections.
- 5.294 Diagnose and manage:
 - a. Acute and chronic sprains.
 - b. Acute and chronic strains.
 - c. Bursitis/tendonitis.
 - d. Discogenic disease.
 - e. Failed back syndrome.
 - f. ADHESIVE Capsulitis.
 - g. Epicondylitis.
 - h. Sciatica/piriformis syndrome.
 - i. Costochondritis.
 - j. Coccydynia.
 - k. Spondylolisthesis.
 - l. Degenerative joint disease.
 - m. Gravitational strain.
 - n. Postoperative hip and knee surgery Pre and post care of the orthopedic patient including OMT.
 - o. Scoliosis.
 - p. Enthesopathy.
 - q. Ligament and joint instability.
 - r. Common sports injuries.
- 5.295 Incorporate osteopathic manipulative treatment into the overall treatment of orthopedic diseases.
- 5.296 Understand the role of pharmacologic management in the acute and chronic pain patient.
- 5.297 Perform an examination of the musculoskeletal system.
- 5.298 Examine for ligamentous laxity and understand use of prolotherapy.

- 5.299 Examine for postural decompensation and apply or refer for orthotics, prosthetics, and or osteopathic postural management strategies to affect coronal, sagittal, and horizontal plane imbalance.
- 5.300 Perform osteopathic manipulative treatment on patients with orthopedic diseases.
- 5.301 Perform trigger point injections.
- 5.302 Develop the skill level necessary to adapt osteopathic manipulative technique to be effective, safe, and appropriate in the patient with pulmonary disease regardless of their age, the severity of their disease, or their overall condition.

Physical Medicine and Rehabilitation

Synopsis

- 5.303 The disease processes evaluated and treated by specialists in Physical Medicine and Rehabilitation are covered in the preceding specialties. Rather than repeat them here, this section will focus on the incorporation of exercise, physical and occupational therapy into the overall care of the patient with Neuromusculoskeletal disease.

Objectives

- 5.304 Understand the role of exercise in the rehabilitation of the patient with neuromuscular disease.
- 5.305 Understand the different responses of postural and phasic muscles when stressed.
- 5.306 Understand the role of physical and occupational therapy in the rehabilitation of the patient with neuromuscular disease.
- 5.307 Learn the various modalities and treatments available through PT and OT, their uses and indications in the rehabilitation process.
- 5.308 Design appropriate exercise, PT, and OT prescriptions for outpatients.
- 5.309 Recognize the need for rehab consultation in complex and difficult cases.
- 5.310 Understand the role of osteopathic manipulative treatment in the overall rehabilitation of the patient with neuromusculoskeletal disease.
- 5.311 Understand the role of orthotic devices.
- 5.312 Perform osteopathic manipulative treatment as part of the overall rehabilitation process.

Anesthesiology

Synopsis

5.313 Anesthesiology provides various treatment modalities for the acute and chronic pain patient as well as diagnostic techniques. The physician that wishes to practice Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine needs to understand the unique talents anesthesiology brings to the treatment of the chronic pain patient.

Objectives

To understand the utility/role of:

5.314 Discography and radio frequency treatment of symptomatic discs.

5.315 Regional sympathetic blocks.

5.316 Regional anesthesia.

5.317 Epidural blocks.

5.318 Facet blocks, medial nerve branch blocks and facet rhizotomies.

5.319 Spinal cord stimulators and implantation of opioid delivery systems in the chronic pain patient.

5.320 Spinoscopy.

5.321 Be able to: Perform an examination of the musculoskeletal system.

5.322 Develop appropriate referral patterns and interrelationships with anesthesiologists who do work with acute and chronic pain patients.

5.323 Perform OMT on acute and chronic pain patients when indicated.

5.324 Assess movement and muscle firing patterns of injured/painful patients and prescribe appropriate exercise and pharmacologic therapeutics.

5.325 Evaluate proprioceptive skills of chronic pain patients and instruct in appropriate retraining.

Radiology

Objectives

- 5.326 NMM residents should **demonstrate a thorough working** knowledge of all radiologic studies and procedures related to the evaluation and treatment of the neuromusculoskeletal systems.
- 5.327 Understand ultrasound technology and know when it would be appropriate to order for patients.

Occupational Medicine

Objectives

- 5.328 Understand the mechanisms of worker's compensation and disability.
- 5.329 Be able to coordinate care and communication between the patient, employer, worker's compensation insurer, rehabilitative nurse, and therapists.
- 5.330 Understand how to provide or access functional capacity evaluations for injured employees who have reached maximal medical improvement.
- 5.331 Understand how to provide or access medical impairment ratings for employees who have reached maximal improvement.

Obstetrics/Gynecology

Synopsis

- 5.332 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. Osteopathic manipulative treatment of Ob/Gyn patients on a consultative basis should be part of both the inpatient and longitudinal care experiences.**
- 5.333 Integrating osteopathic concepts to both the diagnosis and osteopathic management of Ob/Gyn patients including manipulative treatment is essential to residency training in Integrated Osteopathic Family Practice/Neuromusculoskeletal Medicine. This aspect of the residents training should be both didactic and clinical, and must involve training by specialists in Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine, Ob/Gyn and Family Practice. This training should occur in both the inpatient and outpatient setting. Over the course of three (3) years of training, the resident should evaluate and treat patients with a broad variety of the following diagnoses. Training must take place as not only a medical intern and resident rotating in Ob/Gyn but also by participating in the care of Ob/Gyn patients on an NMM consultative basis. **A specialist in Neuromusculoskeletal Medicine and osteopathic manipulative treatment must supervise the osteopathic manipulative treatment.** There must also

be direct interaction with the attending providing the Ob/Gyn care to the patient, and supervised discussion of the physical exam, differential diagnosis, and Ob/Gyn care of the patient. **Both the Family or Ob/Gyn physician and the specialist in Neuromusculoskeletal Medicine and osteopathic manipulative medicine will evaluate the resident's performance.**

- 5.334 The manipulative treatment must address the pathophysiology of the disease process **as well as normal pregnancy related changes**. It is insufficient to treat only the musculoskeletal complaints in the Ob/Gyn patient.

Goal

- 5.335 **To provide the resident thorough 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. The gynecological portion of this training experience should include both ambulatory and in-hospital patient care. Procedures appropriate to the family physician should be taught. The Obstetrical portion must have training in the management of obstetrical patients. This should involve prenatal care, delivery, and post-natal care. The program should make available advance training for residents who desire to participate in family practice obstetrics.
- 5.336 Understand the structural and reflex changes that accompany Ob/Gyn diseases and health.
- 5.337 Understand the role those findings have in the pathophysiology of the disease process and normal pregnancy.
- 5.338 Understand the postural and physiologic changes that accompany pregnancy, and the role of somatic dysfunction plays in difficulties adapting to those changes.
- 5.339 Incorporate the understanding of anatomy; physiology, and pathophysiology into the development of a manipulative treatment plan to directly assist the recovery from Ob/Gyn diseases and support pregnancy at any level.

Objectives:

- 5.340 Integrate the use of osteopathic manipulative treatment in the management of obstetrics and **gynecologic** disorders.
- 5.341 Develop the palpatory skills necessary to recognize the structural changes that accompany Ob/Gyn diseases, to the degree that these findings may assist in the process of differential diagnosis.
- 5.342 Develop skills necessary to apply osteopathic manipulative treatment to the entire spectrum of patients with Ob/Gyn diseases, regardless of their age or the severity of the disease.

- 5.343 Understand the anatomical, physiological, and postural changes, which occur during pregnancy.
- 5.344 Understand how the process of nutation and counternutation improve fetopelvic proportions.
- 5.345 Understand how somatic dysfunction may interfere with the above, and contribute to problems during pregnancy, labor, and delivery.
- 5.346 Understand the role of somatic dysfunction in obstetrical diseases including, but not limited to:
- a. Low back pain.
 - b. Carpal tunnel syndrome.
 - c. Edema.
 - d. Respiratory problems.
 - e. Morning sickness and hyperemesis gravidarum.
 - f. Headache.
 - g. Premature labor.
 - h. Failure to progress.
 - i. Postpartum depression and/or fatigue.
 - j. Dysuria.
 - k. GERD.
- 5.347 Design an osteopathic manipulative treatment program to address the structural considerations in the patient with obstetrical disease.
- 5.348 Understand the anatomy, physiology, and pathophysiology of the female genitourinary system.
- 5.349 Recognize the structural findings that accompany **gynecological** disease.
- 5.350 Understand the role of somatic dysfunction in the pathophysiology of gynecological diseases including, but not limited to:
- a. Pelvic inflammatory disease.
 - b. Ovarian cyst.
 - c. Premenstrual syndrome and menstrual cramps.
 - d. Postoperative changes.
 - e. Vaginismus/Tinasmus/Dysparenia.
 - f. Sexual dysfunction as related to trauma and chronic pain.
- 5.351 Design an osteopathic manipulative treatment program to address the structural considerations in the patient with **gynecological** disease.

Gynecology

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

- 5.352 Diagnose and manage vaginitis.
- 5.353 Counsel patients on family planning options.
- 5.354 Manage abnormalities of the pap smear.
- 5.355 Diagnose and initiate management of abnormal uterine bleeding.
- 5.356 Diagnose and initiate management of pelvic pain.
- 5.357 Counsel and advise patients regarding use or non-use of post-menopausal hormonal therapy.
- 5.358 Participate in pre-operative and post-operative care of gynecological disorders.
- 5.359 Obtain appropriate consultation for selected gynecological abnormalities.

Obstetrics

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

- 5.360 Participate in uncomplicated vaginal delivery.
- 5.361 Provide surgical assistance during cesarean section delivery.
- 5.362 Recognize early signs and symptoms of fetal and/or maternal distress.
- 5.363 Recognize and initiate management for common medical problems in the obstetrical patient.
- 5.364 Diagnose and initiate management for first trimester pregnancy loss.
- 5.365 Diagnose and initiate management for ectopic pregnancy.
- 5.366 Diagnose and initiate evaluation for infertility.
- 5.367 Manage lactation issues.

Pediatrics and Adolescent Medicine

Synopsis

- 5.368 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 ambulatory and hospitalized patients between 2 and 16 years of age.**
- 5.369 Integrating osteopathic concepts to both the diagnosis and osteopathic management of pediatric patients and their diseases including manipulative treatment is essential to residency training in Integrated Family Practice/Neuromusculoskeletal Medicine. This aspect of the residents' training should be both didactic and clinical, and must include training by specialists in Integrated Family Practice/Neuromusculoskeletal Medicine as well as pediatrics or family practice. This training should occur in both inpatient and outpatient settings. Over the course of training, the resident should evaluate and treat patients with a broad variety of the following diagnoses. The training must take place not only as a medical intern and resident, rotating on a pediatric service, but also by participating in the NMM consultative care and treatment of pediatric patients for a minimum of two (2) months.
- 5.370 **A specialist in Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine must supervise the osteopathic structural evaluation and manipulative treatment.** There must be direct interaction with the pediatric or family practice attending providing the medical CARES to the patient, and supervised discussion of the physical exam, differential diagnosis and medical management of the patient. The resident's performance will be evaluated by both the pediatric or family practice and the specialist Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine.

Goal

- 5.371 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:

- 5.372 Diagnose and manage pediatric problems encountered in family practice.
- 5.373 Manage pediatric emergencies.
- 5.374 Provide general care of the newborn in the hospital and office setting.
- 5.375 Provide well childcare up to and including adolescence.
- 5.376 Understand the structural and reflex changes that accompany pediatric diseases.
- 5.377 Understand the role of these findings in the pathophysiology of the disease process.

- 5.378 Understand the unique host response of the pediatric patient to both illness and to enhancement of homeostasis.
- 5.379 Understand how structural findings are incorporated into the overall work-up of the pediatric patient with other aspects of physical exam and diagnostic tests and procedures.
- 5.380 Understand how somatic dysfunction may restrict the process of growth and development, and how osteopathic manipulative treatment may influence this physiological process.
- 5.381 Incorporate the understanding of anatomy; physiology, and pathophysiology into the development of a manipulative treatment plan to directly assist the recovery from the disease process.
- 5.382 Understand the diagnostic procedures and osteopathic medical management of the pediatric patient.
- 5.383 Understand the physical diagnosis and differential diagnosis of the pediatric patient.
- 5.384 Be familiar with age related changes in dosage and drug interactions of medications frequently utilized by the specialist in Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine, including but not limited to:
 - a. Anti-inflammatory medications.
 - b. Skeletal muscle relaxants.
 - c. Antidepressants.
 - d. Analgesics.
- 5.385 Develop the palpatory skills necessary to recognize the structural and reflex changes that accompany pediatric illnesses, to the degree that these findings may assist in the process of differential diagnosis.
- 5.386 Develop the skills necessary to apply osteopathic manipulative treatment to the entire spectrum of pediatric patients, regardless of age or the severity of the disease.
- 5.387 Develop skills to provide preventive medical management and health enhancement to the pediatric patient.
- 5.388 Understand the unique anatomy of the pediatric patient, including the development of osseous structures, the immune system, the circulatory system, and other anatomy different from the adult population.
- 5.389 Learn about normal physical, mental, and behavioral development in the pediatric population.
- 5.390 Understand the role of somatic dysfunction in the pathophysiology of pediatric diseases including, but not limited to:

- a. Acute and recurrent otitis media and tonsillitis.
 - b. Asthma.
 - c. Torticollis.
 - d. Strabismus.
 - e. Developmental delay.
 - f. Learning delay.
 - g. Seizure disorder.
 - h. Upper respiratory infections.
 - i. Scoliosis.
 - j. Cerebral palsy.
 - k. Traumatic injuries.
 - l. Juvenile rheumatic diseases.
 - m. Down's syndrome and other congenital abnormalities.
 - n. Tibial torsion.
 - o. Sinusitis.
- 5.391 Design a manipulative treatment program to address the structural considerations in the pediatric patient with a broad variety of disease processes, as part of the overall treatment plan.
- 5.392 Understand the unique anatomy and physiology of the newborn, including differences in circulation, respiration, skeletal development, and immune development.
- 5.393 Understand traumatic strains developed in utero and during the normal and assisted birthing processes.
- 5.394 Understand the role of somatic dysfunction in the function and development of the newborn, as well as in problems including, but not limited to:
- a. Failure to thrive.
 - b. **Vomiting and/or GERD.**
 - c. **Feeding difficulties.**
 - d. Colic.
 - e. Jaundice.
 - f. Plagiocephaly.
 - g. Molding.
 - h. Shoulder dystocia.
 - i. Clubfoot.
 - j. Respiratory problems.
 - k. Lacrimal duct dysfunction.
 - l. Birth trauma induced palsies.
 - m. **Torticollis**
- 5.395 Design a manipulative treatment program to address the structural considerations of the newborn in the overall treatment program, recognizing the distinctive adaptation of technique necessary in this patient population.

Surgery

Synopsis

- 5.396 The minimum duration of this portion of the curriculum shall be **twenty (20) weeks** with at least **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 postoperative diagnosis and management of all types of surgical patients will be stressed.
- 5.397 Learning the principles of preoperative and postoperative osteopathic manipulative care as it is integrated into overall surgical management is an essential component of residency training in Integrated Osteopathic Family Practice/Neuromusculoskeletal Medicine. The osteopathic resident must also learn to utilize somatic clues in the differential diagnosis of surgical problems. This aspect of the residents training should be both didactic and clinical, and involve training by both specialists in Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine and surgery. This training should occur in both the inpatient and outpatient setting. Over the course of two years of training, the resident should evaluate and treat patients with a broad variety of the following diagnoses. Training must take place not only as a medical intern or resident rotating on a surgical service, but also by participating in the care of surgical patients with NMM consultation and treatment. This requirement can be met through the longitudinal and **the three months of NMM consultative** hospital care portions of the program. **A specialist in Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine must supervise the osteopathic evaluation and manipulative treatment.** There must also be direct interaction with the attending providing primary and/or surgical care to the patient, and supervised discussion of the physical exam, differential diagnosis, and medical/surgical management of the patient.

Goal

- 5.398 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:

- 5.399 Diagnose and manage surgical disorders and surgical emergencies.
- 5.400 Refer patients with surgical problems, in a timely and appropriate surgical specialist.
- 5.401 Assist the surgeon in the operating room.
- 5.402 Perform those specific surgical procedures that family physicians maybe called on to perform.

- 5.403 Manage, in conjunction with the surgeon, the surgical patient during the preoperative and postoperative period.
- 5.404 Understand basic surgical principles, of asepsis, handling of tissue, and assisting in the operating room.
- 5.405 Understand the structural and reflex changes that accompany surgical diseases.
- 5.406 Understand the role these findings play in the pathophysiology of the disease process.
- 5.407 Understand how structural findings are incorporated into the overall work-up of the patient with other aspects of physical exam and diagnostic procedures.
- 5.408 Incorporate the understanding of anatomy, physiology, and pathophysiology into the development of both a preoperative manipulative treatment plan to help prepare the patient for surgery and postoperative treatment to assist recovery and reduce the risk of complications.
- 5.409 Understand the physical diagnosis and differential diagnosis of the surgical patient.
- 5.410 Understand the diagnostic procedures and management of the surgical patient.
- 5.411 Develop skills to provide preventive health management and health enhancement to the surgical patient.
- 5.412 Develop palpatory skills necessary to recognize the structural and reflex changes that accompany surgical problems, to the degree that these findings may assist in the process of differential diagnosis.
- 5.413 Develop skills necessary to apply osteopathic manipulative treatment to the entire spectrum of patients with surgical problems, both pre and post operatively, including critically ill and immediate postoperative patients.

General Surgery

Objectives

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

- 5.414 Recognize and manage, with the surgeon, conditions requiring surgical care.
- 5.415 Provide pre-hospital preparation of the elective surgical patient.
- 5.416 Perform specific surgical procedures as outlined in these basic standards.
- 5.417 Understand the structural and reflex changes that accompany surgical problems.

- 5.418 Understand the structural and reflex changes that result from the incision and surgical procedure.
- 5.419 Understand how these reflex changes may contribute to prolonged ileus following surgery.
- 5.420 Understand the diaphragm dysfunction that follows pelvic and abdominal surgery and its effects on postoperative respiratory function. Understand how the reflex changes from abdominal surgery restrict the mid and lower ribs and thoracic and lumbar spine and impairs respiratory excursion.
- 5.421 Understand the effect of reduced peristalsis and respiration on abdominal lymph drainage.
- 5.422 Understand the role of lymphatic drainage in wound healing, and the production of postoperative adhesions.
- 5.423 Understand the role of the above in the recovery from surgeries including, but not limited to:
 - a. Stomach.
 - b. Gall bladder.
 - c. Liver.
 - d. Spleen.
 - e. Appendix.
 - f. Colon.
 - g. Rectum.
 - h. Breast.
 - i. Pancreas.
- 5.424 Design both preoperative and postoperative osteopathic manipulative treatment plans to help improve surgical outcomes.
- 5.425 Understand the diagnostic procedures and surgical management of general surgical patients.

Ophthalmology

Objectives

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

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

Orthopedics (See Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine)

Objectives

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

- 5.427 Diagnose and manage common orthopedic conditions that patients may present to the family physician's office.
- 5.428 Integrate osteopathic manipulative treatment into the management of orthopedic disorders.

Otolaryngology

Objectives

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

- 5.429 Diagnose and manage common otolaryngologic conditions that may present to the family physician's office.
- 5.430 Integrate osteopathic principles and manipulative treatment into the management of disorders of the ear, nose, and throat.
- 5.431 Understand the structural and reflex changes that accompany EENT diseases.
- 5.432 Understand the structural and reflex changes that result from the incision and surgical procedure.
- 5.433 Understand how anterior and posterior cervical fascial strain will impede drainage of the deep cervical lymphatic chain.
- 5.434 Understand the spectrum of functional and structural problems causing EENT symptoms.
- 5.435 Understand the role of the above in the recovery from surgeries including, but not limited to:
 - a. Tonsils.
 - b. Facial sinuses.
 - c. Pharynx.
 - d. Larynx.
 - e. Thyroid.
 - f. Ears and tympanic membranes.
 - g. Eyes.

5.436 Design both preoperative and postoperative osteopathic manipulative treatment plans to help improve surgical outcomes.

5.437 Understand the diagnostic procedures and surgical management of EENT problems.

Thoracic/Vascular Surgery

Objectives

5.438 Understand the reflex and structural changes that accompany thoracic and vascular surgical problems.

5.439 Understand the reflex changes that result from the incision and surgery.

5.440 Understand the severe somatic dysfunction of the upper thoracic spine, ribs, and sternum that results from sternotomy.

5.441 Understand the rib and spine dysfunctions that accompany thoracotomy.

5.442 Understand the effect of rib, spine, and sternal dysfunction on respiratory function post operatively.

5.443 Understand the role of respiratory excursion on the lymphatic drainage of the heart, lungs, and mediastinum.

5.444 Understand the role of lymphatic drainage in wound healing and the production of postoperative adhesions.

5.445 Understand the role of the above in the recovery from surgeries including, but not limited to:

- a. Arterial and venous system.
- b. Lungs.
- c. Heart valves.
- d. Coronary arteries.
- e. Mediastinal tissues.
- f. Chest tubes.
- g. Thoracotomies.

5.446 Design both preoperative and postoperative osteopathic manipulative treatment programs to help improve surgical outcomes.

5.447 Understand the functional and structural causes of thoracic outlet syndrome. Diagnosis, treatment, and if indicated, refer for surgical treatment.

5.448 Understand the diagnostic procedures and surgical management of thoracic and vascular surgical problems.

Urology

Objectives

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

- 5.449 Diagnose and manage common urologic conditions that may present to the family physician's office.
- 5.450 Integrate osteopathic principles and manipulative treatment into the management of urologic disorders.
- 5.451 Understand the somatic dysfunction, structural and reflux changes of urologic disease.
- 5.452 Understand the function of the pelvic floor and urogenital diaphragm in relation to urogenital organs and their function.
- 5.453 Understand the role of the above in the follow-up.

Geriatrics

Synopsis

- 5.454 **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. This aspect of the residents training should be met by the diversity of patients in the ambulatory and inpatient components of training. The resident in Integrated Osteopathic Family Practice/Neuromusculoskeletal Medicine should recognize the special needs of the geriatric patient, as well as the anatomical and physiological changes that occur with aging.

Goal

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:

- 5.455 Understand the physiologic changes that occur with aging.
- 5.456 Differentiate between normal age-related changes and disease pathology.
- 5.457 Recognize atypical presentations of diseases in elderly individuals.
- 5.458 Utilize basic geriatric assessment tools in clinical practice.

- 5.459 Assess and assign appropriate levels of long-term care for elderly person.
- 5.460 Understand the differences among the continuum of care for elders.
- 5.461 Manage the elderly patient in various levels of care.
- 5.462 Understand the role of the family in the care of the elderly.
- 5.463 Perform a functional assessment of elderly.
- 5.464 Understand the role of a multidisciplinary team in the care of the elderly.
- 5.465 Access available community resources to care for frail and/or homebound elderly patients.
- 5.466 Understand the role of and utilize hospice in the care of the dying patient.
- 5.467 Understand the use of appropriate immunizations in the elderly patient.
- 5.468 Understand the issue of self-determination including advanced directives.
- 5.469 Understand strategies to optimize quality of life.
- 5.470 Understand appropriate pain management in the elderly.
- 5.471 Understand pharmacokinetics in the elderly.
- 5.472 Recognize the importance of being an advocate for accessibility to health care for all elderly patients.
- 5.473 Utilize Osteopathic Manipulative Treatment with special attention in direct techniques in the treatment of the elderly patient.
- 5.474 Develop a knowledge base to design treatment plans that address the diseases of the elderly as well as accommodate for their unique anatomical and physiological condition.
- 5.475 Be familiar with age related changes, drug interactions, and dosages of medications frequently utilized by the specialist in Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine including but not limited to:
 - a. Anti-inflammatory medications.
 - b. Skeletal muscle relaxants.
 - c. Antidepressants.
 - d. Analgesics.

- 5.476 Recognize and be able to provide an osteopathic manipulative treatment plan for disease processes common to the elderly including, but not limited to:
- a. Osteoporosis.
 - b. Degenerative joint disease of the spine.
 - c. Spinal stenosis.
 - d. Osteoarthritis.
 - e. Peripheral vascular disease.
 - f. Compression fractures.
 - g. Gait disturbances.

Community Medicine

Goal

- 5.477 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:

- 5.478 Utilize community resources to assist in the management of patients.
- 5.479 Understand the role of local health departments in the management of patients.
- 5.480 Utilize evidence-based principles to determine appropriate strategies for care.
- 5.481 Identify modifiable risk factors for the prevention of disease.
- 5.482 Understand how physician's personal **behavior** affects the patient's perception of them as a role model for responsibility in their own health.
- 5.483 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.
- 5.484 Understand the role of and utilize Hospice in the care of the dying patient.
- 5.485 Understand the importance of recognizing cultural diversity among the patient population and within the community.

Sports Medicine

Synopsis

5.486 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

5.487 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:

5.488 Evaluate individuals for athletic participation clearance.

5.489 Manage uncomplicated injuries sustained in sports related activities.

Electives

Synopsis

5.490 There shall be a minimum of five (5) months and a maximum of seven (7) months of supervised **Family Practice** electives available to **each** resident during the course of the residency. At least one (1) month must be completed during OGME-1, at least two (2) months in OGME-2, and OGME-3.

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

Goal

5.492 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:

- 5.493 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.

Procedures

Synopsis

- 5.494 **The residency program must ensure that each graduating resident is competent in the performance of appropriate procedures.**

Goal

- 5.495 **Provide the resident thorough observed clinical training, educational experiences that will prepare him/her to perform procedures that are necessary to provide comprehensive patient care.**

Objectives

- 5.496 **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:

- 1. Incision and drainage of abscess**
- 2. Biopsy of skin**
- 3. Excision of subcutaneous lesions**
- 4. Cryosurgery of skin**
- 5. Curretage of skin lesion**
- 6. Laceration repair**
- 7. Injection of shoulder joint**
- 8. Injection/aspiration of knee joint**
- 9. Injection of sacroiliac joint**
- 10. Endometrial biopsy**
- 12. Office microscopy**
- 13. Casting**
- 14. EKG interpretation**
- 15. Office spirometry**
- 16. Toenail removal**
- 17. Defibrillation**

18. Removal of cerumen from ear canal
19. Insertion of urethral catheter
20. Endotracheal intubation

5.497 Optional Procedures

The program must offer residents exposure to the following procedures:

1. Vasectomy
2. Central line placement
3. Vaginal delivery
4. Episiotomy repair
5. Flexible sigmoidoscopy
6. Colonoscopy
7. Lumbar puncture
8. IUD insertion
9. Breast cyst aspiration
10. Epistaxis management (nasal packing/anterior cautery)
11. Trigger point injections
12. Allergy testing
13. Neonatal circumcision
14. Colposcopy with biopsy

Research and Scholarly Activity Requirements

Synopsis

- 5.498 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.
- 5.499 The participation of each resident in two active research activities **is** required, one **of which** must be **related to** NMM. 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 application.

Goal

- 5.500 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:

- 5.501 Understand the concepts of and principles behind evidence based medicine.
- 5.502 Critically evaluate medical literature and its applicability to clinical practice.
- 5.503 Participate in scholarly activities and convey findings to his/her peers.

PART SIX: EVALUATION

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 complete all assignments in a timely fashion.
 - b. Keep a log of each procedure performed.
 - c. Keep a log of patient contacts as required.
 - d. Be responsible for the completion of the Competency-Based Evaluation (CBE) forms and/or other required forms.
 - E. Participate in the annual ACOFP and AAO In-Service Exams as required. The resident should attend the AAO Convocation at least two (2) years during the OGME-2, 3, and 4 years to participate in the written and practical in-training examinations.**
- 6.3 At the completion of each rotation, the **appropriate faculty shall evaluate the resident.** 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, and a copy shall be sent to the central office of ACOFP and AAO as appropriate.

- 6.4 The Program Director will review the performance of each resident quarterly to insure that educational objectives are being met. This will be done together with the DME and the education committee of the institution where applicable. Residents should be advanced to positions of higher responsibility only on the basis of evidence of their satisfactory progressive professional growth.
- 6.5 The program must maintain a permanent record of evaluation for each resident. This must be available to the resident; the ACOFP Committee on Education & Evaluation, **the AAO Postdoctoral Standards and Evaluation Committee**, assigned inspectors, and other authorized personnel.
- 6.6 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 should verify that the resident has demonstrated sufficient professional ability to practice competently and independently. This final evaluation should be a part of the resident's permanent record maintained by the program.
- 6.7 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 Division of Postdoctoral Training 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 and the AAO.

Academic and Disciplinary Dismissals

- 6.8 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.
- 6.9 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 maybe placed on probation for a period of three (3) to six (6) months. The resident maybe dismissed following this period, if deficiencies remain and are judged to be unremediable. 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.

- 6.10 In cases of disciplinary infractions that are judged unremediable, 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 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 maybe 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.
- 6.11 Immediate dismissal without hearing will be allowed where patient or staff safety is judged by the Program Director to be at imminent risk.

Evaluation of Faculty

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

Evaluation of the Program

- 6.13 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 should participate in these reviews, and written resident evaluations should be utilized.
- 6.14 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.
- 6.15 The Program Director, in conjunction with the institution's departments of Osteopathic Family Practice and Osteopathic Manipulative Medicine or their equivalent shall evaluate the residency program annually.

Evaluation of Patient Care

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

Evaluation of Graduates

- 6.17 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.

PART SEVEN: EVALUATION OF THE PROGRAM

Synopsis

- 7.1 The ACOFP Committee on Education & Evaluation and the AAO Postdoctoral Standards and Evaluation Committee 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 & Evaluation will notify all residents in a program that receives a one (1) year continuing approval. This does not include new programs or provisional approval.

Probationary Status

- 7.3 All probationary continuing program approvals and all programs denial actions by **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 **PTRC** shall be effective on June 30, one year from the end of the academic year in which the **PTRC** action occurs. **PTRC** reserves the right to establish an earlier date of termination as appropriate.
- 7.5 All one (1) year continuing program approvals shall be considered probationary status.

Withdrawal of Program Approval

- 7.6 Approval of a training program maybe 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 **PTRC**.

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

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.

Program Lapse

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

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 Substance or continuing variance forms these basic standards.

APPENDIX 1

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 (1) 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 & Evaluation and the AAO Postdoctoral Standards and Evaluation Committee, 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, ECT, 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 (4) 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 (1) 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 or Integrated Family Practice/Neuromusculoskeletal Medicine 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 2

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 Integrated Osteopathic Family Practice/Neuromusculoskeletal Medicine.
- B. There will be an opportunity for these physicians to receive more than 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 & Evaluation and the AAO Postdoctoral Standards and Evaluation Committee, 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 (1) 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 & Evaluation and AAO Postdoctoral Standards and Evaluation Committee, 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 & Evaluation and AAO Postdoctoral Standards and Evaluation Committee, which will make recommendation for final approval to the **Program and Trainee Review Council (PTRC)**. This approval by **PTRC** must occur prior to the start of the program.

APPENDIX 3

GUIDELINES FOR ADVANCED PLACEMENT

- A. If a resident is accepted from another residency training program, the Program Director of the accepting program has the authority to determine which, if any, rotations from previous programs will qualify for a request for advanced standing.
- B. An AOA-approved internship or its equivalent is the prerequisite for acceptance into all ACOFP and AAO OGME-2, OGME-3 and OGME-4 approved training.
- C. Postgraduate medical education training will be considered on an individual basis for advanced credit in Integrated Osteopathic Family Practice/Neuromusculoskeletal Medicine residency programs.

Residents entering Integrated Osteopathic Family Practice/Neuromusculoskeletal Medicine residency programs who have taken previous residency training in accredited osteopathic or allopathic residency programs may request advanced placement of the Program Director. In all instances, the request for advanced standing will be reviewed by the Program Director, who shall forward requests to the ACOFP Committee on Education & Evaluation and the AAO Postdoctoral Standards and Evaluation Committee. The ACOFP Committee on Education & Evaluation and AAO Postdoctoral Standards and Evaluation Committee shall report to COPT of the AOA all approvals for advanced placement, in no instance is the Program Director compelled to recommend advanced standing to the ACOFP Committee and Evaluation and Education and the AAO Postdoctoral Standards and Evaluation Committee. Recommendations will be forwarded to the AOA **Program and Trainee Review Council (PTRC)**.

- D. Credit maybe granted according to the following criteria:
 - 1. Training taken in an Integrated Osteopathic Family Practice/Neuromusculoskeletal Medicine residency will be compared and the quality of that training assessed according to the Basic Standards for Residency Training in Integrated Osteopathic Family Practice/Neuromusculoskeletal Medicine and month-for-month or service-for-service credit maybe recommended.
 - 2. Training taken in any discipline other than Integrated Osteopathic Family Practice/Neuromusculoskeletal Medicine will be assessed by the Program Director to determine if it is applicable to Integrated Osteopathic Family Practice/Neuromusculoskeletal Medicine and a maximum of four (4) months of credit beyond completion of OGME-1 or its equivalent maybe recommended for approval.

APPENDIX 4

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 Program Director's Report on the form provided by the ACOFP with thirty days of the resident's program completion, or within thirty days of the resident's termination from the program. Residents will sign this form and retain a copy for their use.
 - 2. The Program Director must provide a copy of the institutional certificate of completion of the Integrated Osteopathic Family Practice/Neuromusculoskeletal Medicine residency program, to the ACOFP, within thirty days of the program's completion.
 - 3. The resident will be asked to complete a resident evaluation form provided by the ACOFP Committee on Education & Evaluation in evaluating 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 **Program and Trainee Review Council (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.

APPENDIX 5

AOA POLICY ON POSTDOCTORAL TRAINING RESIDENT WORK HOURS AND SUPERVISION POLICIES

It is recognized that excessive numbers of hours worked by resident physicians can lead to errors in judgment and clinical decision-making. These can impact on patient safety through medical errors, as well as the safety of the physician trainees through increased motor vehicle accidents, stress, depression and illness related complications. The training institution, DME and residency Program Director must maintain a high degree of sensitivity to the physical and mental well being of residents and make every attempt to avoid scheduling excessive work hours leading to sleep deprivation, fatigue or inability to conduct personal activities.

A. Work Hours

1. The following work hour's policy will apply to all residents in all specialties.
 - a. The resident shall not be assigned to work physically on duty in excess of eighty hours per week averaged over a four-week period, inclusive of in-house night call.
 - b. The resident shall not work in excess of twenty-four consecutive hours inclusive of morning and noon educational programs. Allowance for, but not to exceed up to six hours for inpatient and outpatient continuity, transfer of care, educational debriefing and formal didactic activities may occur. Residents may not assume responsibility for a new patient after twenty-four hours.
 - c. If moonlighting is permitted, all moonlighting will be inclusive of the eighty hour per week maximum work limit and must be reported.
 - d. The resident shall have alternate forty-eight hour periods off or at least one twenty-four hour period off each week.
 - e. Upon conclusion of a twenty-four hour duty shift, residents shall have a minimum of twelve-hours off before being required to be on duty again. Upon completing a lesser hour duty period, adequate time for rest and personal activity must be provided.
 - f. All off-duty time must be totally free from assignment to clinical or educational activity.
 - g. Those rotations requiring the resident to be assigned to Emergency Department duty shall not be assigned longer than twelve-hour shifts.

