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AMERICAN OSTEOPATHIC ASSOCIATION

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

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## PART ONE: INTRODUCTION

- 1.1 Combined residency training programs in Osteopathic Emergency Medicine and Osteopathic Family Practice and Manipulative Treatment are designed to provide the osteopathic physician with advanced and concentrated training in the specialties of Osteopathic Emergency Medicine and Osteopathic Family Practice. Combined training in Osteopathic Emergency Medicine/Family Practice is the sole recognized pathway for Osteopathic Emergency Medicine (EM) residents to train in Osteopathic Family Practice (FP) and the sole recognized pathway for Osteopathic Family Practice residents to train in Osteopathic Emergency Medicine, other than completion of both categorical EM and FP residency programs accredited by the AOA. These programs must be designed to meet the needs of the osteopathic medical school graduate desiring to be certified in Osteopathic Emergency Medicine and Osteopathic Family Practice and Manipulative Treatment. The osteopathic concept of health care emphasizes that the human body is a unit in which structure and function are mutually and reciprocally interdependent; that the body, through a complex equilibrium system, tends to be self-regulatory and self healing; that adequate function of body systems depends upon the unimpeded flow of blood and nerve impulses; that the musculoskeletal elements comprise a body system, whose importance far exceeds that of providing framework support; and that there are somatic components of disease that are not only manifestations of, but are also important contributing and/or maintaining factors in the diseased area as well as areas distant from the diseased part. Disease prevention is the cornerstone of osteopathic family practice and shall be given major emphasis throughout the curriculum.
- 1.1.2 These basic standards are approved by the American Osteopathic Association (AOA), the American College of Osteopathic Emergency Physicians (ACOEP), and the American College of Osteopathic Family Physicians (ACOFPP).
- 1.2 Upon the successful completion of a residency in Osteopathic Emergency Medicine/Osteopathic Family Practice and Manipulative Treatment, the physician will have advanced and concentrated training in both specialty areas, and be prepared to provide comprehensive osteopathic health care to diverse populations.

### Purpose

- 1.3 To provide the resident with a properly organized training program, in both cognitive and procedural domains, that will provide progressive primary responsibility for patient care in both the inpatient and outpatient setting through continuity of didactic and clinical experiences. The training in the application of osteopathic principles and practice is an integral part of all programs.

### Training Requirements

- 1.4 Combined Osteopathic Emergency Medicine/Family Practice residency training programs must be **five (5)** years in length, with the first year consisting of an AOA-approved OGME-1 year. The program must meet or exceed the requirements listed within this document and meet all the requirements of the AOA Accreditation Document for Osteopathic Postdoctoral Training Institutions (OPTI) and The Basic Document for Postdoctoral Training Programs.
- 1.5 Individuals successfully completing this residency will be eligible for examination for certification in both osteopathic emergency medicine and osteopathic family practice and manipulative treatment.

## Scope of Training

- 1.6 All programs must be designed to provide training that meets the needs of those graduates who intend to become osteopathic emergency medicine and/or osteopathic family practice physicians. The presence of other programs sponsored by the institution i.e. geriatric medicine and/or sports medicine must not result in dilution of the experience available to the osteopathic emergency medicine/family practice residents.
- 1.7 A residency training program shall commence after it has received the approval of the AOA Program and Trainee Review Council (PTRC).

## PART TWO: INSTITUTIONAL REQUIREMENTS

### Sponsoring Institution

- 2.1 To be approved by the American Osteopathic Association for residency training in emergency medicine/ osteopathic family practice and manipulative therapy, 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, and sponsor established AOA-approved residency programs in both emergency medicine and family practice and manipulative treatment.
- 2.2 The institution must provide sufficient patient volume to properly train a minimum of 2 residents annually in this combined program. There must be a minimum of six (6) residents in osteopathic family practice (2 per year) and 6 residents in emergency medicine (2 per year). Residents in the combined program are included in the calculation of the minimum number of required residents. The available patients must provide a broad spectrum of problems, as defined in this document, for the adequate training of residents.
- 2.3 Of the minimum four OGME-1 required positions, there must be a minimum of one approved position dedicated to Family Practice, and one approved position dedicated to Emergency Medicine.
- 2.4 The institution must participate in the AOA match program through linkage with the Family Practice and Emergency Medicine residencies.
- 2.5 The institution must have a Department of Emergency Medicine and a Department of Family Practice at the base institution, organized according to the recommended standards of the American College of Osteopathic Emergency Physicians and American College of Osteopathic Family Physicians respectively. Experienced emergency medicine department faculty and family practice department faculty must participate in the training of the osteopathic emergency medicine/osteopathic family practice and manipulative treatment resident. A minimum of 50% of the emergency medicine department faculty must be board certified in emergency medicine by the AOA. One physician from each department will be designated as the program co-director of the combined residency. The chairperson of the department of emergency medicine must be certified by either the American Osteopathic Board of Emergency Medicine (AOBEM) or the American Board of Emergency Medicine (ABEM), and may not be the program director.
  - 2.5.1 The Department of Emergency Medicine at the base institution must:
    1. Have faculty as well as core faculty to teach and supervise residents. All physicians supervising emergency medicine residents must meet the faculty requirements. In

addition, a group of core faculty must be appointed who meet more stringent core faculty requirements. The role and duties of the core faculty must be clearly defined.

2. Have all additional physicians who are clinically supervising emergency medicine residents certified in emergency medicine by the AOA/AOBEM or ABEM or in the process of being certified. Resident supervision by faculty members must be provided 24 hours a day.
3. Provide significant clinical exposure to osteopathic emergency physicians.
4. There must be a minimum of four (4) FTE core faculty members. **A ratio of one FTE core faculty to every six combined residents must be maintained.**
5. Have the scope, volume, and variety of patients to support the training of residents in the program. This is generally a minimum volume of 25,000 Emergency Department visits annually at the base institution. Larger programs may require higher volumes. Other emergency medicine sites that are affiliated with this base institution must each have a minimum volume of 20,000 Emergency Department visits annually.
6. Provide experience and training in the management of emergency department patients. This training should take place at the base hospital and its affiliated sites; however, at least 50% of the training **must** take place at the base institution.
7. Ensure that osteopathic principles and practice and their application to emergency medicine are emphasized and employed.

2.5.2 The department or section of family practice must comply with the standards set forth in the Basic Standards for Residency Training in Osteopathic Family Practice and Manipulative Treatment (see Part Two of the basic standards).

- 2.6 Upon satisfactory completion of the training program, the institution shall award the resident an appropriate certificate. The certificate shall confirm the fulfillment of the program requirements, starting and completion dates of the program, the name(s) of the training institution(s), and the name(s) of the Program Director(s).
- 2.7 The sponsoring institution must require participation in the AOA Clinical Assessment Program (CAP) or its equivalent.
- 2.8 The sponsoring institution must maintain a participation rate (five year rolling average) of 100% in the AOBFP and AOBEM certification examination. The rate will be calculated from the time of the previous inspection.
- 2.9 The sponsoring institution must maintain an 85% pass rate (5 year rolling average) of the AOBFP and AOBEM rolling average.

### **Participating Institutions**

- 2.10 To assure that all combined osteopathic emergency medicine/osteopathic family practice and manipulative treatment residency programs are committed to and capable of delivering uniquely osteopathic postdoctoral training, each program must be affiliated with an Osteopathic Postgraduate Training Institute (OPTI).

- 2.11 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.
- 2.12 Any institution participating in the training of residents must have an affiliation agreement with the base institution.

### **Appointment of Residents**

- 2.13 The program must provide a written policy and procedures for the selection of residents.
- 2.14 In order to be accepted into a combined osteopathic emergency medicine/family practice residency program, an applicant must:
  - a. Have graduated from an AOA accredited college of osteopathic medicine.
  - b. Have passed COMLEX II, including the clinical skills portion of this exam.
  - c. Be or become a member of the AOA, ACOEP, and ACOFP. These memberships must be maintained throughout the residency training.
  - d. Be appropriately licensed in the state in which the training is conducted.
- 2.15 Each first year resident shall receive a medical evaluation, as well as any routine laboratory studies as required by the institution. All immunizations must be current.
- 2.16 For appointment to advanced standing and other special circumstances see Appendix III.

### **Administration of the Educational Program**

- 2.17 A maximum of twenty (20) business days (Monday through Friday) per year of vacation, professional, sick, or other leave may be granted by the Program Director, unless such leave is designated by federal, state, or union regulations. In such cases, federal, state and/or union regulations shall supersede these policies. No more than twenty (20)-business days of leave per year may be granted for any purpose without extending the residency. If a resident is given a leave of absence for reasons of maternity, physical, or mental disabilities and returns to duty, he/she may continue the training to completion for the required 260 weeks of training. The program shall have a written statement of policies regarding leave in the resident manual.
- 2.18 At the beginning of the residency training program, there shall be a period devoted to the formal orientation of the NEW residents to the administrative and professional organization of the program, including but not limited to, facilities available, 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.
- 2.19 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. A statement indicating outside work for pay is prohibited during OGME-1.
- g. A statement indicating membership in the AOA, ACOFP, and ACOEP is required.
- h. Policies governing evaluation and appeal mechanisms.

### Resident Schedules and Workload

2.20 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. Refer to the “AOA Accreditation Document for Osteopathic Postdoctoral Training Institutions (OPTI) and the Basic Document For Postdoctoral Training Programs.” Current policy from that document reads:

- [2.70] The trainee shall not be assigned to work physically on duty in excess of 80 hours per week averaged over a 4-week period, inclusive of in-house night call.
- [2.71] The trainee shall not work in excess of 24 consecutive hours inclusive of morning and noon educational programs. Allowances for inpatient and outpatient continuity, transfer of care, educational debriefing and formal didactic activities may occur, but may not exceed 6 hours. Residents may not assume responsibility for a new patient after working 24 hours.
- [2.72] The trainee shall have on alternate weeks 48-hour periods off or at least one 24-hour period off each week
- [2.73] Upon conclusion of a 24-hour duty shift, Trainees shall have a minimum of 12 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.
- [2.74] All off duty time must be totally free from assignment to clinical or educational activity.
- [2.75] Rotations in which the trainee is assigned to Emergency Department duty shall ensure that trainees work no longer than 12-hour shifts.
- [2.76] The trainee and training institution must always remember that patient care responsibility is not precluded by the work hour policy. In cases where a trainee is engaged in patient responsibility that cannot be interrupted, additional coverage should be provided as soon as possible to relieve the resident involved.
- [2.77] The trainee may not be assigned to call more often than every third night averaged over any consecutive four-week period.

2.21 During the on-call period, the resident must have a room with a bed, phone, and lavatory. There shall be a faculty member assigned as back up to the resident during each on call day.

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

- 2.23 The Program Director and Director of Medical Education shall provide for the proper supervision and clinical teaching of all training assignments.
- 2.24 Outside employment will not be allowed during OGME-1.
- 2.25 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.
- 2.26 Outside employment (moonlighting) by residents may be done only with approval of the Program Directors 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. Any other criteria established by the institution, program, DME, Program Director or OPTI.
  - d. All policies must be consistent with the AOA moonlighting policy for trainees found in the “AOA Accreditation Document For Osteopathic Postdoctoral Training Institutions (OPTI) And The Basic Document For Postdoctoral Training Programs.” (See 2.78-2.80 in that document.)
  - e. **Residents may not work in the same emergency department in which they are currently training as a resident or in any emergency department that they may serve as a resident at an affiliated institution.**

## **PART THREE: FACULTY QUALIFICATIONS AND RESPONSIBILITIES**

### **Program Director**

#### **Synopsis**

- 3.1 A combined osteopathic emergency medicine/osteopathic family practice and manipulative treatment residency program may not share the program director(s) with another institution.
- 3.2 The program director(s) of the combined osteopathic emergency medicine/osteopathic family practice and manipulative treatment residency program must be a compensated position.

#### **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 certified in **his or her** respective specialty by the American Osteopathic Board of Emergency Medicine (AOBEM) or the American Osteopathic Board of Family Physicians. A single program director can be appointed from either specialty if they are certified by both specialty boards or co-directors may be appointed from both specialties. A single director who is board certified in each discipline must hold an appointment in each

- department. The supervising directors from both specialties must document meetings with one another and the leadership of their respective departments at least twice a year to monitor the success of the program and the progress of each resident.
- 3.5 The Program Director(s) must be a member in good standing of the AOA and their respective Osteopathic Specialty College.
  - 3.6 The Program Director/s must be an active member of their respective department (emergency medicine or family practice or its equivalent), and engaged in patient care.
  - 3.7 The Program Director(s) must demonstrate experience and/or interest in the field of medical education as well as demonstrate administrative ability and sufficient expertise to implement educational programs.
  - 3.8 The Program Director(s) must meet the standards of the position as formulated in the AOA Accreditation Document for Osteopathic Postdoctoral Training (OPTI) And The Basic Document for Postdoctoral Training Programs.
  - 3.9 The Family Practice Program Director shall have no less than three (3) years of family practice experience (not including time as a resident), prior to becoming a Program Director. The Emergency Medicine Program Director must have practiced emergency medicine for five (5) years or been full time faculty with an emergency medicine residency program for three (3) years.
  - 3.10 A new Program Director of a residency with more than twelve approved slots shall fulfill one of the following:
    - a. Have served as Program Director of another residency for no less than three (3) years.
    - b. Have served as Associate Program Director of a residency for no less than three (3) years.
  - 3.11 **New or acting program directors must be approved by the evaluating committee of their respective specialty college before assuming the position of program director. They may serve in an acting capacity until final approval is given.** A program director certified in both specialties must be approved by **the evaluating committees of both specialty colleges.**
  - 3.12 Exceptions to the requirements for Program Director may be approved by an ad hoc committee of the ACOFP Committee on Education & Evaluation, or ACOEP Committee on Graduate Medical Education respectively.

## Responsibilities

- 3.13 The Family Practice Program Director, or physician designee, must attend a residency directors' workshop sponsored by the American College of Osteopathic Family Physicians every year in order to qualify the residency program for approval. The Emergency Medicine Program Director, or physician designee, must attend a residency directors' workshop sponsored by the American College of Osteopathic Emergency Physicians every year in order to qualify the residency program for approval. Each Program Director must personally attend **his or her specialty college forum** 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 (1) year from their appointment. .
- 3.14 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 combined Osteopathic Emergency Medicine/Osteopathic Family Practice and Manipulative Treatment as outlined in this document.

- 3.15 The Program Director(s) shall provide for the proper supervision and clinical teaching of all training assignments. Continuity of the faculty is to be encouraged.
- 3.16 The Program Director(s) shall assure the arrangement of affiliations and/or outside rotations necessary to meet the program objectives.
- 3.17 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.
- 3.18 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.
- 3.19 The Program Director (s) shall report annually by August 1 to the ACOFP Committee on Education & Evaluation and the ACOEP Committee on Graduate Medical Education. This report shall contain documentation of all residents in the program along with other information as specified on forms furnished by ACOFP and the ACOEP.
- 3.20 The Program Director (shall) verify that each resident demonstrates competency in meeting or exceeding the minimum standards for quality patient care utilizing a competency-based evaluation.
- 3.21 The Program Director(s) shall report to the ACOFP Committee on Education & Evaluation or the ACOEP committee on Graduate Medical Education respectively, deficiencies in the residency or internal problems in the parent institution that could adversely affect the educational component of the residency.
- 3.22 The Program Director(s) shall devote a minimum of 400 hours per-year to teaching and administrative activities exclusive of patient care. He/she must be compensated for this time.
- 3.23 The Program Director(s) shall assure that he/she and/or the faculty are qualified to perform and teach all the required procedures listed in Part Five (Program Requirements, Procedures) of this document.
- 3.24 The Program Director(s) must assume leadership for the coordination of inspections as required by the AOA.

#### **Director of Medical Education (DME)**

- 3.25 The residency training program shall have faculty and administrative staff who are qualified by training and experience to teach osteopathic graduates. These professionals shall not only be competent medical practitioners, but they shall also be dedicated to the science and art of education.
- 3.26 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"

- 3.27 The duties of the DME will include meeting with all residents at least quarterly to insure that program objectives are being met.
- 3.28 The DME and/or program directors shall be required to return accurate information to the AOA in electronic format sixty days after requested and if information is not returned, the AOA reserves the right to remove all associated program listings from Opportunities.
- 3.29 The Director of Medical Education, with the Program Director(s), must verify the accuracy of the Resident Competency-Based Evaluations.

### **Family Physician Faculty**

#### **Synopsis**

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

#### **Qualifications**

- 3.31 All faculty members must be licensed to practice medicine in the state in which the training site is located.
- 3.32 All family physician faculty members must be certified in family practice. The ACOFP Committee on Education & Evaluation will determine the acceptability of alternate qualifications.
- 3.33 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.
- 3.34 The faculty shall consist of teachers with diverse interests and expertise to ensure the training responsibilities of the program are met. There must be a critical mass of family physician faculty to assure sufficient continuity of teaching and supervision. When part-time faculty is used, continuity of teaching and supervision must be maintained.
- 3.35 There must be family physician faculty with admitting privileges in the hospital(s) where the residents' patients are hospitalized.
- 3.36 The family physician faculty shall, as a group, be qualified to teach all of the required procedures as listed in Part Five (Program Requirements, Procedures) of this document.

- 3.37 The Program family practice program director must attend a regional, or national ACOFP procedural institute, or its equivalent, every two (2) years.

### **Responsibility**

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

### **Emergency Medicine Faculty**

- 3.39 The department of emergency medicine shall designate core faculty members who shall be specifically designated, full-time members of the department of emergency medicine at the base institution.**
- 3.40 Core faculty members must be certified or an active candidate in the process of certification by the AOA/AOBEM or ABEM.**
- 3.41 Core faculty members must be qualified by training and experience to perform their teaching role, including recertification within the prescribed time frame of the certifying body.**
- 3.42 Fifty percent (50%) of the core faculty must be osteopathic emergency physicians who participate in the training of residents.**
- 3.43 Core faculty must demonstrate sufficient scholarly activity, such as lecturing on a national basis, participation in textbook chapters, research or active involvement in national emergency medicine organizations. Faculty credentials must be on file and available at the time of inspection.**
- 3.44 Core faculty must be provided sufficient non-clinical time to provide instruction, leadership and participation in scholarly activities. Furthermore, core faculty must participate in the academic educational program, such as formal lectures, case conferences and journal clubs and other requirements of the core curriculum (see Appendix 2). This will require at least four (4) hours of compensated, non-clinical time per week.**
- 3.45 The program director may be counted as a member of the core faculty.**
- 3.46 The institution shall have administrative and other non-physician staff committed to the program to support teaching and administrative in the emergency medicine residency program.**

### **Faculty Research and Scholarly Activity**

- 3.47 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 states, and the application of this knowledge to clinical practice.

## **FAMILY PRACTICE FACULTY**

- 3.48 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.

## **EMERGENCY MEDICINE FACULTY**

- 3.49 The program director(s) must show evidence of active involvement in research and academic pursuits such as publication in peer reviewed journals, textbook, local or specialty publications, formal lectures, and visiting professorships within the last five (5) years.**
- 3.50 Core faculty must demonstrate sufficient scholarly activity, such as lecturing on a national basis, participation in textbook chapters, research or active involvement in national emergency medicine organizations within the last five (5) years.**
- 3.51 Evidence of the program director's and core faculty scholarly activity must be on file and available at the time of inspection.**

### **Other Faculty**

- 3.52 Physicians from other specialties are an essential component of the faculty. These faculty members must spend sufficient time in teaching and supervising the residents to ensure the accomplishment of the program goals in their specialty area. This may be accomplished through direct supervision or serving as a consultant in the care of the resident's patients.
- 3.53 Additional teaching faculty/staff are encouraged, especially in the areas of behavioral science, nutrition, addiction, and pharmacology.
- 3.54 All faculty members must have appropriate credentials in their respective field. The sponsoring institution shall have the responsibility of determining the acceptability of qualifications for all faculties.

### **Administrative Director of Medical Education**

- 3.56 Refer to section 2.22-2.24 of the Basic Documents for OPTI and Postdoctoral Training Programs.
- 3.57 This person shall report to the DME of the sponsoring institution.
- 3.58 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 The medical staff should be organized so that family **and emergency** physicians participate in the hospital governance on an equivalent level to that of other specialties. There must be clinical departments of family practice and emergency medicine.

### Ambulatory Continuity of Care Training Site

- 4.5 The primary setting for training in the knowledge, skills, and attitudes of osteopathic family practice is the model ambulatory office (continuity of care training site). It is here that the resident will learn to provide continuing, comprehensive care. This will be accomplished by being responsible for a panel of patients over the course of the training period.
- 4.6 Each program shall provide a minimum of one osteopathic family practice training site. Multiple sites will be approved only if the program shows adherence to all standards set forth in this document. This facility will help insure that each osteopathic family practice resident will receive an adequate continuity of care experience with a panel of patients and families over a sixty month or 260 week continuum.
- 4.7 Each facility should include a waiting area, examination rooms, consultation room, resident's office, 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 available as appropriate to the location of the site.
- 4.9 Each continuity of care site must have the capability to perform the following procedures at the time of the patient visit: glucose, throat culture or rapid strep screen, urinalysis, wet mount of vaginal secretions, EKG, spirometry, screening audiometry, and microscopic evaluation of urine.
- 4.10 It is desirable to have the availability of flexible sigmoidoscopy, colposcopy, and minor surgery on site. If these procedures are not done in the continuity of care training site, there must be a mechanism in place that allows the resident to perform, under supervision, these procedures on his/her patients.

- 4.11 The economic aspect of the osteopathic family practice training site must be self-contained and patterned after that of a private practice. This includes, but is not limited to, appointments, statements, insurance form filings, etc. Data, specific to each resident is to be used in the economics section of the residency.
- 4.12 Faculty and support staff must be available in appropriate numbers. There shall be a ratio of one FTE faculty for every six osteopathic family practice residents in the program. Residents must not provide for patient care in an unsupervised setting.
- 4.13 Allied health professionals should be part of the site's health provider team when appropriate to both facilitate patient care and familiarize the resident to their function in the delivery of primary care.
- 4.14 A professional medical records system must be maintained that provides for patient care audit and chart review. Chronic medication lists, problem lists, and prevention protocols should be prominent and used to assist in continuity of care. The medical record system can be maintained in any manner that easily provides recognition of each resident's patient panel.
- 4.15 An ambulatory setting, providing primarily episodic care, cannot be used as a continuity of care site. Patient care visits at the continuity of care facility must be predominantly by appointment.
- 4.16 The continuity of care training site may be located in proximity with a multi specialty site provided the operations are separate. The osteopathic family practice residency continuity of care patient panel appointments must be made through the osteopathic family practice section. An appropriate mechanism must be in place to assure that a proportionate number of new patients are assigned to the osteopathic family practice resident panel.

### **Library Services**

- 4.17 Residents must have ready access to a major medical library. **This library shall include access to standard medical reference texts and current medical journals, and computer-assisted literature search capabilities, and must have on-line access to medical databases. After hours availability of library services is essential.**

### **Patient Population**

- 4.18 The patient population served by the residency program facilities shall be diverse. This implies gender, cultural, and age diversity. The ability to provide care to these populations in the hospital, at home, in the continuity of care training site, and long term care facilities must be demonstrated.
- 4.19 A sufficient number of inpatients must be available to provide adequate training in all the specific component parts of the curriculum.
- 4.20 The disease spectrum available for the resident's education must demonstrate a broad range of problems and mirror that which is common to the community in general.

### **Emergency Medicine Facilities**

- 4.21 While emergency medicine residency training may take place in many places, the program must provide training in at least two distinct clinical sites.

- 4.22 The institution must provide emergency facilities that provide sufficient space and ancillary medical assistance to provide expedient and excellent patient care.
- 4.23 The emergency medicine department at the base institution must have a minimum of 25,000 emergency department visits annually. Other training sites must have a minimum of 20,000 emergency department visits annually. Each institution must have the appropriate scope and volume of patient visits to support a residency training program.
- 4.24 The emergency medicine department must have an attending emergency physician on duty at all times who fulfills the faculty requirements.

## **PART FIVE: PROGRAM REQUIREMENTS**

### **Core Competencies**

- 5.1 The following Core Competencies shall be required of all residents to successfully complete a residency in osteopathic family practice and manipulative treatment. The following core competencies 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 osteopathic family practice faculty in conjunction with the emergency 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 Any major change to a combined Osteopathic Emergency Medicine/Osteopathic Family Practice residency program must be approved in writing by the ACOFP Committee on Education & Evaluation, and the ACOEP Committee on Graduate Medical Education 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 combined osteopathic emergency medicine/osteopathic family practice residency training program a required and structured curriculum. This shall incorporate the educational objectives listed in these basic standards. Each phase of the curriculum shall be properly allocated as to time, either longitudinally or as an intensive experience of shorter duration.
- 5.14 The following "core" curriculum is required. In addition to this portion of the training, each program is to define those areas of instruction that are unique to that specific program.
- 5.15 Specific methods of teaching and evaluation with written objectives and goals for each portion of the curriculum shall exist.
- 5.16 The residency training shall be five (5) years or sixty 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, as well as emergency 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.
- 5.17 Pilot or experimental programs and/or projects will be considered. Proposals must demonstrate equivalent training to the basic program as outlined in this document. All such proposals must be approved in advance by the ACOFP Committee on Education & Evaluation and the ACOEP Committee on Graduate Medical Education.
- 5.18 From the start of the OGME-1 year, the physician will have up to eight (8) years to complete the program requirements.
- 5.19 Rotations will not be completed on a weekend-only basis. Residents whose training is less than full-time will be included in the approved number of positions for the training site.

### **Principles of Osteopathic Family Practice**

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

### **Continuity of Care**

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

- 5.22 Learning continuity of care is not limited to the continuity of care site and the hospital. For those patients unable to visit the continuity of care site, appropriate assignment to resident panels will be made in order to provide the resident with experience in home care and care in long-term care facilities.
- 5.23 Each resident is expected to maintain continuity of responsibility for his/her patients when such patients require hospitalization or consultation with other health care providers. The resident must maintain active participation in the decisions involving the health of the patient.

### **Osteopathic Comprehensive Health Care**

- 5.24 Recognizing the validity of the principles of osteopathic medicine, especially that of treating the whole person, each program shall provide the opportunity for the resident to gain a thorough understanding of the role social, cultural, behavioral, spiritual, and biologic dimensions play in the health of the individual.
- 5.25 Structure and function are integrally related. With this relationship intact, the body has the capacity to maintain health. The resident shall be provided the opportunity to achieve competence in health maintenance and disease prevention, utilizing the principles promoted in the osteopathic philosophy.
- 5.26 Health promotion and disease prevention is a major responsibility of the family physician. Teaching this to residents is an essential part of each component of the curriculum. This shall be done through stressing health assessment, health education, preventive care, behavioral counseling, genetic counseling, the role of the family in the care of the patient (especially end of life care), aging, nutrition, and epidemiology of illness, as well as acute and chronic disease management.
- 5.27 Methods of record keeping that facilitate longitudinal, comprehensive, preventive care shall be utilized. The resident will be taught the importance of this as it relates to health promotion and quality of care assessment.

### **Component Sections of Core Curriculum**

#### **General Information**

- 5.28 Recognizing that family physicians do the majority of their patient care in an ambulatory setting, and emergency physicians spend the majority of time in the emergency department, the major portion of the training time must be spent providing comprehensive care for patients in ~~the~~ those settings.
- 5.29 Flexibility in curriculum is desirable and necessary. A basic core exists to provide a comparable educational experience for all graduates of the program. The expected goal of osteopathic family practice education is to train a physician to manage the majority of the patients presenting to his/her office and to provide the opportunity to acquire the knowledge and behavioral skills to render continuing and comprehensive health care to those patients. This curriculum is designed as a general guide to concepts and skills that should be acquired while in a residency. The curriculum assumes a five (5) year integrated program, inclusive of an AOA-approved OGME-1 year. Other sequences of educational experiences may result in deficiencies that would have to be corrected in order to attain the level of experience listed. Each of the topics listed on the following pages must be included in every residency program.

- 5.30 For each component section of the curriculum, a set of basic competencies has been identified. These should set the standard for the performance skills of all residents. These competencies can be found in the Competency-Based Evaluation document.

### **Continuity of Care Training Site**

#### **Synopsis**

- 5.31 The "core" of the osteopathic family practice 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 osteopathic emergency medicine/osteopathic family practice residency program. The continuity of care training requirement cannot be fulfilled by any discipline other than osteopathic family practice. The test of continuity of care is whether or not the same resident has seen the same patient each time the patient presents to the continuity of care site. This should occur a majority of the time, except in emergencies. Schedules should be adjusted to accommodate this phase of the residency. It is the continuity of care training that has a defined time element.
- 5.32 The osteopathic family practice training site shall be the central focus for the osteopathic family practice resident's continuity of care experience. Osteopathic family practice is a comprehensive specialty that encompasses the total health care of the individual and the family. Physiological, emotional, cultural, economic, psychological, and environmental factors as they relate to the disease process are considered.

#### **Facility**

- 5.33 For a given resident, the continuity of care experience may be at no more than two sites. If the residency program elects to use two sites; the resident may be assigned to both sites simultaneously, or each site for a minimum of twelve consecutive months during OGME-2 through OGME-5. During OGME-1, the continuity experience must be at the same continuity site. Each site must meet all the requirements for the continuity of care experience as outlined in these basic standards. Each site must be self-contained as to the required elements of patient care and education. With multiple sites, the sponsoring institution must have in place mechanisms to insure the required educational experiences at each site. Assignment of a resident to a single continuity of care site for the entire residency is the preferred method.
- 5.34 Osteopathic manipulative treatment will be integrated into the continuity of care experience and documented on the charts.
- 5.35 Supervision of the continuity of care experience will be provided by a family physician certified by the American Osteopathic Board of Family Physicians. A ratio of one FTE faculty for every six osteopathic residents in the program shall be maintained.

#### **Patient Pool for Continuity of Care**

- 5.36 The patient population of the continuity of care facility should mirror that of the community as far as age, gender, ethnicity, and payer mix.
- 5.37 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 designated patient panel must have

documented multiple visits to the facility. Each panel must reflect a variety of diagnosis compatible with the educational objectives of the residency. This 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 six patients per half day at the beginning of the residency and at least ten patients per half day at the completion of the residency. This is of course variable depending on the complexity of the patients' problems. Patients will be assigned exclusively to faculty only after the needs of the residents are met.

### **Scheduling of Continuity of Care**

- 5.38 The continuity of care assignment is the most important single feature of the residency. No rotation or discipline or other duties are to interfere with the intent or implementation of the continuity of care experience portion of the residency.
- 5.39 The first year resident will spend one-half day per week for the entire year in the continuity of care training site. The patients seen during this longitudinal experience will be the nucleus of the resident's panel of patients that he/she will follow during the remaining months of the residency. This experience should be scheduled on the same day, Monday through Friday, throughout the year. In programs that have more than one continuity of care training site, each resident must complete this experience in the same facility so as to assure continuity of care training with the same patient population.
- 5.40 During years two through five there must be documented a minimum of **four** hundred half days in the continuity of care experience. This continuity of care experience is separate from other ambulatory care experiences.
- 5.41 Fifty-one percent or **two** hundred and four half days of the continuity of care experience should be completed at the institution granting the residency certificate.
- 5.42 The sequence of the required half days may be adjusted to accommodate the need to utilize outside rotations.

### **Goals**

- 5.43 To provide didactic and clinical learning experiences in an ambulatory setting to assure competence in treating patients in this aspect of osteopathic family practice.
- 5.44 To provide the opportunity for progressive responsibility in longitudinal patient care.
- 5.45 To provide instruction in outpatient procedures and ambulatory care practice.

### **Objectives**

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

- 5.46 Deliver osteopathic care to patients in an ambulatory setting.

- 5.47 Manage effectively a normal caseload during a scheduled day.
- 5.48 Develop medical practice management skills.
- 5.49 Increase his/her expertise in:
  - a. Methods of referring patients.
  - b. Methods of counseling.
  - c. Providing patient education.
  - d. Delivery of osteopathic manipulative treatment.
  - e. Diagnosis and treatment of patients in all age groups.
  - f. Providing preventative measures for a varied patient population.
  - g. Diagnosing and managing medical and surgical problems.
- 5.50 Develop a thorough understanding of family oriented care.
- 5.51 Become familiar with the evaluation of industrial injury and criteria for returning to work.
- 5.52 Become familiar with the basic guidelines for reporting communicable diseases.
- 5.53 Become familiar with the use of community resources in total patient care.
- 5.54 Learn how to be a part of a health care team.
- 5.55 Demonstrate team leadership skills.

## **Hospital Care**

### **Synopsis**

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

### **Goal**

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

### **Objectives**

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

- 5.58 Manage hospitalized patients.

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

## **Osteopathic Principles and Practice**

### **Synopsis**

- 5.60 This component of the curriculum shall be taught in a longitudinal fashion in all patient care settings. This may be accomplished through didactic lectures, one-on-one tutorial instruction, direct application of osteopathic manipulative treatment or other appropriate formats.
- 5.61 The continuity of care training site is key to the development of good skills in osteopathic manipulative treatment. Appropriate supervision shall be provided so that the resident will integrate these skills into the daily care of his/her patients. This shall be documented in the medical record.

### **Goals**

- 5.62 To teach the resident, through didactic as well as clinical settings, the application of osteopathic principles and osteopathic manipulative treatment in all patient care settings.
- 5.63 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:

- 5.64 Describe the philosophy behind osteopathic manipulative treatment.
- 5.65 Describe the role of the musculoskeletal system in disease, including somato/visceral reflexes, alterations in body framework, and trauma.
- 5.66 Describe contraindications to osteopathic manipulative treatment.
- 5.67 Utilize multiple methods of treatment including, but not limited to, High-Velocity/Low Amplitude (HVLA), strain/counter strain, and muscle energy.
- 5.68 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**

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

### **Goals**

- 5.70 To provide training so the resident will be able to diagnose and manage the psychological component of disease.
- 5.71 To provide training so the resident will understand the importance of his/her own well-being and the prevention of impairment.

### **Objectives**

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

- 5.72 Understand psychological growth and development.
- 5.73 Utilize appropriate interviewing skills.
- 5.74 Utilize appropriate counseling skills.
- 5.75 Diagnose and manage substance abuse.
- 5.76 Diagnose and manage eating disorders.
- 5.77 Diagnose and manage common psychiatric disorders.
- 5.78 Manage the emotional aspects of non-psychiatric disorders.
- 5.79 Recognize signs of family violence including abuse, and neglect.
- 5.80 Recognize the role of ethics in patient care.
- 5.81 Understand the importance of being sensitive to gender, age, race, and cultural differences within his/her patient population.
- 5.82 Demonstrate knowledge of psychopharmacology.
- 5.83 Demonstrate an understanding of situations that have the potential of leading to his/her impairment.

### **Practice Management**

#### **Synopsis**

- 5.84 Health care in our society is undergoing significant dynamic changes that will impact the resident on completion of his/her training. In order to adequately prepare the resident for entry into the health care environment, experiences shall be provided to assist him/her in assuming a productive role in this complex environment.
- 5.85 Data from the resident's own continuity of care training site experience will be used to illustrate the basic economic principles of medical practice. This data will include timely statements indicating the volume of patients seen; revenue generated per patient visit, gross charges, contractual adjustments, balance billing, overhead costs and prorated economic data. The program shall have a structured curriculum in aspects of personal and practice financial management education. This must include modules on debt consolidation, student loan repayment, retirement planning, and financial planning. A minimum of one hundred (100) hours of instruction shall be devoted to this area of the curriculum.

## Goal

- 5.86 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:

- 5.87 Enter into contractual arrangements with health care systems.
- 5.88 Understand issues of medical jurisprudence.
- 5.89 Understand community systems and agencies that enter into aspects of health care.
- 5.90 Understand risk management.
- 5.91 Understand principles of office management.
- 5.92 Understand the principles of reimbursement, and coding, including coding for osteopathic manipulative treatment.
- 5.93 Understand the differences of Group Practice vs. Private Practice vs. Employment as part of a hospital system.

## Core Areas of Specialty

### Emergency Medicine

#### Synopsis

- 5.94 Training in emergency medicine shall be a minimum of three months duration and include both didactic and clinical experiences. These shall consist of four-week blocks with a minimum of thirty-six hours per week. During OGME-1 the resident will spend **four weeks** in the emergency room treating patients under direct supervision. Unless otherwise specified, all program and curricular requirements as described in the AOA Basic Standards for Residency Training in Emergency Medicine must be met, including those related to the education and evaluation of residents in the six core competencies. **One hundred and twenty (120) weeks** of training must be provided under the direction of Emergency Medicine faculty and must be done in the Emergency Department **and** include at least fifty (50) weeks emergency department experience.
- 5.95 The emergency department experience must provide the resident the opportunity to manage an adequate number of patients of all ages and both sexes with a wide variety of clinical problems. At least three percent of the patient population must present with critical illness or injury. A pediatric experience, defined as care of patients less than 18 years of age, must be provided consisting of 16% of all emergency department encounters or 16 weeks four months of full-time equivalent experience in the care of infants and children. The latter should include critical care and 50% (eight 8 weeks) of the experience should be in the emergency department.
- 5.96 There must be 8 weeks two months of in-patient critical care experience provided with documented decision-making authority. Experience in performing invasive procedures,

monitoring unstable patients, and directing major resuscitations of all types in all age groups must be provided.

- 5.97 A structured EMS experience must be provided.
- 5.98 Additionally, the program shall create and implement a core curriculum for emergency medicine residency training that prepares the resident for specialty certification in emergency medicine as well as family practice. Therefore, the emergency medicine curriculum shall also include the following components.**
- 5.99 Use of osteopathic principles and practice relating to emergency medicine.**
- 5.100 Development of a growing competence on the part of the resident in the clinical practice of emergency medicine.**
- 5.101 Development of a philosophy of emergency medicine directed toward delivery of the best possible patient care.**
- 5.102 Advanced training in the basic sciences, which shall include structured learning and clinical experience in the basic sciences and clinical skills in emergency medicine.**
- 5.103 Participation in required OPTI educational programs.**
- 5.104 The EM/FP program must provide a minimum of four (4) hours of planned emergency medicine educational activity per week (not including sign-out rounds).
- 5.105 While on assignment to the emergency medicine portion of the training program:
- a. Residents must be excused from clinical duties to attend planned educational experiences.
  - b. No more than fifty percent of the conference may be planned and presented by residents.
  - c. Residents must be exposed to the core curriculum during their training.
  - d. Residents are required to attend the academic portions of the program, unless excused by the program director.
  - e. Core faculty must be involved in the planning and administration of the planned educational activities.
- 5.106 Progression through the residency program must be based on documented achievement of educational goals and objectives.
- 5.107 This portion of the program must provide an environment that is conducive to resident education. This environment must include exposure to the clinical applications of emergency medicine as well as the skills necessary to develop the proper attitudes towards patients, professional staff, and administration of the institution.
- 5.108 The program must ensure that the resident demonstrates increasing competence in emergency medicine skills and techniques in the use of its diagnostic and therapeutic modalities. This shall be done through:
- a. Documented educational outcomes through multiple measures. Faculty input is required.

- b. Observation, assistance, and supervised participation leading toward greater responsibility for diagnosis, care, and treatment of patients.
  - c. Opportunities to attend or participate in teaching and training inside and outside of the parent institution.
  - d. Participation in available seminars, divisional society meetings, workshops in other institutions, programs provided by universities and clinical activities in affiliated outpatient clinics or specialty institutions.
- 5.109 Residents in the program will learn teaching skills by actively participating in the process of instructing interns, medical students, and other residents.

**5.110 The curriculum will include instruction in medical ethics and interpersonal skills.**

**5.111 The curriculum will be based on written objectives for each rotation.**

**5.112 The curriculum will provide for annual evaluation by faculty and residents as a method for revision and updating the curriculum.**

### **Goal**

- 5.113 To provide the resident with advanced and concentrated training, through 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:

- 5.114 Demonstrate the appropriate triage of emergency patients of all ages.
- 5.115 Stabilize and provide initial treatment for medical and surgical emergencies.
- 5.116 Evaluate and treat lacerations.
- 5.117 Evaluate sprains, strains, and other soft tissues injuries.
- 5.118 Evaluate, immobilize, and refer skeletal fractures as appropriate.
- 5.119 Provide emergency management for toxic ingestions.
- 5.120 Provide emergency management for substance abuse.
- 5.121 Provide emergency management for chest pain.
- 5.122 Provide emergency management for anaphylaxis.
- 5.123 Maintain certification in ACLS, ATLS, and PALS.

- 5.124 Use osteopathic principles and practice relating to emergency medicine.
- 5.125 Practice medicine with a philosophy directed toward delivery of the best possible patient care.

## **Internal Medicine**

### **Synopsis**

- 5.126 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 OGME-2 and OGME-3, emphasis will be placed on the specific subspecialty areas listed below.

### **Goal**

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

### **Objectives**

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

- 5.128 Recognize those patients who should be managed in a hospital setting.
- 5.129 Manage patients in the hospital setting.
- 5.130 Manage hospitalized patients after discharge.
- 5.131 Seek specialty consultation when appropriate, and maintain direct responsibility for the management of the patient.
- 5.132 Perform specific medical procedures as outlined in the procedure section of these basic standards.
- 5.133 Understand and utilize appropriate pharmacologic interventions.

## **Allergy and Immunology**

### **Objectives**

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

- 5.134 Understand the physiology of the allergic response.
- 5.135 Understand immunosuppression.
- 5.136 Understand the mechanism of desensitization.
- 5.137 Care for the allergic patient.

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

## **Cardiology**

### **Objectives**

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

- 5.139 Understand the variety of management strategies for cardiac disease.
- 5.140 Recognize symptoms of cardiac disease.
- 5.141 Understand the cardiac effects of pulmonary disease.
- 5.142 Understand cardiac manifestations of systemic diseases.
- 5.143 Understand the indications for open-heart surgery.
- 5.144 Understand the role of somatic dysfunction in cardiac disease.
- 5.145 Integrate osteopathic manipulative treatment into the management of patients with cardiac disease.
- 5.146 Perform a preoperative cardiac assessment.

## **Dermatology**

### **Objectives**

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

- 5.147 Recognize and manage common dermatological conditions.
- 5.148 Identify allergic etiologies of dermatologic lesions.
- 5.149 Know the indications for dermal biopsy.
- 5.150 Recognize dermatologic manifestations of systemic disease.

## **Endocrinology**

### **Objectives**

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

- 5.151 Diagnose and manage uncomplicated endocrine disorders.
- 5.152 Understand the indications for surgery in the management of endocrine disorders.

## **Gastroenterology**

### **Objectives**

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

- 5.153 Screen appropriately for colorectal cancer.
- 5.154 Understand the role of osteopathic principals and treatment in the diagnosis and management of gastrointestinal disease.
- 5.155 Understand the indications for surgery in gastrointestinal disease.
- 5.156 Manage uncomplicated diseases of the gastrointestinal system.

## **Hematology**

### **Objectives**

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

- 5.157 Manage common hematologic disorders.
- 5.158 Understand hematopoiesis.
- 5.159 Understand the diagnosis and management of coagulopathies.

## **Infectious Diseases**

### **Objectives**

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

- 5.160 Diagnose and manage common infectious diseases.
- 5.161 Understand the epidemiology of infectious diseases.
- 5.162 Appreciate the role of the health care team in the control of infectious disease.
- 5.163 Understand the role of the immune system in health and disease.
- 5.164 Understand the role of antibacterial, anti-fungal, and anti-viral agents in the management of infectious disease.

## **Nephrology**

### **Objectives**

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

- 5.165 Understand electrolyte and acid-base disturbances.
- 5.166 Understand the etiology and diagnosis of nephrotic diseases.
- 5.167 Diagnose and manage common medical disorders of the kidney.
- 5.168 Utilize pharmacologic agents appropriately in patients with renal disease.

## **Neurology**

### **Objectives**

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

- 5.169 Diagnose and manage common disorders of the nervous system.
- 5.170 Understand the role osteopathic manipulation plays in the management of neurologic disorders.

## **Oncology**

### **Objectives**

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

- 5.171 Screen for and diagnose common cancers.
- 5.172 Participate with the oncologist in the care of cancer patients.
- 5.173 Utilize a team approach for the care of cancer patients.
- 5.174 Utilize Hospice in the management of the terminally ill patient.

## **Pulmonology**

### **Objectives**

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

- 5.175 Perform a preoperative pulmonary assessment.
- 5.176 Diagnose and manage common pulmonary diseases.
- 5.177 Understand the role of osteopathic manipulation in the treatment of pulmonary disease.

## **Rheumatology**

### **Objectives**

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

- 5.178 Diagnose and manage common disorders of the musculoskeletal system.
- 5.179 Diagnose diffuse connective tissue disease.
- 5.180 Understand the role osteopathic manipulation plays in the management of patients with rheumatologic disease.

## **Obstetrics/Gynecology**

### **Synopsis**

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

## **Goal**

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

## **Gynecology**

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

Diagnose and manage vaginitis.

- 5.184 Counsel patients on family planning options.
- 5.185 Manage abnormalities of the PAP smear.
- 5.186 Diagnose and initiate management of abnormal uterine bleeding.
- 5.187 Diagnose and initiate management of pelvic pain.
- 5.188 Counsel and advice patients regarding use or non-use of post-menopausal hormonal therapy.
- 5.189 Participate in pre-operative and post-operative care of gynecological disorders.
- 5.190 Integrate the use of osteopathic principles in the management of gynecological disorders.
- 5.191 Obtain appropriate consultation for selected gynecological abnormalities.

## **Obstetrics**

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

- 5.192 Participate in uncomplicated vaginal delivery.
- 5.193 Provide surgical assistance during cesarean section delivery.
- 5.194 Recognize early signs and symptoms of fetal and/or maternal distress.
- 5.195 Recognize and initiate management for common medical problems in the obstetrical patient.
- 5.196 Diagnose and initiate management for first trimester pregnancy loss.
- 5.197 Diagnose and initiate management for ectopic pregnancy.
- 5.198 Diagnose and initiate evaluation for infertility.
- 5.199 Integrate the use of osteopathic principles in the management of obstetrical patients.

5.200 Management of lactation issues.

## **Pediatrics and Adolescent Medicine**

### **Synopsis**

5.201 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, and the care of the ambulatory and hospitalized patient between 2 and 16 years of age.

### **Goal**

5.202 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:

5.203 Diagnose and manage pediatric problems encountered in family practice.

5.204 Manage pediatric emergencies.

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

5.206 Provide well childcare up to and including adolescence.

## **Surgery**

### **Synopsis**

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

### **Goal**

5.208 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:

5.209 Diagnose and manage surgical disorders and surgical emergencies.

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

- 5.211 Assist the surgeon in the operating room.
- 5.212 Perform those specific surgical procedures that family physicians may be called on to perform.
- 5.213 Manage, in conjunction with the surgeon, the surgical patient during the preoperative and postoperative period.
- 5.214 Understand basic surgical principles, of asepsis, handling of tissue, and assisting in the operating room.

### **General Surgery**

#### **Objectives**

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

- 5.215 Recognize and manage, with the surgeon, conditions requiring surgical care.
- 5.216 Provide pre-hospital preparation of the elective surgical patient.
- 5.217 Integrate osteopathic principles and manipulative treatment in the management of surgical patients.
- 5.218 Perform specific surgical procedures as outlined in these basic standards.

### **Ophthalmology**

#### **Objectives**

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

- 5.219 Diagnose and manage common ophthalmologic conditions that may present to the family physician's office.
- 5.220 Diagnose and manage corneal lesions.
- 5.221 Remove a foreign body from the eye.

### **Orthopedics**

#### **Objectives**

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

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

### **Otolaryngology**

#### **Objectives**

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

- 5.224 Diagnose and manage common otolaryngologic conditions that may present to the family physician's office.
- 5.225 Integrate osteopathic principles and manipulative treatment into the management of disorders of the ear, nose, and throat.

## **Urology**

### **Objectives**

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

- 5.226 Diagnose and manage common urologic conditions that may present to the family physician's office.
- 5.227 Integrate osteopathic principles and manipulative treatment into the management of urologic disorders.

## **Community Medicine**

### **Goal**

- 5.228 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:

- 5.229 Utilize community resources to assist in the management of patients.
- 5.230 Understand the role of local health departments in the management of patients.
- 5.231 Utilize evidence-based principles to determine appropriate strategies for care.
- 5.232 Identify modifiable risk factors for the prevention of disease.
- 5.233 Understand how physicians' personal behavior affects the patient's perception of them as a role model for responsibility in their own health.
- 5.234 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.
- 5.235 Understand the role of and utilize Hospice in the care of the dying patient.
- 5.236 Understand the importance of recognizing cultural diversity among the patient population and within the community.

## **Geriatrics**

### **Synopsis**

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

### **Goal**

- 5.238 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:

- 5.239 Understand the physiologic changes that occur with aging.
- 5.240 Differentiate between normal age-related changes and disease pathology.
- 5.241 Recognize atypical presentations of diseases in elderly individuals.
- 5.242 Utilize basic geriatric assessment tools in clinical practice.
- 5.243 Assess and assign appropriate levels of long-term care for elderly persons.
- 5.244 Understand the differences among the continuum of care for elders.
- 5.245 Manage the elderly patient in various levels of care.
- 5.246 Understand the role of the family in the care of the elderly.
- 5.247 Perform a functional assessment of elderly.
- 5.248 Understand the role of a multidisciplinary team in the care of the elderly.
- 5.249 Access available community resources to care for frail and/or homebound elderly patients.
- 5.250 Utilize osteopathic manipulative treatment (with special attention to myofascial release, strain counter strain, and muscle energy) in the treatment of the elderly patient.
- 5.251 Understand the role of and utilize hospice in the care of the dying patient.
- 5.252 Understand the use of appropriate immunizations in the elderly patient.
- 5.253 Understand the issue of self-determination including advanced directives.
- 5.254 Understand strategies to optimize quality of life.
- 5.255 Understand appropriate pain management in the elderly.
- 5.256 Understand pharmacokinetics in the elderly.
- 5.257 Recognize the importance of being an advocate for accessibility to health care for all elderly patients.

## **Sports Medicine**

### **Synopsis**

- 5.258 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. The orthopedic portion of sports medicine training may be integrated into the orthopedic portion of the curriculum; however, time devoted to sports medicine should be in addition to the minimum requirement for orthopedics.

### **Goal**

- 5.259 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:

- 5.260 Evaluate individuals for athletic participation clearance.
- 5.261 Manage uncomplicated injuries sustained in sports related activities.

## **Diagnostic Imaging**

### **Goal**

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

### **Objective**

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

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

## **Electives**

### **Synopsis**

- 5.264 There shall be a minimum of twenty weeks and a maximum of forty weeks of supervised electives available to all residents during the course of the residency. At least four (4) weeks must be completed during OGME-1, at least four (4) weeks in OGME-2, and at least four (4) weeks in OGME-3.
- 5.265 All electives must be approved by the Program Director in advance of the start of the rotation.

### **Goal**

- 5.266 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:

- 5.267 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

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

### Goal

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

## Objectives

- 5.270 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. Curettage 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
11. Colposcopy with 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** intubations
21. Vaginal delivery
22. Bedside ultrasonography
23. Rapid sequence intubation (RSI)
24. Procedural sedation
25. Central line placement
26. Lumbar puncture
27. Epistaxis management (nasal packing/anterior cautery)

#### 5.271 Optional Procedures

The program must offer residents exposure to the following procedures:

1. Vasectomy
2. Episiotomy Repair
3. Flexible sigmoidoscopy
4. Colonoscopy
5. IUD insertion
6. Breast cyst aspiration
7. Trigger point injections
8. Allergy testing
9. Neonatal circumcision

### Research and Scholarly Activity Requirements

#### Synopsis

5.272 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.

5.273 The participation of each resident in an **original** research activity is required.

**5.274 The resident must submit an outline of the research project with the first year annual report and interim reports on the progress of the research project with the third year annual report, and the completed project with the fifth year annual report.**

#### Goal

5.275 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:

- 5.276 Understand the concepts of and principles behind evidence based medicine.
- 5.277 Critically evaluate medical literature and its applicability to clinical practice.
- 5.278 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 completes all assignments in a timely fashion.
  - b. Keep a log of each procedure performed.
  - a. Participate in the annual ACOFP and ACOEP In-Service Exams.
  - d. Residents must attend a minimum of one national ACOFP and one national ACOEP Scientific Seminar during OGME-2-5. This requirement can be met by the resident attending either a national ACOFP or ACOEP Scientific Seminar or the AOA Fall Scientific Seminar. If they attend the Fall AOA Meeting the resident must register as an ACOFP or ACOEP member for the Fall Meeting to count towards this requirement.
- 6.3 At the completion of each rotation, the resident shall be evaluated by the appropriate faculty. These evaluations shall be signed by the responsible faculty and the resident and reviewed by the Program Director(s). A copy of these evaluations shall be maintained on file at the program office.
- 6.4 The Program Director(s) will review the performance of each resident quarterly to insure that educational objectives are being met.
- 6.5 Residents should be advanced to positions of higher responsibility only on the basis of evidence of their satisfactory progressive professional growth.
- 6.6 All residents must have successfully completed COMLEX Part III in order to be advanced to OGME-3.
- 6.7 The program must maintain a permanent record of evaluation for each resident. This must be available to the resident, the ACOFP Committee on Education & Evaluation, the ACOEP Committee on Graduate Medical Education, the assigned inspector, and other authorized personnel.

- 6.8 The Program Director(s) 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 shall be a part of the resident's permanent record maintained by the program. The Competency Based Evaluation (CBE) document must be a part of this final evaluation. A copy of this final evaluation shall be placed on file at the central office of the ACOFP and ACOEP.
- 6.9 In cases of early termination of a resident contract, the Program Director(s) shall provide the resident with documentation regarding which rotations, if any, were completed satisfactorily. The AOA Postdoctoral Division must be promptly notified and the terminated contract submitted to the AOA. A copy of this documentation shall be forwarded to and kept on file at the central office of the ACOFP and ACOEP.

### **Academic and Disciplinary Dismissals**

- 6.10 The hospital and department must have clearly defined procedures for academic and disciplinary action. Academic dismissals result from failure to attain a proper level of scholarship or non-cognitive skills, including clinical abilities, interpersonal relations, and/or personal and professional characteristics. Institutional standards of conduct include such issues as cheating, plagiarism, falsifying records, stealing, alcohol and/or substance abuse, or any other inappropriate actions or activities.
- 6.11 In cases of academic dismissal, the hospital and department will inform residents, orally and in writing, of inadequacies and their effects on academic standing. The resident will be provided a specified period in which to implement specified actions required to resolve academic deficiencies. Following this period, if academic deficiencies persist, the resident may be placed on probation for a period of three to six months. The resident may be dismissed following this period, if deficiencies remain and are judged to be irremediable. In accordance with institutional policy, the resident will be provided an opportunity to meet with appropriate program supervisors to appeal decisions regarding probation or dismissal. Legal counsel at hearings concerning academic issues will not be allowed to participate.
- 6.12 In cases of disciplinary infractions that are judged irremediable, the hospital and department will provide the resident with adequate notice, in writing, of specific ground(s) and the nature of the evidence on which the disciplinary action is based. The resident will be given an opportunity for a hearing in which the disciplinary authority will provide a fair opportunity for the resident's position, explanations and evidence. Finally, no disciplinary action will be taken on grounds, which are not supported by substantial evidence. The department and/or hospital intern training committee, or house staff education committee, or other appropriate committees will act as the disciplinary authority. Residents may be allowed counsel at hearings concerning disciplinary issues. Pending procedures on such disciplinary action, the hospital in its sole discretion may suspend the resident, when it is believed that such suspension is in the best interests of the hospital or of patient care.
- 6.13 Immediate dismissal without hearing will be allowed where patient or staff safety is judged by the Program Director(s) to be at imminent risk.

### **Evaluation of Faculty**

- 6.14 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 Program**

- 6.15 Each program must incorporate all elements of these basic standards. The educational effectiveness of a program must be evaluated in a systemic manner. This shall include regular self-evaluation within the context of the educational goals and objectives of the needs of the residents, teaching responsibilities of the faculty, the availability of administrative and financial support, and of the availability of health care resources within the community. This evaluation must examine the balance between education, research, and service. The teaching faculty must hold regular meetings to accomplish these reviews. At least one resident representative should participate in these reviews, and written resident evaluations should be utilized.
- 6.16 At the completion of each rotation, the resident shall evaluate the rotation. These evaluations shall be reviewed by the Program Director(s) and remain on file at the institution.
- 6.17 The Program Director(s), in conjunction with the institution's department of family practice and emergency medicine or their equivalents shall evaluate the residency program annually.

### **Evaluation of Patient Care**

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

### **Evaluation of Graduates**

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

## **PART SEVEN: EVALUATION OF PROGRAM**

### **Synopsis**

- 7.1 The ACOFP Committee on Education & Evaluation and the ACOEP Committee on Graduate Medical Education 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 Osteopathic Board of Family Physicians (AOBFP) and the American Osteopathic Board of Emergency Medicine (AOBEM).
- 7.2 The ACOFP Committee on Education & Evaluation and the ACOEP Committee on Graduate Medical Education will notify all residents in a program that receives a one 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(s), 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 year continuing program approvals shall be considered probationary status.

#### **Withdrawal of Program Approval**

- 7.6 Approval of a training program may be withdrawn if the program or the sponsoring institution fails to meet the following criteria:
- 7.7 Non-compliance with the approval requirements:
- a. Refusal to undergo on-site inspection for program review.
  - b. Failure to supply requested documentation within thirty days of notification of deferral of action by the 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 Department of Education and closed during the third year of inactivity. In the event that a program is declared lapsed, the institution will have to apply to the AOA, through its division of Postdoctoral Training, as a new program.

#### **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 emergency medicine/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 (1) year and may not recruit potential residents during that probationary time.

## APPENDIX I

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

- A. There will be an opportunity for these physicians to receive more than the four months of advanced standing, but not to exceed twelve months. This would constitute one year of credit toward the three 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, which will take final action on the request.
- B. A board certified specialist may receive credit for four months in a primary discipline, two months of ER, four months of elective, etc., not to exceed twelve months. The credit will be given if the physician has worked in these areas of expertise and has demonstrated enough evidence of meeting the Basic Standards.
- C. The continuity of care portion of training is required. The physician may participate in the program on a part-time basis; however, the program must be completed within a four year time period.
- D. For the allotment of residency slots, the program will provide slots according to the time spent by the physician. For example, a  $\frac{1}{2}$  time program will constitute  $\frac{1}{2}$  a resident slot, a  $\frac{1}{4}$  time program will constitute  $\frac{1}{4}$  resident slot, and a full-time program will constitute one resident slot. These residents must be included within the approved number of training positions for the training site.
- E. These programs must take place in an already approved and fully accredited osteopathic family practice residency program. They must be equivalent to residency training as stated in the basic standards for residency training in osteopathic family practice and manipulative treatment.
- F. The program may not be completed as a weekend-only rotation and it must be done in a continuous period.

## APPENDIX II

### Guidelines for Residency Completion Programs for AOA-Certified Family Physicians

- A. These physicians may complete a third or second and third years of training on a flexible or alternative basis. The program must meet the requirements of the AOA/ACOFP Basic Standards for Residency Training in Osteopathic Family Practice and Manipulative Treatment. The physician will have up to four years to complete the program. The program will take place at an institution within an approved and fully accredited residency in osteopathic family practice and manipulative treatment.
- B. There will be an opportunity for these physicians to receive more than the four months of advanced standing, but not to exceed twelve months. The request for advanced standing credit will be made by the Program Director to the ACOFP Committee on Education & Evaluation, which will take final action on the request.
- C. The training must qualify as residency training. The continuity of care portion will be required and the rotations will not be completed on a weekend-only basis. The program will be on at least ¼ time. The training site will allot either ¼ or ½ or one resident slot for the training physicians according to the amount of time spent in the program. These residents must be included within the approved number of positions for the training site.
- D. It is recommended that all part-time programs be affiliated with a College of Osteopathic Medicine. Affiliation is an on-going academic interaction between the program and the college as it relates to organization and academic support of the program. The affiliation agreement must be in writing and approved by the ACOFP Committee on Education & Evaluation, and indicate specific responsibilities assigned to the college as included in the affiliation agreement.
- E. The program will not be open to any physicians who have graduated from an osteopathic college after 1994.
- F. Initial review of all flexible or alternative training program applications will be made by the ACOFP Committee on Education & Evaluation, 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 III

### 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 **OGME-1 year** is the prerequisite for acceptance into all ACOFP/ACOEP programs at an OGME-2 or higher level.
- C. Post graduate medical education training will be considered on an individual basis for advanced credit in osteopathic emergency medicine/osteopathic family practice residency programs.

Residents entering osteopathic emergency medicine/osteopathic family practice residency programs who have taken previous residency training in accredited osteopathic or allopathic residency programs may submit a request for advanced placement to the Program Director(s). In all instances, the request for advanced standing will be reviewed by the Program Director(s), who shall forward requests to the ACOFP Committee on Education & Evaluation and the ACOEP Committee on Graduate Medical Education. In no instance is the Program Director(s) compelled to recommend advanced standing to these committees. The ACOFP Committee on Education & Evaluation, and the ACOEP Committee on Graduate Medical Education shall report to the AOA PTRC all approvals for advanced placement.

- D. Credit may be granted according to the following criteria:
  - 1. Training taken in an osteopathic family practice residency will be compared and the quality of that training assessed according to these basic standards, and week for week or service for service credit may be recommended.
  - 2. Training taken in an osteopathic emergency medicine residency will be compared and the quality of that training assessed according to these basic standards, and week for week or service for service credit may be recommended.
  - 3. Training taken in any discipline other than osteopathic emergency medicine or osteopathic family practice will be assessed by the Program Director to determine if it is applicable to osteopathic emergency medicine/family practice and a maximum of **sixteen (16) weeks** of credit beyond completion of OGME-1 may be recommended for approval.