Basic Standards for
Residency Training in
Combined Osteopathic Emergency Medicine
And
Osteopathic Family Medicine and Manipulative Treatment

American Osteopathic Association
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And
American College of Osteopathic Family Physicians

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Basic Standards for Residency Training in Combined Emergency Medicine and Family Medicine and Manipulative Treatment

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I. INTRODUCTION

These are the Basic Standards for Residency Training in Osteopathic Emergency Medicine and Osteopathic Family Medicine and Manipulative Treatment as approved by the American Osteopathic Association (AOA), the American College of Osteopathic Emergency Physicians (ACOFP) and the American College of Osteopathic Family Physicians (ACOFP). The standards are designed to provide the osteopathic resident with advanced and concentrated training in both emergency medicine and family medicine and osteopathic manipulative treatment and to prepare the resident for examination for certification in Emergency Medicine and Family Medicine and Osteopathic Manipulative Treatment by American Osteopathic Board of Emergency Medicine (AOBEM) and American Osteopathic Board of Family Practice (AOBFP).

II. MISSION

The mission of the combined emergency medicine and family medicine and osteopathic manipulative treatment training program is to provide residents with comprehensive structured cognitive and clinical education that will enable them to become competent, proficient and professional osteopathic emergency physicians and family physicians.

III. EDUCATIONAL PROGRAM GOALS

3.1 All osteopathic emergency medicine/family medicine programs must formulate goals that will allow the resident to master the following core competencies as specified in the basic standards of both disciplines:

A. Osteopathic Philosophy and Osteopathic Manipulative Medicine.

3.1. Training in osteopathic principles and practice must be provided in both structured educational activities and clinical formats.

3.2. Residents must complete an OPP/OMM curriculum.

B. Medical Knowledge.

3.1 The formal structure of educational activities must include monthly family medicine and emergency medicine journal clubs.

3.2 The formal structure of educational activities must include four hours per week of structured faculty didactic participation.

3.3 Attendance at required educational activities must be documented.

3.4 Residents must participate in the family medicine structured educational activities while they are on family medicine designated rotations.

3.5 Residents must participate in the emergency medicine structured educational activities while they are on emergency medicine designated rotations.

3.6 Each resident must participate in both family medicine and emergency medicine board review, either in the form of an ongoing program, or by the program sponsoring the resident's attendance at a family medicine and emergency medicine board review course.

C. Patient Care.

3.1 The resident must have training and experience in comprehensive histories and physicals, including structural examinations, pelvic exams, rectal exams, breast exams and male genital exams.
3.2 The resident must have training and experience in arterial puncture for arterial blood gases, rapid sequence intubation, osteopathic manipulative treatment to include, at a minimum: knowledge of the indications; contraindications; complications; limitations and evidence of competent performance.

3.3 The resident must have training and experience in exercise stress tests, ambulatory ECG monitors, spirometry, urine microscopy, vaginal wet mounts, thoracentesis and arthrocentesis to include, at minimum: knowledge of the indications; contraindications; complications; limitations and interpretation.

3.4 The resident must have training and experience in the interpretation of electrocardiograms, chest x-rays, and flat and upright abdominal films.

3.5 The resident must have training and experience in cardioversion/defibrillation to include, at minimum: knowledge of the indications; contraindications; complications; limitations and evidence of competent performance of ten (10) procedures.

3.6 The resident must have training and experience in chest tube insertion to include, at minimum: knowledge of the indications; contraindications; complications; limitations and evidence of competent performance of ten (10) procedures.

3.7 The resident must have training and experience in central venous line placement to include, at minimum: knowledge of the indications; contraindications; complications; limitations and evidence of competent performance of twenty (20) procedures.

3.8 The resident must have training and experience in closed fracture reduction to include, at minimum: knowledge of the indications; contraindications; complications; limitations and evidence of competent performance of twenty (20) procedures.

3.9 The resident must have training and experience in dislocation reduction to include, at minimum: knowledge of the indications; contraindications; complications; limitations and evidence of competent performance of ten (10) procedures.

3.10 The resident must have training and experience in splinting to include, at minimum: indications; knowledge of the contraindications; complications; limitations and evidence of competent performance of twenty (20) procedures.

3.11 The resident must have training and experience in procedural sedation to include, at minimum: knowledge of the indications; contraindications; complications; limitations and evidence of competent performance of twenty (20) procedures.

3.12 The resident must have training and experience in cricothyroidotomy to include, at minimum: knowledge of the indications; contraindications; complications; limitations and evidence of competent performance of fifteen (15) procedures.

3.13 The resident must have training and experience in intraosseous line to include, at minimum: knowledge of the indications; contraindications; complications; limitations and evidence of competent performance of three (3) procedures.

3.14 The resident must have training and experience in pericardiocentesis to include, at minimum: knowledge of the indications; contraindications; complications; limitations and evidence of competent performance of three (3) procedures.
3.15 The resident must have training and experience in transvenous pacing to include, at minimum: knowledge of the indications; contraindications; complications; limitations and evidence of competent performance of two (2) procedures.

3.16 The resident must have training and experience in thoracotomy to include, at a minimum: knowledge of the indications; contraindications; complications; limitations and evidence of competent performance of one (1) procedure.

3.17 The resident must have training and experience in endotracheal intubation to include, at minimum: knowledge of the indications; contraindications; complications; limitations and evidence of competent performance thirty-five (35) procedures.

3.18 The resident must have training and experience in laceration repair to include, at minimum: knowledge of the indications; contraindications; complications; limitations and evidence of competent performance of fifty (50) procedures.

3.19 The resident must have training and experience in lumbar puncture to include, at minimum: knowledge of the indications; contraindications; complications; limitations and evidence of competent performance fifteen (15) procedures.

3.20 The resident must have training and experience in bedside ultrasound to include, at a minimum: knowledge of the indications; contraindications; complications; limitations and evidence of competent performance forty (40) procedures.

3.21 The resident must have training and experience in vaginal deliveries to include, at minimum: knowledge of the indications; contraindications; complications; limitations and evidence of competent performance of ten (10) procedures.

3.22 Procedural Medicine in Family Medicine

Train residents to competency in the following procedures:

3.22.1 Joint injections.
3.22.2 Biopsy of dermal lesions.
3.22.3 Excision of subcutaneous lesions.
3.22.4 Incision and drainage of abscess.
3.22.5 Cryosurgery of skin.
3.22.6 Curettage of skin lesion.
3.22.7 Laceration repair.
3.22.8 Endometrial biopsy.
3.22.9 Office microscopy.
3.22.10 Splinting.
3.22.11 EKG interpretation.
3.22.12 Office spirometry.
3.22.13 Toenail (whole or partial) removal.
3.22.14 Defibrillation.
3.22.15 Removal of cerumen from ear canal
3.22.161 Endotracheal intubation

D. **Interpersonal & Communication Skills.**

The resident must have training in communication skills with patients, patient families and other members of the health care team, including patients with communication barriers such as sensory impairments, dementia and language differences. This would include educational sessions in Cultural Competency.

E. **Professionalism.**

3.1 The resident must have training in health care disparities.

3.2 The resident must have training in ethical conduct in interactions with patients, patient families and other members of the health care team.

3.3 The resident must have training in health information protection policies.

F. **Practice-Based Learning and Improvement.**

3.1 The resident must have training in teaching skills.

3.2 The resident must participate in the training of students and/or other residents.

3.3 The resident must have training in the use of electronic health records.

3.4 The resident must have learning activities and participation in quality improvement processes.

3.5 The resident must have learning activities in medical research throughout the program including, at minimum:

   3.5.1 A resident scholarly project within the department of family medicine and emergency medicine.

   3.5.2 Institutional or regional research programs in which family physicians/emergency physicians are actively involved.

   3.5.3 Original paper on health care related topic.

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

   3.5.4 Authoring a grant.

G. **Systems-Based Practice.**

3.1 The resident must have training in practice management.

3.2 The resident must have training in health policy and administration.

H. **Ambulatory Continuity of Care Site(s)**

3.1 The institution must provide a minimum of one osteopathic family medicine training site.

3.2 Multiple sites may be utilized only if all sites meet the standards set forth in this document.

3.3 Each must be organized to support resident continuity of care training with a designated panel of patients. At a minimum each site must provide the following:

   3.3.1 Defined space for waiting area, examination rooms, resident’s office, laboratory, business office.
3.3.2 OMM capability.

3.3.3 On site procedural capability including: blood sugar, throat culture or rapid strep screen, urinalysis, EKG, spirometry, and screening audiometry.

3.3.4 Minor surgery capability.

3.3.5 Online access to reference sources.

3.4 A professional medical records system that provides for quality assurance and quality improvement processes must be utilized. At a minimum this shall include:

3.4.1 A system for documentation of structural examinations and OMM treatments.

3.4.2 A mechanism to identify each patient’s primary care physician.

3.4.3 Chronic medication lists.

3.4.4 Problem lists.

3.4.5 Health maintenance flow sheets.

3.4.6 Chronic disease management flow sheets.

3.5 The economic aspect of the site must be self-contained and patterned after that of a private practice. At a minimum this shall include:

3.5.1 Appointments.

3.5.2 Statements.

3.5.3 Billing functions.

3.5.4 Faculty must be available in appropriate numbers to ensure that residents always have readily available on site supervision.

3.5.5 Support staff must be available in appropriate numbers to ensure efficient patient care.

3.5.6 Patient care visits at the continuity of care site must be predominantly by appointment. An urgent care center may not be utilized for this portion of the training.

3.5.7 The continuity of care training site may be located in proximity with a multi-specialty site provided the operations are separate.

3.5.8 Continuity of care must be taught as a core value of osteopathic family medicine.

3.5.9 For those patients unable to visit the continuity of care site, training opportunities must be provided for the resident to gain experience in home care and care in long-term care facilities.

3.5.10 For a given resident the continuity of care experience may be at no more than two sites. Each site must meet all facility requirements and all continuity educational requirements as outlined in these standards.

3.5.11 If the residency program elects to use two sites, the resident may be assigned to both sites simultaneously or each site for at least twelve consecutive months. During OGME-1, the continuity experience must be at a single site.
3.5.12 The patient population of the continuity of care site must include a variety of patients in terms of age, gender, and ethnicity.

3.5.13 The resident must be responsible, under supervision, for the health care needs of their ambulatory panel of patients.

3.5.14 As the skill and proficiency of the resident improves; an increasing daily patient load is expected.

3.6 The five year continuity of care site experience must include at least 2,000 patient visits, with a minimum of 150 occurring in the OGME-1 year.

3.7 Residents must see patients in the continuity of care site for a minimum of thirty six weeks per year.

3.8 The ambulatory care experience must train residents to be both productive and efficient in a primary care setting. At a minimum this must include:

3.8.1 Appropriate utilization of osteopathic principles and manipulative treatment.

3.8.2 Diagnose and manage medical and surgical conditions.

3.8.3 Perform office procedures.

3.8.4 Incorporate preventive measures.

3.8.5 Provide patient education.

3.8.6 Provide counseling.

3.8.7 Coordinate care.

3.8.8 Manage consultations.

3.8.9 Maintain medical records.

IV. INSTITUTIONAL REQUIREMENTS

4.1 The institution must provide a patient volume to train a minimum (on average) of two (2) residents in osteopathic emergency medicine/family medicine per year as defined in the individual specialty basic standards.

4.2 The institution must maintain a program description that describes all the elements of the integrated program.

4.3 This program description must be updated and reviewed annually.

V. PROGRAM REQUIREMENTS AND CONTENT

Recognizing the unique and integrated nature of the combined residency training, the following requirements are specific to the emergency medicine/family medicine residency program:

5.1 The integrated residency program in osteopathic emergency medicine/family medicine is five (5) years in duration. Training in each specialty and related rotations shall occur during each training year.

5.1.1 The first year (OGME-1) must include four weeks of elective rotation.

5.1.2 A minimum of 88 weeks (22 months) of rotations must occur within the Emergency Medicine Department during the five-year curriculum. There should be a minimum of three months of emergency medicine training in year one and a minimum of four months of emergency medicine training in each of training years two through five.
5.1.3 There must be a minimum of four weeks surgical rotation (trauma or general surgery) during the first year (OGME-1).

5.1.4 There must be a minimum of four weeks critical care medicine during the first year (OGME-1).

5.1.5 The EM/FM residents’ weekly ambulatory continuity of care family medicine office/clinic experience shall include a minimum of 2,000 patient visits during the five year curriculum. The continuity of care location may occur at one (preferably) or two family medicine training sites.

5.2 All other rotation requirements as specified in the basic standards for both osteopathic emergency medicine and osteopathic family medicine must be met by the completion of training in the integrated program.

VI. PROGRAM DIRECTOR/FACULTY

A. Program Director

6.1 The program must have either: a program director that is AOA-certified in both osteopathic emergency medicine and osteopathic family medicine, or a co-director certified by the AOA in osteopathic emergency medicine and a co-director certified by the AOA in osteopathic family medicine, or an AOA certified director in either specialty along with an AOA certified co-director in the other specialty. Additionally:

6.1.1 The program director and/or co-directors must work jointly in supervising and directing the training program.

6.1.2 The program director and/or co-directors may be the program directors of existing programs in their respective disciplines.

6.1.3 The program director and/or co-directors must meet on a quarterly basis to evaluate the program, residents and teaching faculty.

6.2 The program director(s) must meet all other requirements that are specified in the basic standards for each of the two specialties.

6.3 The program director must devote a minimum of 1,000 hours per year to residency training activities. This may include time spent in teaching, precepting, administration, and scholarly activities.

6.4 The program director (or program director designee) must attend their respective specialty college’s residency directors’ workshop every year. Each program director must personally attend at least once every two years.

B. Emergency Medicine Core Faculty

6.1 The core faculty must make available 4 hours per week of non-clinical, protected and compensated time to provide instruction to residents.

6.2 There must be a minimum of one (1) core emergency medicine faculty and one (1) additional core faculty for each eight (8) residents in the combined program.

6.3 Emergency medicine core faculty must practice medicine a minimum of 30 hours (on average) per week at the base institution.
6.4 Emergency medicine core faculty must be certified in emergency medicine by the AOBEM or ABEM.

6.5 Emergency medicine core faculty must demonstrate scholarly activity prior to and throughout the duration of their appointment. Scholarly activity is the academic pursuit that serves either the specialty or profession and/or involves creative, intellectual work that is peer-reviewed and publicly disseminated (presenting at conferences, publications, etc.). Scholarly activity shall occur within a four-year period. Acceptable activities include a minimum of 2 major or 1 major and 2 minor scholarly activities (as defined in the Basic Standards for Training in Emergency Medicine) within this time frame for each core faculty member.

6.6 All EM/FM programs, regardless of the number of residents, must have a minimum of two family physician faculties including the Program Director.

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

   6.7.1 2 half days/week.
   6.7.2 500 hours/year.
   6.7.3 40 hours/month.

6.8 There must be family practice program faculty with admitting privileges in the hospital(s) where the residents’ patients are hospitalized.

C. Family Medicine Faculty Qualifications

6.1 The family medicine program faculty shall, as a group, be qualified to teach all required procedures as listed in this document.

6.2 In addition to meeting all faculty qualifications stipulated in the AOA Basic Documents, family medicine faculty members shall:

   6.2.1 Hold a current licensed to practice medicine in the state in which the training is located.
   6.2.2 Be certified in family medicine.
   6.2.3 Commit specific time to patient care, independent of supervision of residents.

6.3 The supervisor of the ambulatory continuity of care experience must:

   6.3.1 Be a member of the ACOFP.
   6.3.2 Be certified by the AOBFP.
   6.3.3 Have a reporting relationship to the Program Director.

D. Family Medicine Faculty Research and Scholarly Activity

6.1 The faculty as a whole must demonstrate involvement in scholarly activity. At a minimum this must include at least one the following:

   6.1.1 Participation in clinical discussions and resident conferences.
6.1.2 Participation in national and regional professional societies, particularly through presentations and publications.

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

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

VII. RESIDENT REQUIREMENTS

7.1 Residents in the combined program must attend the educational portions required by the basic standards of each discipline, as described below:

7.1.1 The resident must be a full participant in the educational programs provided by the department (EM or FM) in which the resident rotation is linked (EM or FM) at the particular time in the rotational schedule. Additionally, there must be a minimum of four (4) dedicated educational program hours per week.

7.1.2 The residents must be members of the ACOFP and the ACOEP.

7.1.3 Final reports of graduating residents must be submitted within thirty (30) days of completion of the training year.

7.1.4 The residents must attend a minimum of 70 percent of all Family Medicine meetings as directed by the program director.

7.1.5 The residents must participate in hospital committee meetings as directed by the program director.

7.1.6 The residents must participate each year in the annual Resident In-Service Examinations sponsored by the ACOFP and the ACOEP.

7.1.7 The residents must maintain certification in Advanced Cardiac Life Support (ACLS) throughout the residency.

7.1.8 The residents must maintain certification in Advanced Trauma Life Support (ATLS) throughout the residency.

7.1.9 The residents must maintain certification in Pediatric Advanced Life Support (PALS) or APLS throughout the residency.

7.1.10 The residents must attend the ACOFP Annual Convention and Scientific Sessions or another ACOFP continuing education program once during the training program.

7.1.11 The resident must complete a research project that is approved by the program director which follows the requirements set forth in the Basic Standards for Residency Training In Emergency Medicine.

7.1.12 Emergency medicine residents may not moonlight in the department of emergency medicine at the base or affiliated training sites.

VIII. EVALUATION OF PROGRAM

8.1 The program director must evaluate the program and curriculum annually to ensure that it is consistent with the current goals of the program and further address, at a minimum: performance on the annual ACOFP and ACOEP Resident In-Service Examinations; pass rates on the AOBFP and AOBEM certification examinations; resident retention rates in the program; percent of graduates completing the program in 60 months; placement of graduates and professional accomplishments of graduates.
8.2. The ambulatory continuity of care director must complete semiannual written evaluations of the resident’s performance.

8.3. All evaluations must be signed by the person completing the evaluation, the program director and the resident. Electronic signatures are acceptable.

8.4. The program director or a designee must meet with the resident quarterly to review and document the resident’s progress.

8.6. Residents’ identities in faculty evaluations must remain confidential.

8.7. Faculty performance must be reviewed on an annual basis by the program director.

8.8. Confidential resident evaluations must be included as part of the assessment of faculty performance.