Accreditation of Colleges of Osteopathic Medicine:

COM Continuing Accreditation Standards

(Effective July 1, 2019)

Third Party Comments

Element 1.1

Element 1.1: Program Mission: (CORE)

A College of Osteopathic Medicine (COM) must produce and publish a written mission statement for the program that explains the overall purpose of the program and serves as guide for program planning and assessment. If the COM is part of a larger educational institution or parent institution, the COM's mission shall be consistent with the institution's mission. The COM must review the program mission periodically and revise it as appropriate, including faculty and students, at a minimum, in the process.

Proposed Revision:

A COM must have a mission statement that: 1) explains the overall purpose of the COM's program; and 2) serves as guide for program planning and assessment. Where the COM is part of a larger educational institution or parent institution, the COM's mission must be consistent with the institution's mission. The COM must review its program mission periodically and upon review, if the COM deems it to be appropriate to do so, the COM should revise its mission to meet the COM's growth and continued development. The COM must consider the input of its faculty, staff, and students when reviewing and revising its mission.

Submission 1.1: Program Mission

1. *Provide copies of program mission / vision (optional) / goals or objectives (optional) and a public link to where the documents are published.*
2. *If the COM is part of a larger educational institution (parent institution), provide a copy of the parent institution's mission statement. The documents should show last updated date (or effective date) and revision history.*
3. *Provide documentation of the revision process, participants, and meeting minutes documenting the most recent governing board approval of the COM's mission.*

Comment
Element 1.1: Program Mission: (CORE) "The COM must review its program mission periodically" is imprecise and open to interpretation. I recommend revising to create a consistent standard as follows: "The COM must review its program mission ~~periodically~~ at least once every five years"
Submission item 1.1: If the COM is part of a larger educational institution (parent institution), provide a copy of the parent institution's mission statement. The documents should show last updated date (or effective date) and revision history. a. This requirement may be a challenge to fulfill for COMs with parent institutions that are many years old (i.e., > 100 years). Tracking mission changes and associated dates may require substantial time and resources of an institution. A possible suggestion to reduce burden may be to designate a timeframe (i.e., within the past 10 years) for schools to provide parent institution mission changes and then for COMs to be required to inform COCA of mission changes for the COM and parent institution going forward.

Element 1.7

Element 1.7: Clinical Education Affiliation Agreements: (CORE)

A COM must be able to demonstrate executed affiliation agreements addressing the required clinical educational experiences for students.

Proposed Revision:

A COM must be able to produce agreements, including executed affiliation agreements that support the clinical educational experience for its students.

Submission 1.7: Clinical Education Affiliation Agreements

1. *Provide a copy of the COM approved affiliation agreement*

Proposed Revision:

1. *Provide a copy of a COM approved affiliation agreement.*
2. *Provide a list of all contracted clinical sites.*
3. *Provide the three year average number of OMS II students who matriculated for the academic year, including the number of students repeating from any previous academic years by completing Table 6.*
4. *At the time of the site visit, a COM must produce all documents that evidence the acceptance of the COM's students to participate at the affiliate site, including all executed affiliation agreements.*
5. *For mid-cycle reports, nos. 1 - 3 above must be provided. If warranted, the COCA may require that a COM provide copies of all documents (including all executed affiliate agreements) that evidence the acceptance of the COM's students to participate at an affiliate site.*

Comment

Evidentiary Submission #3
Provide the three year average number of OMS II students who matriculated for the academic year, including the number of students repeating from any previous academic years by completing Table 6.

This statement is confusing – do you want the average number at the start of the M2 year or how many students are starting the M3 year? Or instead of saying a year, should you specify "the start of clinical education rotations at the COM"? Schools start their clinical rotations at different times in the academic program. Should it be "Provide the three year average number of students in the academic year during which they begin clinical education, including the number of students repeating from any previous academic years." There are COMs that start clinical experiences in their first year. I don't see that factored into these standards/submissions any where.

Submission 1.7: Is Table 6 on student population, supposed to go with submission 1.7?
Consider providing a definition for "contracted" in #2.

Submission 1.7: Clinical Education Affiliation Agreements

1. Provide a copy of the COM approved affiliation agreement

Proposed Revision:

1. Provide a copy of a COM approved affiliation agreement.
2. Provide a list of all contracted clinical sites.
3. Provide the three year average number of OMS II students who matriculated for the academic year, including the number of students repeating from any previous academic years by completing Table 6.

Submission 1.7: Clinical Education Affiliation Agreements
1. Provide a copy of the COM approved affiliation agreement

Proposed Revision:
1. Provide a copy of a COM approved affiliation agreement.
2. Provide a list of all contracted clinical sites.
3. Provide the three year average number of OMS II students who matriculated for the academic year, including the number of students repeating from any previous academic years by completing Table 6.
4. At the time of the site visit, a COM must produce all documents that evidence the acceptance of the COM's students to participate at the affiliate site, including all executed affiliation agreements.
5. For mid-cycle reports, nos. 1 - 3 above must be provided. If warranted, the COCA may require that a COM provide copies of all documents (including all executed affiliate agreements) that evidence the acceptance of the COM's students to participate at an affiliate site

Comment: I would request clarification on item 4. What is the COCA looking for in addition to signed affiliation agreements? It is unclear what is required based on information provided.

Element 2.2

Element 2.2: Full Time Dean: (CORE)

The Dean must be employed full-time by the COM and/or its parent institution.

Proposed Revision:

The Dean must be employed full-time by the COM and/or its parent institution. In carrying out the full-time responsibilities of the dean, the dean of a COM is administratively responsible for the conduct and quality of the medical education program and for ensuring the adequacy of faculty at the COM and each of its additional campuses. The principal academic officer at each campus is administratively responsible to the dean.

Editor's Note: *This element requires a dean to be employed full-time without any conflicting, secondary employment. Any secondary employment for which remuneration is given must be: 1) under the auspices of the COM, or its parent institution's authorization; and 2) not in conflict with the time commitments required to carry out the full-time responsibilities of the dean.*

Submission 2.2: Full Time Dean

1. *Provide the employment contract (compensation redacted) demonstrating that the Dean is employed full time.*

Comment
Element 2.2: Proposed Revision: The Dean must be employed full-time by the COM and/or its parent institution. In carrying out the fulltime responsibilities of the dean, the dean of a COM is administratively responsible for the conduct and quality of the medical education program and for ensuring the adequacy of faculty at the COM and each of its additional campuses. The principal academic officer at each campus is administratively responsible to the dean. COM Comment: Will the COCA please clarify as to whether the issue of principal academic officer at each campus being administratively responsible to the dean applies equally to both branch campuses and additional locations?
Element 2.2: Full Time Dean: (CORE) The Dean must be employed full-time by the COM and/or its parent institution. Proposed Revision: The Dean must be employed full-time by the COM and/or its parent institution. In carrying out the full-time responsibilities of the dean, the dean of a COM is administratively responsible for the conduct and quality of the medical education program and for ensuring the adequacy of faculty at the COM and each of its additional campuses. The principal academic officer at each campus is administratively responsible to the dean. Editor's Note: This element requires a dean to be employed full-time without any conflicting, secondary employment. Any secondary employment for which remuneration is given must be: 1) under the auspices of the COM, or its parent institution's authorization; and 2) not in conflict with the time commitments required to carry out the full-time responsibilities of the dean. **Comment: This is a positive change and needed clarification.**

Element 3.4

Element 3.4: Financial Audit: (CORE)

A COM or its parent institution must commission an annual independent audit confirming financial viability and provide evidence of resolution of concerns cited in the audit's accompanying management letter.

Submission 3.4: Financial Audit

1. *Provide the annual audited financial statement and audit report for the COM or its parent institution for the latest complete fiscal year.*

Comment

I would suggest **the edits in yellow below** to be included in the COCA accreditation standard 3 changes. **The rational for those changes is detailed in grey below them:**

Standard 3 Finances, Element 3.4: Financial Audit

1) A COM or its parent institution must commission an annual independent audit confirming financial viability and provide evidence of resolution of concerns cited in the audit's accompanying management letter. **The total dollar and percent each COM takes in and spends within COM must be reported annually and will be made public for all COMs to see. The percentage spent within COM must be broken down into the following 9 categories and subcategories**

a. salaries
- **i. faculty,**
- **ii. staff,**
- **iii. administration)**

b. capital expenditures

c. student resources (e.g. texts, ipads, test banks, club funds)

d. scholarships

e. overhead

f. building endowment
- **i. COM specific,**
- **ii. University**

g. other.

Dollars spent within COMS is the most discrete and consistent metric across COMs. Some Institutions may use COMs as a piggybank more than others, siphoning money to raise endowment. Putting money back into educational resources, COM campus infrastructure, faculty salaries/positions, and research raises the quality of COMs. Incoming students, as well as all stakeholders in COMs, deserves to know this number for COM institutions. In short transparency is the best disinfectant.

Note: Couldnt highlight in yellow so text is red. Couldnt highlight in gray, so text is green.

Element 4.1

Element 4.1: Facilities: (CORE)

A COM must have facilities for the program of instruction that enable the authorized class size of students and faculty to pursue the mission, curriculum, and scholarly activity of the COM.

Submission 4.1: Facilities

1. *Provide the floorplan diagrams of all buildings used by the COM on all campuses utilized by the COM.*

2. *Complete and submit Tables 4.1a and 4.1b to describe the facilities. (Tables are located within the electronic accreditation system)*

Proposed Revision:

1. *Provide the floorplan diagrams of all buildings used by the COM on all campuses utilized by the COM.*

2. *Complete and submit Table 4.1 to describe the on-campus facilities.*

3. *Describe how the COM assesses the adequacy of the CORE clinical rotation facilities, including how students are involved in the assessment.*

Table 4.1: "On-campus facilities."

Comment

For the last column “How many other students will be on the COM’s campus?”: Since each line represents a particular space, Are you wanting to know, for those spaces that are shared, the approximate number of other students sharing that same space? Some clarification around this wording would be helpful.

On Campus Facilities

Name of Space for Use by DO Students (as referenced in floor plan)	Space Description	Purpose (Role in Daily Operation eg. Curriculum, Student Services, etc)	Square Feet	Occupancy According to the Fire Code	Number of hours per day space is available to DO students	Is the space shared? With whom?	How many other students will be on the COM's campus?

Standard 4:1 Facilities

1. Please clarify/specify buildings "operated by the COM" - as written this could include all buildings students are training in which may not be operated by COM in the case of clinical rotations sites.

Element 4.4

Element 4.4: Learning Resources:

A COM must ensure access to learning resources to support its mission.

Submission 4.4: Learning Resources

1. *Complete and submit Table 4.4 to describe the learning resources. (Tables are located within the electronic accreditation system)*

Proposed Revision:

Table 4.4: In the column labeled "Resource Type," include the parenthetical phrase "suggested examples." The drop down menu option for "other" should be amended to "other learning resources."

Comment
Proposed Revision: Table 4.4: In the column labeled "Resource Type," include the parenthetical phrase "suggested examples." The drop down menu option for "other" should be amended to "other learning resources." Would be helpful to specify "learning resources" better somewhere in the standard. One could say the library is a learning resource while another could feel the need to itemize everything in the library. We struggled with this for our comprehensive site visit and found Table 4.4 to be too simplistic for the purpose – or at least not clear enough in terms of what it was looking for. We ended up submitting a 14-page narrative that included such things as the simulation clinic inventory of task trainers, a listing of the required textbooks, a listing of the board resource materials supplied by the college among other things.
Element 4.4: COM appreciates the additional of dropdown menu categories such as board prep materials, LMS, e-journals, databases which help COMs to more comprehensively complete this table.

Element 5.1

Submission 5.1: Professionalism

1. *Provide a copy of all professionalism policies. The professionalism policies should extend to items including, but not limited to, patient safety, cultural competence, and interprofessional collaborative practice.*
2. *Provide a link to where the documents are published.*
3. *Provide a copy of the membership of any professionalism committee and a copy of the charge or purpose of the committee.*

Proposed Revision:

1. *Provide a public link to where the professionalism documents are published.*
2. *Include the membership of the committee that addresses issues of professionalism and ethics.*
3. *Provide a published description and charge of the committee that addresses issues of professionalism and ethics.*

Comment
From an evidentiary standpoint I suggest asking for artifacts that demonstrate ongoing development of professional behaviors, ie faculty development records (events, descriptions, outcomes and attendance) and/or curriculum/performance data relating to professionalism as evidenced through learning and assessment.
Element 5.1: Will the COCA expect that all policies related to professionalism be available to the public? There may be employee specific policies that could apply to professionalism but remain somewhat confidential and should not be placed in a public environment.

Element 5.2

Element 5.2: Diversity:

A COM must publish and follow policies to achieve mission-appropriate diversity outcomes among its students, faculty, senior administrative staff, and other relevant members of the academic community.

Proposed Revision:

A COM must publish effective policies and have in place practices that engage in ongoing, systematic, and focused recruitment and retention activities, to achieve mission-appropriate diversity outcomes among its students, faculty, senior administrative staff, and other relevant members of its academic community. The COM must include in these activities the use of programs and/or partnerships aimed at achieving diversity among qualified applicants for medical school admission and the evaluation of program and partnership outcomes.

Submission 5.2: Diversity

1. *Provide a copy of the policies addressing diversity for students, faculty, senior administrative staff, and other relevant members of the academic community*
2. *Provide a public link to where the documents are published.*

Proposed Revision:

1. *Complete Table 5.2.*
2. *Provide the policies that demonstrate the COM's current practice of systematic and focused recruitment and retention activities, to achieve mission-appropriate diversity outcomes among its students, faculty, senior administrative staff, and other relevant members of its academic community.*

Comment
Proposed Revision: A COM must publish effective policies and have in place practices that engage in ongoing, systematic, and focused recruitment and retention activities, to achieve mission-appropriate diversity outcomes among its students, faculty, senior administrative staff, and other relevant members of its academic community. The COM must include in these activities the use of programs and/or partnerships aimed at achieving diversity among qualified applicants for medical school admission and the evaluation of program and partnership outcomes. This is the only place that the word "effective" is used to describe COM policies. Very dangerous (deserved the red font) – who determines if a policy is effective? The individual site team member, that particular site team, the COM, the COCA?
Complete Table 5.2 Need to see what Table 5.2 is asking for in order to comment on this change…
Submission 5.2: Diversity *1. Provide a copy of the policies addressing diversity for students, faculty, senior administrative staff, and other relevant members of the academic community* *2. Provide a public link to where the documents are published.* *Proposed Revision:* *1. Complete Table 5.2.* *2. Provide the policies that demonstrate the COM's current practice of systematic and focused recruitment and retention activities, to achieve mission-appropriate diversity outcomes among its students, faculty, senior administrative staff, and other relevant members of its academic community.* **Comment: Table 5.2 has not been provided for public comment.**
1. COM is committed to a diverse academic community. We would like the COCA to consider removing or clarifying the terms "systematic and focused in this proposed revision.

Standard 6

Standard 6: Curriculum

The faculty of a COM must define how the students will achieve the educational program objectives, including osteopathic core competencies, and is responsible for the detailed design and implementation of the components of a curriculum that enables its students to achieve those competencies and objectives. Educational program objectives are statements of the knowledge, skills, behaviors, and attitudes that osteopathic medical students are expected to demonstrate as evidence of their achievement prior to successful completion of the program.

The faculty of a COM must periodically and regularly review and revise the COM's curriculum and evaluate the COM's educational program to ensure that the quality of the program meets the current standards of osteopathic core competencies and that students achieve all program objectives and participate in required clinical training experiences and environments.

Comment
Standard 6: Curriculum Proposed New Text: For all of the Elements under Standard 6, a new Table 6 is proposed. **Comment: Table 6 that is provided in the table document is the Table 6 that is referenced on page 4 of the continuing accreditation evidentiary submission document under Element 1.7. Table 6 that is referenced under Standard 6 on page 10 of the continuing accreditation evidentiary submission document has not been provided. This table needs to be made available for public comment prior to implementation given it is the primary method of supplying information for Standard 6 and its sub-elements.**
Proposed New Text: For all of the Elements under Standard 6, a new Table 6 is proposed Need to see what the new Table 6 is asking for in order to comment on this change…
It would be very helpful to be able to preview the updated version of the standard 6 table that requires (by course) colleges show when competencies are introduced, taught and assessed. I could not find it on this document: New and Developing COM Standards Public Posting table Additionally, more details on the expectations for the curriculum map would help colleges ensure they are tracking the fields you are expecting.

Element 6.3

Element 6.3: Maximum Length of Completion:

A COM must ensure that each single degree DO student completes the DO degree within 150% of the standard time to achieve the degree (six years).

Submission 6.3: Maximum Length of Completion

1. *Provide the policy that describes that single degree DO students must complete their education within 150% of the standard time (six years following matriculation)*
2. *Provide the public link to where the document is published.*

Proposed Revision:

1. *Provide the policy that describes that single degree DO students must complete their education within 150% of the standard time (six years following matriculation)*
2. *Provide the public link to where the document is published.*
3. *Identify any single-degree DO student(s) who graduated beyond 150% of the standard time and provide a detailed explanation as to the student's inability to graduate within the 150% of the standard time.*

Comment
1. This request appears to directly contradict that in #1 since all students must finish in 150% time. If this is to remain then #3 should specify only students since the standard is implemented...as written this could be any student in the history of the COM. 2. Additionally, we feel like there may be exceptions for certain medical reasons. We have had students with cancer diagnoses, for example, who may take time off during treatment and illness. We would not want this rule to count against those students if they surpassed the 6 year time requirement. 3. Can the COCA-AOA clarify what this means for our 3 year accelerated pathways? The way we interpret this is as follows, a student in a 3 year pathway would have 4.5 years to complete the curriculum.

Element 6.4 – 6.8

Element 6.4: Osteopathic Core Competencies: (CORE)

A COM must apply best practices to teach, train, and assess students in order to ensure development of the seven osteopathic core competencies of medical knowledge, patient care, communication, professionalism, practice-based learning, systems-based practice, and osteopathic principles and practice/ osteopathic manipulative treatment.

Proposed Revision:

A COM must teach and train students in order to ensure the development of the seven osteopathic core competencies of medical knowledge, patient care, communication, professionalism, practice-based learning, systems-based practice, and osteopathic principles and practice/osteopathic manipulative treatment.

Submission 6.4: Osteopathic Core Competencies

1. *Complete and submit Table 6. (Tables are located within the electronic accreditation system)*

Proposed Revision:

1. *Provide a description of the COM's delivery of its curriculum including teaching and training its students to ensure the development of the seven osteopathic core competencies of medical knowledge, patient care, communication, professionalism, practice based learning, systems based practice, and osteopathic principles and practice/osteopathic manipulative treatment. Not to exceed 250 words.*
2. *A curriculum map demonstrating how the content of these courses is delivered must be made available during any site visit.*

Element 6.5: Scientific Method:

A COM must ensure that the curriculum includes instruction in the scientific method including data collection to test and verify hypotheses or address questions regarding biomedical phenomena and in the basic scientific and ethical principles of clinical and translational research. The curriculum must include the methods by which such research is conducted, evaluated, explained to patients and applied to patient care.

Proposed Revision:

A COM must ensure that the curriculum includes instruction in the scientific method including data collection to test and verify hypotheses or address questions regarding biomedical phenomena and in the basic scientific and ethical principles of clinical and translational research. The curriculum must include the methods by which such research is conducted, evaluated, explained to patients who are part of clinical studies, and applied to patient care.

Submission 6.5: Scientific Method

1. *Complete and submit Table 6. (Tables are located within the electronic accreditation system)*

Proposed Revision:

1. *Provide a description of the COM's delivery of its curriculum including instruction in the scientific method addressing data collection, testing and verifying hypotheses or questions regarding biomedical phenomena and the basic scientific and ethical principles of clinical and translational research. The curriculum must include the methods by which such research is conducted, evaluated, explained to patients/subjects of a clinical study, and applied to patient care. Not to exceed 250 words.*

2. *Provide a curriculum map demonstrating how the content of these courses is delivered must be made available during any site visit.*

Element 6.6: Principles of Osteopathic Medicine: (CORE)

A COM must provide each student, in each year of the curriculum, with opportunities for learning Osteopathic Principles and Practice (OPP), including both observation and hands-on application of osteopathic manipulative medicine (OMM) supervised by COM credentialed physicians (DO or MD).

Submission 6.6: Principles of Osteopathic Medicine

1. *Complete and submit Table 6. (Tables are located within the electronic accreditation system)*

Proposed Revision:

1. *Provide a description of the COM's delivery of its curriculum including opportunities for learning osteopathic principles and practice (OPP), including both observational and hands-on application of osteopathic manipulative medicine (OMM). Not to exceed 250 words.*

2. *A curriculum map demonstrating how the content of these courses is delivered must be made available during any site visit.*

Element 6.7: Self-Directed Learning:

A COM must ensure that the curriculum includes self-directed learning experiences and time for independent study to allow students to develop skills for lifelong learning. Self-directed learning includes students' self-assessment of learning needs; independent identification, analysis, and synthesis of relevant information; and appraisal of the credibility of sources of information.

Submission 6.7: Self-Directed Learning

1. *Complete and submit Table 6. (Tables are located within the electronic accreditation system)*

Proposed Revision:

1. *Provide a description of the COM's delivery of its curriculum including self-directed learning experiences and time for independent study allowing students to develop skills for lifelong learning. Not to exceed 250 words.*
2. *A curriculum map demonstrating how the content of these courses is delivered must be made available during any site visit.*

Element 6.8: Interprofessional Education for Collaborative Practice: (CORE)

A COM must ensure that the core curriculum prepares osteopathic medical students to function collaboratively on health care teams by providing opportunities, in each year of the curriculum, to learn in academic and/or clinical environments that permit interaction with students enrolled in other health professions degree programs or other health professionals.

Submission 6.8: Interprofessional Education for Collaborative Practice

1. *Complete and submit Table 6. (Tables are located within the electronic accreditation system)*

Proposed Revision:

1. *Provide a description of the COM's delivery of its curriculum including preparation of students to function collaboratively on health care teams by providing opportunities, in each year of the curriculum, to learn in academic and/or clinical environments that permit interaction with students enrolled in other health professions degree programs or other health professionals. Not to exceed 250 words.*
2. *A curriculum map demonstrating how the content of these courses is delivered must be made available during any site visit.*

Comment
Submission 6.4: Osteopathic Core Competencies **Submission 6.5: Scientific Method** **Submission 6.6: Principles of Osteopathic Medicine** **Submission 6.7: Self-Directed Learning** **Submission 6.8: Interprofessional Education for Collaborative Practice** **(For all of the above) 2. A curriculum map demonstrating how the content of these courses is delivered must be made available during any site visit.** The standards mention items that must be included in the curriculum more so than how the course content is delivered. Curriculum maps rarely include "how the content of the course is delivered". They always include what is included in the course content and how that content is "mapped", in the case of a COM, to the osteopathic core competencies. Table 6 used to ask for both the mapping of the courses to the competencies and identification where "hands on OMM", "Scientific Method", Self-Directed Learning" and Interprofessional Practice" was included in the curriculum. Is the new table 6 going to ask if a course or the scientific method is delivered by "lecture", "small group instruction", "assigned independent reading", "flipped classroom", "hands on practice", etc.? Those are all addressing "how the content of these courses is delivered". I really don't think that is what COCA is looking for but that is what I would give you based on #2. Better wording for 2 would be "A curriculum map demonstrating (insert the corresponding item below) must be made available during any site visit." 6.4 when and where in the curriculum students receive instruction in each of the osteopathic core competencies 6.5 when and where in the curriculum students receive instruction in the scientific method 6.6 when and where in the curriculum students receive instruction in the principles of osteopathic medicine and the practice of osteopathic manipulative medicine 6.7 when and where in the curriculum students are expected to practice self-directed learning 6.8 when and where in the curriculum students have opportunities to participate in interprofessional education for collaborative practice – including which of the other health professions are included in these opportunities.
Submission 6.4: Osteopathic Core Competencies **1. Provide a description of the COM's delivery of its curriculum including teaching and training its students to ensure the development of the seven osteopathic core competencies of medical knowledge, patient care, communication, professionalism, practice based learning, systems based practice, and osteopathic principles and practice/osteopathic manipulative treatment. Not to exceed 250 words** There are 52 words just in #1. There is no way anyone could write a meaningful description addressing all that in 250 words or less. Maybe 250 words per competency.

Submission 6.5: Scientific Method
Provide a description of the COM's delivery of its curriculum including instruction in the scientific method addressing data collection, testing and verifying hypotheses or questions regarding biomedical phenomena and the basic scientific and ethical principles of clinical and translational research. The curriculum must include the methods by which such research is conducted, evaluated, explained to patients/subjects of a clinical study, and applied to patient care. Not to exceed 250 words.

This one is 70 words long. There is no way anyone could write a meaningful description addressing all that in 250 words or less.
Same thing for 6.6, 6.7, and 6.8.

Element 6.4: Osteopathic Core Competencies

A COM must ~~teach and train students in order to~~ ensure the development **in each individual student**, of the seven osteopathic core competencies of medical knowledge, patient care, communication, professionalism, practice- based learning, systems-based practice, and osteopathic principles and practice/osteopathic manipulative treatment.

Explanation: The language needs to allow for the evolution of active-learning curricula. This suggested language focuses on assessment of the competencies without language constraining the curricular process.

Element 6.4: Please keep the "best practices" language in this element and consider using it in other elements as well. We should be all be using best practices in the field of medical education, etc. to support the decisions we make.

Element 6.4: Osteopathic Core Competencies: (CORE)

A COM must apply best practices to teach, train, and assess students in order to ensure development of the seven osteopathic core competencies of medical knowledge, patient care, communication, professionalism, practice-based learning, systems-based practice, and osteopathic principles and practice/ osteopathic manipulative treatment.

Table 6- Student Population: This table doesn't seem to relate to elements 6.4 – 6.8. Is there a table missing?

Student Population

For each year of the last three years, provide the number of OMS II and repeating students.

Academic year	Number of OMS II students	Number of repeating students	Total of Column 2 and 3

Element 6.6: Principles of Osteopathic Medicine: (CORE)
A COM must provide each student, in each year of the curriculum, with opportunities for learning Osteopathic Principles and Practice (OPP), including both observation and hands-on application of osteopathic manipulative medicine (OMM) supervised by COM credentialed physicians (DO or MD).

How does an MD become "COM credentialed" in OPP and OMM?

Element 6.4: Proposed Revision:
A COM must teach and train students in order to ensure the development of the seven osteopathic core competencies of medical knowledge, patient care, communication, professionalism, practice- based learning, systems-based practice, and osteopathic principles and practice/osteopathic manipulative treatment.

COM Comment: It appears that the COCA has removed the word assessment from this element. Is that simply due to the description of assessment that occurs in Element 11.1, or is the COCA simply focusing more on ensuring the delivery of this curricular content?

Elements 6.4 – 6.8: Will the COCA be able to provide additional clarity about what type of curriculum map the COCA wishes to have submitted? Will this map need to connect lecture and lab objectives to assessments? And, is this at a course level or individual learning activity level? Finally, at the level of each objective, this could generate hundreds of pages of data very quickly.

Submission 6.4: Osteopathic Core Competencies
1. Complete and submit Table 6. (Tables are located within the electronic accreditation system)

Proposed Revision:
1. Provide a description of the COM's delivery of its curriculum including teaching and training its students to ensure the development of the seven osteopathic core competencies of medical knowledge, patient care, communication, professionalism, practice based learning, systems based practice, and osteopathic principles and practice/osteopathic manipulative treatment. Not to exceed 250 words.
2. A curriculum map demonstrating how the content of these courses is delivered must be made available during any site visit.

Comment: Is the COCA looking for a specific format for the referenced curriculum map? Is this the purpose of Table 6 that is unavailable for public comment?

1. The language in these standards should be more specific. As written, each one asks for description of the curriculum including each of the separate pieces specified in each of the standards with a 250 word limit. It appears the intention was for each piece to specifically only cover that pertaining to the standard in question and that each would not reiterate the full COM curriculum -we suggest revisions to make this more clear.

• "Provide a description of how the COM's curriculum includes teaching and training its students to ensure development of the seven osteopathic core competencies...?
• "Provide a description of how the COM's curriculum includes instruction in the scientific method... "
• "Provide a description of how the COM's curriculum includes self directed learning experiences..."
• "Provide a description of how the COM's curriculum includes preparation of students to function collaboratively on health care teams..."
2. Also, as the COCA is aware, LECOM has several different pathways for student learning, which we feel would be difficult to describe in a 250 word limit.

Element 6.9

Element 6.9: Clinical Education: (CORE)

A COM must define the types of patients and clinical conditions that osteopathic medical students are required to encounter, the skills to be performed by the students, the appropriate clinical setting for these experiences and the expected levels of student responsibilities. COMs must be able to provide clinical education rotations, including demonstration of adequate faculty, for at least 110% of the three-year rolling average of the number of first-year matriculates and repeat students. A COM must also have published policies and procedures (protocols) addressing methodologies by which students can complete the entire clinical education curriculum.

Proposed Revision:

A COM must: a) define the types of patients and clinical conditions that osteopathic medical students are required to encounter, the skills to be performed by the students, the appropriate clinical setting for these experiences and the expected levels of student responsibilities; b) be able to provide clinical education rotations, including demonstration of adequate faculty, for the three-year rolling average of the number of second-year matriculates and repeating students; and c) have published policies and procedures (protocols) addressing methodologies by which students can complete the entire clinical education curriculum.

Submission 6.9: Clinical Education

1. *Provide a sample syllabus for a required clinical rotation.*
2. *Provide policies and procedures (protocols) demonstrating how students will obtain all clinical education through the COM.*
3. *Complete and submit Table 6.9 demonstrating adequacy of core clinical rotation capacity.*

Proposed Revision:

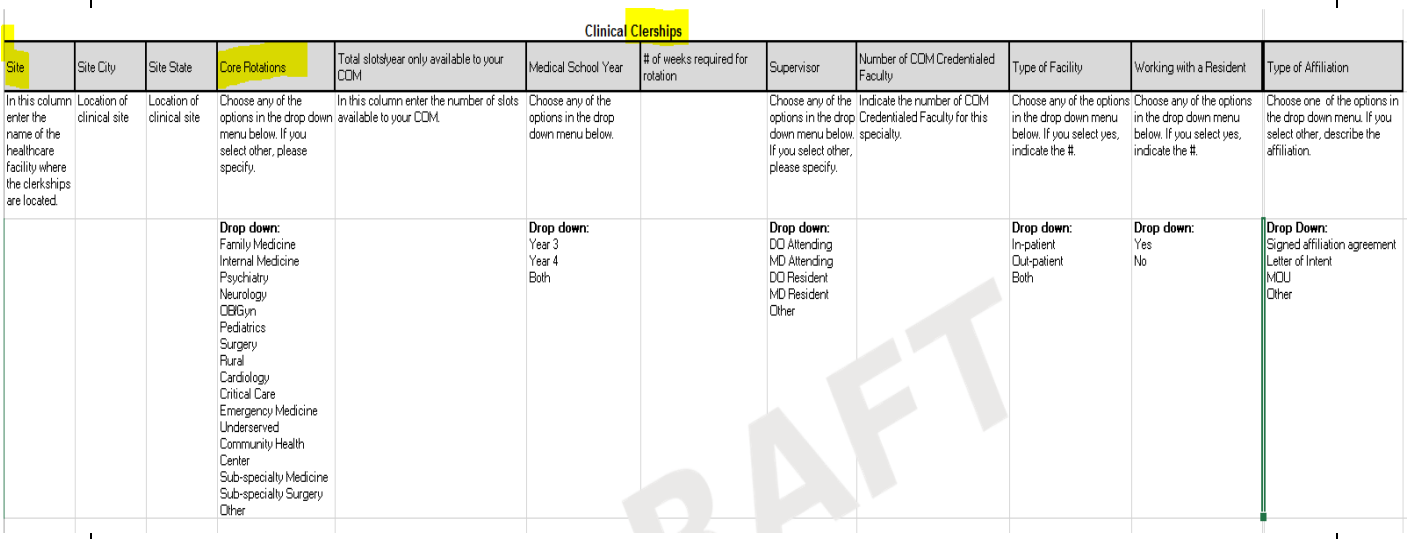
1. *Provide a sample syllabus for core clinical rotations.*
2. *Provide policies and procedures (protocols) demonstrating how clinical education is delivered to all students through the COM.*
3. *Complete Table 6.*
4. *Complete Table 6.9 demonstrating adequacy of core clinical rotation capacity.*
5. *Provide a contingency plan for all core rotations indicating how students will be placed in clinical education in the event opportunities are no longer available.*

Comment

Submission 6.9: Clinical Education
Provide a contingency plan for all core rotations indicating how students will be placed in clinical education in the event opportunities are no longer available.

This statement should be included in the proposed change to standard 6.9. The standard does not mention the need for any contingency plan.

Table 6.9- Clinical Clerkships: I would suggest adding the word "Rotation" Site to the title of the first column.
Would also suggest adding the word "Required/Core" to the title of the fourth column.
There is a spelling error in the word clerkship in the table title.



Clinical Clerships

Site	Site City	Site State	Core Rotations	Total slotsyear only available to your COM	Medical School Year	# of weeks required for rotation	Supervisor	Number of COM Credentialed Faculty	Type of Facility	Working with a Resident	Type of Affiliation
In this column enter the name of the healthcare facility where the clerkships are located.	Location of clinical site	Location of clinical site	Choose any of the options in the drop down menu below. If you select other, please specify.	In this column enter the number of slots available to your COM.	Choose any of the options in the drop down menu below.		Choose any of the options in the drop down menu below. If you select other, please specify.	Indicate the number of COM Credentialed Faculty for this specialty.	Choose any of the options in the drop down menu below. If you select yes, indicate the #.	Choose any of the options in the drop down menu below. If you select yes, indicate the #.	Choose one of the options in the drop down menu. If you select other, describe the affiliation.
			Drop down: Family Medicine Internal Medicine Psychiatry Neurology OB/Gyn Pediatrics Surgery Rural Cardiology Critical Care Emergency Medicine Underserved Community Health Center Sub-specialty Medicine Sub-specialty Surgery Other		**Drop down:** Year 3 Year 4 Both		**Drop down:** DO Attending MD Attending DO Resident MD Resident Other		**Drop down:** In-patient Out-patient Both	**Drop down:** Yes No	**Drop Down:** Signed affiliation agreement Letter of Intent MOU Other

Element 6.9: Proposed Revision:
A COM must: a) define the types of patients and clinical conditions that osteopathic medical students are required to encounter, the skills to be performed by the students, the appropriate clinical setting for these experiences and the expected levels of student responsibilities; b) be able to provide clinical education rotations, including demonstration of adequate faculty, for the three-year rolling average of the number of second-year matriculates and repeating students; and c) have published policies and procedures (protocols) addressing methodologies by which students can complete the entire clinical education curriculum.

COM Comment: This proposed revision changes the calculation number utilized to determine adequacy of rotation positions to use of the number of second year students (including repeat students), and no longer requires the extra positions to meet 110% of the student body. This raises the issue of whether the COM be responsible for the calculation of the number of needed rotation positions or will the COCA provide the number of required rotation positions?

Element 6.9: Clinical Education: (CORE)
A COM must define the types of patients and clinical conditions that osteopathic medical students are required to encounter, the skills to be performed by the students, the appropriate clinical setting for these experiences and the expected levels of student responsibilities. COMs must be able to provide clinical education rotations, including demonstration of adequate faculty, for at least 110% of the three-year rolling average of the number of first-year matriculates and repeat students. A COM must also have published policies and procedures (protocols) addressing methodologies by which students can complete the entire clinical education curriculum.
Proposed Revision:
A COM must: a) define the types of patients and clinical conditions that osteopathic medical students are required to encounter, the skills to be performed by the students, the appropriate clinical setting for these experiences and the expected levels of student responsibilities; b) be able to provide clinical education rotations, including demonstration of adequate faculty, for the three-year rolling average of the number of second-year matriculates and repeating students; and c) have published policies and procedures (protocols) addressing methodologies by which students can complete the entire clinical education curriculum.

Comment: This is a positive change and needed clarification.

1. #5 - Please make this more clear. As written it is unclear if COCA wants contingency for ALL spots/ALL rotations collectively or if this is asking for one for each rotation site in case it is no longer available.

Element 6.10

Element 6.10: Clinical Experience:

A COM must ensure that each student participates in one or more required core rotations during the third-year clinical clerkship experience that is conducted in a health care setting in which the student works with resident physicians currently enrolled in an accredited program of graduate medical education. In addition to the above expectation, a minimum of one required third year clinical clerkship must be completed under the supervision of an osteopathic physician and a minimum of one required third year clinical clerkship must be completed in an inpatient facility.

Submission 6.10: Clinical Experience

1. *Complete Table 6.9*

Comment

Element 6.10: Clinical Experience:

I recently completed a retrospective study investigating the OMM practice patterns of 3rd and 4th year students as documented by the ATSU-KCOM required OMM Practice Logs. These practice logs documented 30 supervised OMT treatments that each student completed during their 3rd and 4th years. Over 10,000 practice treatments were reviewed. Data included whether the OMT involved a clinical or volunteer patient and whether it was supervised by an MD or DO. Third years students performed OMT on clinical patients significantly more often than fourth year students and MDs supervised the OMT significantly more often for fourth year students than for third year students. This data is currently in final review for publication in JAOA.

I believe this data is a direct reflection of the following COCA requirement: "a minimum of one required third year clinical clerkship must be completed under the supervision of an osteopathic physician". Given the marked increase in the number osteopathic physicians in practice over the past decade, I recommend the following revision:

*"a minimum of one required third year **and one fourth year** clinical clerkship must be completed under the supervision of an osteopathic physician"*

Element 7.1

Element 7.1: Faculty and Staff Resources and Qualifications: (CORE)

At all educational teaching sites, including affiliated sites, a COM must have sufficient faculty and staff resources to achieve the program mission, including part time and adjunct faculty, and preceptors who are appropriately trained and credentialed. The physician faculty, in the patient care environment, must hold current medical licensure and board certification/ board eligibility. The non-physician faculty must have appropriate qualifications in their fields.

Proposed Revision:

At all educational teaching sites, including affiliated sites, a COM must have sufficient faculty and clinical staff resources to achieve the program mission, including part time and adjunct faculty, and preceptors who are appropriately trained and credentialed. The physician faculty, in the patient care environment, must hold current medical licensure and board certification/board eligibility. In the event a COM is unable to fill physician faculty positions with board certified or board eligible physicians, the COM may, under exceptional circumstances and upon good cause, employ physician faculty who are not board certified or board eligible based on that physician's demonstrated educational and clinical practice experience. All non-physician faculty must have demonstrated, appropriate qualifications in his/her disciplinary field.

Submission 7.1: Faculty and Staff Resources and Qualifications

1. *Complete and submit Tables 7a and 7b*

Proposed Revision:

1. *Complete Tables 7.1a and 7.1b*

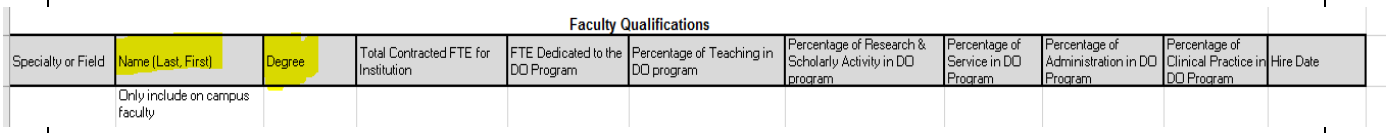
2. *Submit a comprehensive statement explaining the circumstances why the COM has employed any physician faculty in the patient care environment who are not board certified or board eligible.*

3. *At the time of the site visit, the COM must have available for inspection the complete faculty file, including the most recent and complete curricula vitae and credentialing information, of all faculty, including all adjunct faculty.*

Note: Tables 7a and 7b to be re-labeled 7.1a and 7.1b

Comment

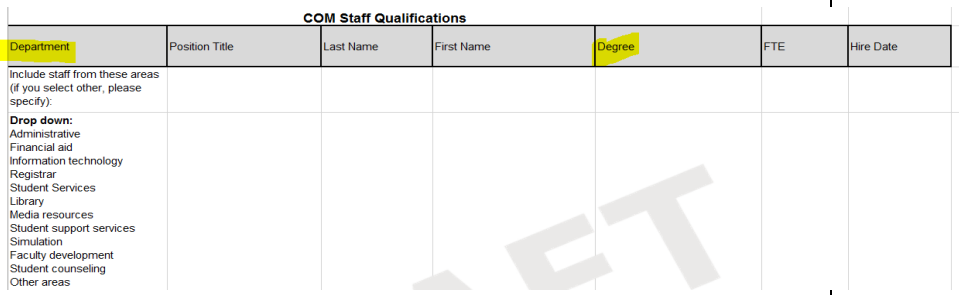
Table 7.1A- Faculty Qualifications: Please separate out Last Name and First Name into separate columns.
Add "(s)" after Degree in the third column.



Faculty Qualifications

Specialty or Field	Name (Last, First)	Degree	Total Contracted FTE for Institution	FTE Dedicated to the DO Program	Percentage of Teaching in DO program	Percentage of Research & Scholarly Activity in DO program	Percentage of Service in DO Program	Percentage of Administration in DO Program	Percentage of Clinical Practice in DO Program	Hire Date
	Only include on campus faculty									

Table 7.1C- COM Staff Qualifications: Consider adding the following to the drop down list under Department in the first column.
Academic Affairs/Curriculum Office
Admissions
Communications
Finance
GME
Human Resources
Research/Grants
Intuitional Assessment
Learning Technologies
Student Affairs
Academic Departments (i.e., FM, BMS, IM, Peds, etc.)
Dean's Office



COM Staff Qualifications

Department	Position Title	Last Name	First Name	Degree	FTE	Hire Date
Include staff from these areas (if you select other, please specify):						
Drop down: Administrative Financial aid Information technology Registrar Student Services Library Media resources Student support services Simulation Faculty development Student counseling Other areas						

Add a "(s)" after Degree in the fifth column.

Element 7.1: Faculty and Staff Resources and Qualifications: (CORE)
I disagree with the following change "In the event a COM is unable to fill physician faculty positions with board certified or board eligible physicians, the COM may, under exceptional circumstances and upon good cause, employ physician faculty who are not board certified or board eligible based on that physician's demonstrated educational and clinical practice experience." Many schools have trouble filling vacancies for faculty physicians due to a variety of factors including non-competitive salaries. By including this statement as an accreditation standard, COMs can lower salaries such that physicians with board certification would be less likely to accept a position. After a period of open recruitment, COMs with noncompetitive salaries can simply declare that no boarded individuals were available and can employ physicians with subjective credentials rather than objective credentials. This is a bad precedent to set, if the goal is to ensure quality education at our COMs.

I talked with xxxxx on March 13, 2019 about the proposed Table 7.1A, which she believes is confusing. Here are her recommendations: 1. Column F "Percentage of Teaching in DO program" should be re-labeled as " Percentage of Teaching in Pre-clinical education". 2. Column J "Percentage of Clinical Practice in DO Program" should be re-labeled as "Percentage of Teaching in Clinical Education". 3. The COCA should question if it really needs to know the amount of time spent in just clinical practice (no teaching). 4. Should all of the clinical faculty be included in this table?
Element 7.1: Many COMs have well over 1000 preceptors. A requirement to maintain active CVs on file may restrict our ability to utilize central Credentialing agencies, as we often do not receive the CV in that situation. This may then require additional employees for a COM, resulting in increased cost to students in tuition dollars.
Element 7.1: Faculty and Staff Resources and Qualifications: (CORE) At all educational teaching sites, including affiliated sites, a COM must have sufficient faculty and staff resources to achieve the program mission, including part time and adjunct faculty, and preceptors who are appropriately trained and credentialed. The physician faculty, in the patient care environment, must hold current medical licensure and board certification/ board eligibility. The non-physician faculty must have appropriate qualifications in their fields. Proposed Revision: At all educational teaching sites, including affiliated sites, a COM must have sufficient faculty and clinical staff resources to achieve the program mission, including part time and adjunct faculty, and preceptors who are appropriately trained and credentialed. The physician faculty, in the patient care environment, must hold current medical licensure and board certification/board eligibility. In the event a COM is unable to fill physician faculty positions with board certified or board eligible physicians, the COM may, under exceptional circumstances and upon good cause, employ physician faculty who are not board certified or board eligible based on that physician's demonstrated educational and clinical practice experience. All non-physician faculty must have demonstrated, appropriate qualifications in his/her disciplinary field. **Comment: I strongly disagree with allowing non-board certified/non-board eligible physicians to teach within our COMs. We should hold faculty to a higher standard of academic and professional performance than practicing physicians. Our COMs should not employee or utilize physicians that are ineligible to work within hospital settings or receive reimbursement by third-party payers.**

Element 7.1: Faculty & Staff Resources & Qualifications, COCA proposes the following qualifications for Faculty & Staff Resources & Qualifications.

At all educational teaching sites, including affiliated sites, a COM must have sufficient faculty and clinical staff resources to achieve the program mission, including part time and adjunct faculty, and preceptors who are appropriately trained and credentialed. The physician faculty, in the patient care environment, must hold current medical licensure and board certification/board eligibility. In the event a COM is unable to fill physician faculty positions with board certified or board eligible physicians, the COM may, under exceptional circumstances and upon good cause, employ physician faculty who are not board certified or board eligible based on that physician's demonstrated educational and clinical practice experience. All non-physician faculty must have demonstrated, appropriate qualifications in his/her disciplinary field.

COUME Proposes:

At all educational teaching sites, including affiliated sites, a COM must have sufficient faculty and clinical staff resources to achieve the program mission, including part time and adjunct faculty, and preceptors who are appropriately trained and credentialed. The physician faculty, in the patient care environment, must hold current medical licensure and **AOA/ABMS** board certification/board eligibility. In the event a COM is unable to fill physician faculty positions with **AOA/ABMS** board certified or board eligible physicians, the COM may, under exceptional circumstances and upon good cause, employ physician faculty who are not **AOA/ABMS** board certified or board eligible based on that physician's demonstrated educational and clinical practice experience. All non-physician faculty must have demonstrated, appropriate qualifications in his/her disciplinary field.

Submission 7.1: Faculty and Staff Resources and Qualifications, COCA proposes no revisions for Faculty & Staff Resources & Qualifications.

COUME proposes:

2. Submit a comprehensive statement explaining the circumstances why the COM has employed any physician faculty in the patient care environment who are not **AOA/ABMS** board certified or board eligible.

With regard to the change in 7.1; in attempting to fashion a practical solution to a credible problem, the current proposal is unacceptable because it does not stipulate what circumstances would satisfy the criteria to acceptably designate an event to qualify as "exceptional circumstances and upon good cause", and by not specifying that such an exceptional solution would necessarily be temporary, it allows the influence of one specialty organization (ACOPF) to set a standard that is clearly designed to dilute the value of certification from another specialty organization (AAO) while at the same time participating in a public relations blitz on how we should all get along and speak with one voice during the SAS process. Is this an appropriate function for COCA?

This effort to devalue the most osteopathic of our osteopathic organizations is convergent with the action of the AOA BOT to approve osteopathic residency training without requiring osteopathic content or testing....which also bothered me greatly until I understood that the AMA, in a desperate scramble to gain future membership and to not be outmaneuvered by our cagey AOA leadership, will be promoting AMA residencies without any medical content. I feel like I have just stepped through the looking glass,

Alice.
Table 7.1A Continuing Standards- revised table asks for "hire date" -we do not believe this is relevant to the standard or necessary for COCA to collect.

Element 7.2

Element 7.2: Faculty Approvals at All Teaching Sites:

A COM must academically credential and/or approve the faculty at all COM and COM-affiliated and educational teaching sites.

Submission 7.2: Faculty Approvals at All Teaching Sites

1. *Provide a copy of the policies and procedures for credentialing and/or approval of all COM faculty.*

Proposed Revision:

1. *Provide a copy of the policies and procedures for credentialing and appointment, or approval of all COM faculty.*
2. *Submit a comprehensive and detailed statement explaining the circumstances why the COM employed any physician faculty in the patient care environment who are not board certified or board eligible.*
3. *Complete Table 7.2. (in summary of tables)*

Table includes:
Preceptor Name
Clinical Site
# of Students per rotation supervised by the preceptor
Preceptor's status - Board cert? Board eligible
Preceptor's discipline
Preceptor appointed or approved as faculty?
(must define appointment vs. approval)

Comment

Standard 7: Faculty and Staff
Submission 7.2: Faculty Approvals at All Teaching Sites
Complete Table 7.2. (in summary of tables)

Need to be clear if table 7.2 (which is new) should include those faculty in table 7.1a who also precept students in the patient care environment. I think they should be but that needs to be more clearly stated in the on-line platform. Including them would give a better report on faculty adequacy for clinical training.

Table 7.2- Preceptor Qualifications: Separate out First Name and Last Name in first column into two separate columns.
What does "Full" Degree mean?
Add "(s)" to Degree in the second column.
In the drop down menu for Preceptor Status, fourth column, add "multiple board certifications" as an option.
Does this table include "volunteer" clinical faculty? If so, I would make that explicit (i.e., add to the title). Also, in a note or instructions make clear that this table should only include active preceptors (i.e., those who've taken students within a reasonable amount of time, such as the last 3 years.)

Preceptor Qualifications

Name (Last, First)	Full Degree	Discipline of Preceptor	Preceptor Status	Clinical Site	# of Students per Rotation Supervised by the Preceptor	Faculty Status
			Drop Down:			**Drop Down:**
			Board Certified			Appointed
			Board Eligible			Approved

Submission 7.2: Faculty Approvals at All Teaching Sites, COCA proposes the following qualifications for Faculty Approvals at All Teaching Sites.

2. Submit a comprehensive and detailed statement explaining the circumstances why the COM employed any physician faculty in the patient care environment who are not board certified or board eligible.
3. Complete Table 7.2. (in summary of tables) Table includes:
Preceptor Name
Clinical Site
# of Students per rotation supervised by the preceptor
Preceptor's status - Board cert? Board eligible
Preceptor's discipline
Preceptor appointed or approved as faculty? (must define appointment vs. approval)

COUME proposes:

2. Submit a comprehensive and detailed statement explaining the circumstances why the COM employed any physician faculty in the patient care environment who are not AOA/ABMS board certified or board eligible.
3. Complete Table 7.2. (in summary of tables) Table includes:
Preceptor Name
Clinical Site
# of Students per rotation supervised by the preceptor
Preceptor's status - **AOA/ABMS** Board cert? Board eligible
Preceptor's discipline
Preceptor appointed or approved as faculty? (must define appointment vs. approval)

Element 7.3

Element 7.3: Department Chair Qualifications:

A COM must employ Department Chairs, or their equivalent, with proven experience in teaching and academic leadership in a medical education setting. For clinical department chairs, the chair must have an active medical license and active board certification in the discipline in which they serve as chair.

Submission 7.3*:* Department Chair Qualifications

1. *Provide the organizational chart demonstrating the reporting hierarchy for each department.*
2. *Provide the current job description and complete curriculum vitae for each department chair or its equivalent.*
3. *Provide a complete curriculum vitae for each department chair or its equivalent.*
4. *For each clinical department chair, provide a copy of the department chair's medical license.*
5. *For each clinical department chair, provide a copy of the department chair's board certification documents.*

Comment
Element 7.3: Department Chair Qualifications, COCA proposes no revisions for Department Chair Qualifications. COUME proposes: A COM must employ Department Chairs, or their equivalent, with proven experience in teaching and academic leadership in a medical education setting. For clinical department chairs, the chair must have an active medical license and active **AOA/ABMS** board certification in the discipline in which they serve as chair.
Submission 7.3: Department Chair Qualifications, COCA proposes the following qualifications for Department Chairs. 5. For each clinical department chair, provide a copy of the department chair's board certification documents. COUME proposes: 5. For each clinical department chair, provide a copy of the department chair's **AOA/ABMS** board certification documents.
I am writing to express my concerns with regards to revising the standards to state that physician faculty need to be board certified/board eligible. With the current lawsuit against American Board Of Internal Medicine, the certification process for IM is currently being questioned. I'm wondering if it would be prudent to defer board certification in the standards until this issue has resolved.

Element 7.4

Element 7.4: Primary Care Leadership:

A COM must employ a Doctor of Osteopathic Medicine with an active medical license and active board certification from a primary care discipline to serve as the Department Chair of Primary Care (or equivalent). If the COM does not have an organized Department of Primary Care, the Department Chair of either Family Medicine or Internal Medicine or Pediatrics must be a Doctor of Osteopathic Medicine with active board certification.

Submission 7.4: Primary Care Leadership

1. *Provide a copy of the job description for the chair of primary care (or equivalent).*
2. *Provide a complete and current curriculum vitae for the chair of primary care (or equivalent).*
3. *Provide a copy of the chair's medical license.*
4. *Provide a copy of the chair's board certification documents.*

Comment

Element 7.4: Primary Care Leadership, COCA proposes no revisions for Primary Care Leadership.

COUME proposes:

A COM must employ a Doctor of Osteopathic Medicine with an active medical license and active **AOA/ABMS** board certification from a primary care discipline to serve as the Department Chair of Primary Care (or equivalent). If the COM does not have an organized Department of Primary Care, the Department Chair of either Family Medicine or Internal Medicine or Pediatrics must be a Doctor of Osteopathic Medicine with active board certification.

Element 7.5

Element 7.5: OMM/OPP Leadership: (CORE)

A COM must employ a Doctor of Osteopathic Medicine with an active medical license and active board certification from the American Osteopathic Board of Neuromusculoskeletal Medicine (AOBNMM) or a Certificate of Special Proficiency in OMM (C-SPOMM) to serve as the Department Chair of OMM/OPP, or equivalent.

Note:

The COCA has received a request from the American College of Osteopathic Family Physicians (ACOFP) to revise this element to permit physicians other than those listed in this element to be eligible for chair leadership positions. At the December, 2018, meeting, the COCA received oral comments from the ACOFP, the Educational Council on Osteopathic Principles, the American Academy of Osteopathy, and the American Osteopathic Association Bureau of Osteopathic Specialties. The COCA will take those comments into consideration, along with any other public comments that may be received to fashion a proposed revision, if any is to be made.

Submission 7.5: OMM/OPP Leadership

1. *Provide a copy of the job description for the chair of OMM/OPP (or equivalent).*
2. *Provide a complete curriculum vitae for the chair of OMM/OPP (or equivalent).*
3. *Provide a copy of the chair's medical license.*
4. *Provide a copy of the chair's board certification documents.*

Comment
I am writing to express my continued support for maintaining the requirement that OPP Chair be NMM Board certified. Having completed both FM and NMM osteopathic residencies I assure you that the OPP content of the two is not even remotely comparable. If the schools are having difficulty finding faculty to fill these positions they need to make their positions more attractive, not lobby for an easier requirement to meet. It's an osteopathic school, the OPP chair should be one of the highest paid faculty. Our NMM colleagues do very well in private practice so faculty positions as they are, are not very attractive. Our profession continues to ax away at OPP and those things that make us distinct. We now have single accreditation from ACGME resulting in less OPP content in residencies. Now the AOA is taking osteopathic content out of our boards. All of these things make our profession weaker, not stronger. I regularly precept 3rd and 4th year medical students on clinical rotations and their collective knowledge of OPP has declined over the past 10 years. We are now planning to do regularly scheduled OMM labs through out the year with our core students because they are coming to us without the basic knowledge we expect. Having a Chair who is not NMM trained will only make this worse. Please maintain the requirement as it is so that we have a hope of passing along OPP to our future osteopathic physicians.
As an AOBOG Board Certified OBGYN, AAO member, and Founding Member of the Fascia Research Society who has spent much of my postgraduate career researching clinical applications of manual and movement therapies for female and pelvic health, I believe that expanding the field of candidates for NMM program directors to family practice physicians would dilute training and ultimately the profession. An osteopathic perspective and skill in practice requires a commitment and focus that must be reflected in solid training and deepened by years of focused practice. A family practice certification would not provide the necessary concepts or skills necessary for a program director in neuromuscular medicine.
This is a comment on the proposed revisions to COCA. As a residency-trained board certified OMM Specialist, I support requiring the chair of an OMM Department of a COM to have my qualifications. At one point in my training, I realized that I was proficient in more than 20 modalities. More have evolved since then. I have lost count of all of the different ways in which I can tackle a patient problem whether in or out-patient, old or young patient, large or small patient with medical, surgical, neurological or structural problems. Such a person is ideal as chairman. He/she will be proficient in all of the new techniques and old. He will be able to solve the problem of teaching a wide range of students, even if the students are handicapped in some way. Much of his/her knowledge will be beyond the scope of the medical school curriculum, as is proper. Just as all osteopathic students must learn cardiology, a COM does not teach them all that a fellowship trained, board certified cardiologist knows. So, the chairman of an OMM department should be of the highest caliber of training. An Osteopathic Family Physician cannot possibly have the scope of knowledge necessary to chair a department of OMM, whose knowledge must be superior and up to date in all of the latest osteopathic philosophy and principles. Likewise, an osteopathic family physician should not be the chairmen of internal medicine or surgery departments. I am also a board-certified ophthalmologist. I would not want a family physician teaching me ophthalmology, if I was an osteopathic student. I would want him to teach me family practice. Family Physicians are expected to be competent in basic OMM, but not expected to know the entire scope of the discipline. The field has grown tremendously since I graduated medical school in 1991. If I was practicing Family Practice, I would be expected to maintain up to date knowledge in so many different areas of medicine and surgery that I would be unable to keep up with all of the newest osteopathic principles and practice.

Please keep the requirement that a COM must employ a Doctor of Osteopathic Medicine with an active medical license and active board certification from the American Osteopathic Board of Neuromusculoskeletal Medicine (AOBNMM) or a Certificate of Special Proficiency in OMM (C-SPOMM) to serve as the Department Chair of OMM/OPP, or equivalent. I an Osteopathic Physiatrist, with current board certifications in NMM/OMM and PMR. I currently work in a Family Practise residency program. There is very little OPP training in a typical FP residency. The vast body of knowledge to get to take and pass NMM/OMM boards is not required in FP training. Therefore, with insufficent training and competency testing, it there is no reason for FP physicians to be Chair of OMM/OPP departments.
I am board certified in family medicine, hold NMM certification and FAAO status. I am also a member of the ACOFP and the AAO. I have been an OMM chair for 15 years, so I believe I have a good understanding of both SIDES of this argument. Chairs need to manipulative medicine skill inability strong enough to supervise and contribute to years one through four, and be involved in the curriculum testing, and evaluation, research, and OMM /graduate medical education. The argument is also one of fiscal matters, as many schools (especially new small ones) do not want to pay for a NMM specialist. There is also an availability component, as many new schools are in less desirable locations, and they have to pay large amounts of money to attract qualified faculty. There is also fewer available NMM specialists nationally due to the growth of the profession, and how many or turned out by the program. I personally believe that the chairman of OMM , as well as the chairman of any medical school department should have the highest degree possible in their field a specialty. I believe that the chair position for OMM, at the minimum should be NMM certified, and the FAAO desired, with a minimum of 5 years clinical experience, after residency. Although there are many excellent family physicians in the ACOFP, the Musculoskeletal knowledge, and manipulative medicine skills need to be at a significantly higher level than what is taught and tested at the ACOFP level. The ACOFP testing of manual medicine skills, is rudimentary, compared to the knowledge and skill that is required for Chairs of OMM departments.
As a physician who certified by AOBFP and C-SPOMM I would like to comment on element 7.5 of the current proposal. This mandates that departments of OPP be headed by D.O.s who are certified as C-SPOMM or NMM. I strongly agree with this. While there are some F.P.s who are talented OMM physicians, those who wish to lead in the education of OMM should come from the ranks of the most highly trained physicians in OMM. I have taken the certification tests of the ABOFP and AAO. I can tell you that there was a significant difference in the demands for OMM excellence between the two. My AOBFP exam asked me to evaluate 1 case history and then orally asked me to explain how I would treat the patient. This took all of 1 minute with no follow up questions. It was a “warm and breathing” standard. While the general medical portion of the exam was rigorous, the OMM portion required minimal preparation. The CSPOMM required the submission of case histories. The exam was a 3 day written (essay, 2 step case evaluation, and multiple choice) followed by thorough oral exam, defense of the case histories and then thorough practical exam. I studied for 6 months for it. By the logic of the ACOFP (which I am a member of) FPs are qualified to chair OMM departments because we are educated in OMM and use it in our practices. The same is true of our qualifications in cardiology, all forms of surgery, pathology and every other form of medicine. Does anyone argue that FPs should be able to head these departments. Our profession would be justifiably laughed out of the

house of medicine. All academic departments should be headed by the physicians who have proven that they are among the best prepared to do so. OMM departments should be headed by C-SPOMM or NMM certified physicians.
Concerning Element 7.5 discussing OMM/OPP leaders, I ask that you take heed the comments made by the AAO. There is a difference between a Family Practice physician and an OMM specialist. Yes, there can be crossover, just like there is between Cardiology and Family Medicine. As a general surgeon who has studied Osteopathic Medicine as a Research Fellow during Osteopathic Medical School and thereafter in courses and AAO Convocations, then going through the NMM/OMM certification process, I can speak with some authority about this topic. NMM/OMM certification brings a deeper level of understanding needed to teach our students. We are at a critical juncture joining with our allopathic colleagues in residencies and training programs. Please help us maintain the depth and breadth of knowledge and understanding of Osteopathy within our institutions. Our philosophy and understanding of anatomy and how it integrates with our physiology and treatment is exactly what medicine and our patients are hungry for. Numerous related fields are reaching for what we have. Please do not allow our field to be watered down. Please maintain our highest standards by requiring NMM/OMM board certification for OMM Department Chairs. If we don't keep it, no one else will.

I am writing this email in continued support of the proposed changes to Element 7.5: OMM/OPP Leadership of the COCA standards. It was previously suggested to modify the standards to include board certification in Family Medicine and OMT by the AOBFP as an equal qualification to AOBNMM for serving as the Chair of a Department of OPP/OMM.

A Department of OPP/OMM is not a Department of NMM, but a Department of OPP/OMM, whose job is to educate and promote the integration of Osteopathic principles and techniques into the overall practice of medicine, throughout all four years of osteopathic pre-doctoral education. The AOBFP appropriately tests and certifies Family Medicine physicians in Family Medicine and OMT through the written, oral and practical components of their examination. I have taken both the NMM/OMM and Family Medicine/OMT initial certification and recertification examinations and have served as an OMT practical examiner for AOBFP. The Family Medicine/OMT examination is just as clinically relevant as the NMM/OMM examination, and holds to the early 1900's ideas of John Martin Littlejohn, the founder of the Chicago College of Osteopathic Medicine, that Osteopathic physicians should be skilled in overall general practice, not just OMM as an isolated specialty.

I agree with ECOP's previous insight that an MD with little or no OMM training should not serve as an OMM/OPP Department Chair. However, a properly trained Osteopathic physician in an Osteopathically Recognized non-ONMM residency, with an appropriate OMM curriculum, will be a better example for our students of what a complete Osteopathic physician should be, versus a pure OMM specialist. Dr. A.T. Still admonished us to treat the whole patient. The philosophy and techniques of Osteopathy transcend all specialties and must be integrated into the totality of medicine if it is to survive.

Additionally, the increasingly stringent ACGME ONMM residency guidelines are making it difficult for a physician to gain entry into and complete an ONMM2 (NMM+1) program in one year. It is unrealistic to expect any physician, who has already completed their primary residency, to spend more than one additional year completing an ONMM2 (NMM +1) residency. This is one reason why we are only filling forty to fifty percent of the available ONMM2 (NMM +1) residency positions annually. This barrier will ultimately lead to an extreme shortage of Osteopathic physicians who have the current "qualifications" to lead a Department of OPP/OMM.

I also feel that the profession needs to reopen an AOBSPOMM-like pathway for obtaining advanced certification in OMM. This will provide an avenue for those physicians, who are unable to complete an additional year of ONMM2 training, to obtain certification and contribute to our great profession. Our undergraduate OPP fellows are an example of a group that could benefit from this pathway. At this time, we are losing the great contributions that our undergraduate OPP fellows could make to the Osteopathic profession due to the current restrictions. They should not have to complete an additional one-plus years of ONMM training after having already completed an additional year of undergraduate OMM training. Many of our outstanding Department of OPP/OMM chairs did not complete an ONMM residency, and received their education though an undergraduate OPP fellowship program. Our profession would have lost their many contributions under the current guidelines.

In conclusion, the NMM/OMM and Family Medicine/OMT examinations need to be considered equivalent for allowing a physician to serve as Chair of a Department of OPP. This will help provide a continuous supply of talent for all of our COM's and help assure the longevity of our wonderful profession for future generations.

I wanted to comment on 7.5 in regards to NMM certification for OMM chair or equivalent. I want to support that this remain unchanged despite pressures from certain organizations. The current wording allows flexibility on whether the NMM certified person is the chair or equivalent. This insures that someone guiding the osteopathic content at the schools is NMM certified. I am board certified by both the AOBNMM and the AOBFP and can speak to the level of OMM needed to pass both exams. While there are definitely FP only DO's that have good osteopathic skills, the AOBNMM exam tests this knowledge and skill to a much higher level. I think this is an important standard to help maintain the quality and consistency of our osteopathic content in our COMs.
I oppose having a non NMM/OMM board certified physician be the chair of a COM's OMM department. In regards this issue I ask: Can any DO be a chair of any department? In other words, if an FP board certified osteopathic physician is permitted to be chair of a COM OMM department, then can an NMM/OMM board certified osteopathic physician be permitted to be chair of the FP department? I say no. Having department chairs with specialty training in the department's focus will provide the highest quality education to our students.
It would be imprudent for COCA to allow anyone other than a BOARD CERTIFIED OMM/NMM/ONMM Faculty Member to be Chair of an OMM/OPP/NMM/ONMM Department at an Osteopathic College of Medicine. It is hard enough to continue to instill proper philosophical and mechanical training aspects of Neuromusculoskeletal Medicine having this protocol in line currently. And, with the ACGME merger, Osteopathic Recognition in Residency Programs has been faltering. From my aspect as a Resident and Fellow Trainer, allowing anyone not Boarded in Osteopathic Manipulative Medicine would be yet ANOTHER shot in the profession's foot and allow a further tailspin for us to no longer be an independent profession. With the current NMM+1 and future ONMM2 one year programs yielding an additional board certification in NMM, absolutely any doctor with any prior AOA acknowledged residency program can get certified and then be an NMM Department Chair. The one year of additional training can take a motivated doctor and make an NMM Leader with actual practical training, like any professional fellowship training. In addition, a truly motivated doctor could do this AND moonlight at a COM or NMM clinic and continue to make ends meet. This is really not too much to ask to uphold the legacy of Osteopathy.

I am writing to share my opinions on the COCA Continuing Accreditation Standards. I am aware that Element 7.5 is a contentious issue regarding OMM/OPP standards for COMs.

I am writing as an AOBNMM-certified OMM specialist from a 3-year OMM residency. I have served as clinical faculty at MSUCOM for the past 7 years. I was full-time core faculty at Mercy Health (Muskegon, MI) full 3-year OMM residency for 2 years, and I am adjunctive faculty for the past 2 years. I have taught at 9 CME conferences with the Michigan Osteopathic Association and its subchapters as well as MSUCOM itself over the past 5 years. From this perspective, I hope you see my involvement in medical education and with OPP/OMM.

I also disclaim that I am NOT involved with the AOA and COMs at a national level. I recognize that there are powers at work here beyond my experience.

These, then, are my opinions:
1. An osteopathic physician does NOT need AOBNMM board-certification to be an excellent osteopath and teacher of osteopathy.
2. The standard set by ACOFP board-certification is significantly lower than that of AOBNMM in almost all cases I have observed in my role as an educator.
3. Because of this, #1 above is the exception to the rule.
4. AOBNMM board-certification is a reliable, objective standard for an applicant's OMM/OPP fidelity.
4. It may be irresponsible to broadly open the core OPP position at COMs to a much, much larger applicant pool who, in my experience, does not perform or have experience at the level of the narrower specialist field.
5. If there are insufficient applicants due to the smaller C-NMM pool, then it is the prerogative of COMs to raise them within our ranks with pre- and post-doctoral fellowships, competitive salaries, creation and promotion of OMM residency training sites, and general interest among DOs in actual, true, core osteopathy.

As a physician board certified by both the American Osteopathic Board of Family Medicine (AOBFP) and the American Osteopathic Board of Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine (AOBNMM) I appreciate the perspective of both organizations in regards to the issue of the requirements necessary to serve as a Department Chair of Osteopathic Manipulative Medicine (OMM).

I want to be very clear that while I appreciate the value of both certifications, only certification by AOBNMM is adequate and appropriate for a physician to serve as the Chair of an OMM Department!

While both board certification processes require the demonstration of some expertise in OMM, the two boards are worlds apart in the depth, breadth, and levels of proficiency in OMM required to be board certified.

The AOBNMM testing is much more demanding, much more rigorous, and much more sophisticated in the written exam, oral exam, and practical exam regarding OMM. There is no question in my mind that physicians board certified by the AOBNMM have demonstrated a level of OMM expertise that is much greater than that required for certification by AOBFP.

The Chair of an OMM Department is responsible for the OMM courses for the first and second year year medical students, as well as OMM education for third and fourth year students. At the institution where I am a professor, we also are responsible for training our NMM/OMM residents. We are also involved in teaching OMM with out state osteopathic organization as well as providing OMM CME courses for faculty and attending physicians in practice.

The responsibilities of an OMM Department Chair absolutely require the level of expertise proven by certification by the AOBNMM. The AOBFP certification is a meaningful and worthwhile certification for osteopathic physicians in family practice. I am proud to be one of those. However, I can also attest that the level of expertise in OMM demonstrated by certification by the AOBNMM is much higher, much broader, and of greater depth than the level of expertise demonstrated by the AOBFP certification.

Continuing to require that OMM Department Chairs be certified by AOBNMM is vital to the survival and well-being of the osteopathic profession. It is necessary for osteopathic students to be adequately prepared for osteopathic national boards and for them to be well-trained in OMM for the rest of their careers. Certification by AOBFP is no substitute for certification by AOBNMM. Please understand that my perspective is that of a physician who has been certified by both organizations and practiced extensively as an osteopathic family physician as well as a specialist in OMM. I have been in practice for over twenty years.

It is very clear to me that Department Chairs of OMM must be certified by the AOBNMM and nothing else.

I am respectfully requesting that you DO NOT destroy the Osteopathic profession by allowing NON AAO BOARD OMM/NMM Certified DOs becoming DO School OMM Department chairs. This will be a huge mistake. Do not allow this to happen.

I am in favor of allowing any osteopathic physician who has proven her or his skills and abilities to be allowed to chair or hold any position in the area of osteopathic principles and practice. I am an “old fashioned” state of the art Osteopathic Physiatrist. I have pushed the envelope in osteopathic practices. I am boarded by the AOCRM. 90% of my visits include Osteopathic manual evaluation and treatment. I consider myself more than qualified to teach and direct the forward movement of osteopathic practice and principles. I know there are many many in various specialties also more than qualified. Osteopathy is not limited to neuro muskulo skeletal systems. It is the study of life itself, and how it maintains and heals itself. Very broad scope. The academy of osteopathy was establish to further these principles. Not to narrow it down to a sub-specialty. We have OMT specialists in probably every specialty. And it belongs square in family medicine from before birth till death, AND it belongs in every specialty to boot.
I do not agree with this revision. It is my strong opinion that NMM/OMM board certification should be required.
Thank You for this opportunity to respond. I wish to OPPOSE changes suggested to measure 7.5 OMM/OPP Leadership. As a dual certified osteopathic physician in FP and NMM-OMM, I feel that the Leadership of an OPP/OMM department SHOULD be certified by AOBNMM-OMM due to the advanced rigor and comprehensive nature of the board certification exam. This is NOT equivalent to the certification exam offered by AOBFP.

Regarding Element 7.5 on page 17 of the COCA's Continuing Accreditation Standards, I have a few comments which are mine personally and do not necessarily reflect those of my department, my department chair, nor my college.

I was board-certified in Family Medicine for 16 years and have been formally involved in osteopathic education since my stint as an OMM fellow in 1995. Since, I've served as a Program Director for a parallel-accredited family medicine residency for 5 years and as an osteopathic DME for 2 years. I am board-certified in NMM for 13 years through the practice track before that option was closed. I've served as Discipline Chair of OMM at VCOM-Blacksburg for 4 years and subsequently as an Associate Professor in the OMM Department at OU-HCOM for the past 4 years. I've recently allowed my Family Medicine certification to lapse, primarily due to costs and cumbersome nature of maintaining multiple board certifications (in particular, the OCC practice track requirements).
With the above experience, I feel that I have an appreciation for the involved viewpoints on this topic. And with this experience, I offer the following comments:

- Family Medicine is a specialty of general practice with a broad scope and is not meant to have specialization to any significant degree within this scope. Additional experience and specialization can be achieved through additional recognized training (such as derm, palliative care, NMM, sports med, etc,) outside the FM residency. But these all lead to additional certifications that aren't mentioned in the standards. I cannot imagine that suggesting that because OB is covered in a FM residency program that an FM physician (even with OB privileges and practice in a hospital) would oversee an OB/GYN department in a medical school.
- The request by the ACOFP to allow for other board-certified specialists to chair an OMM department is not rational, let alone desirable. The demonstration of osteopathic manipulative skill, depth/breadth of knowledge, and experience is neither taught or required in Family Medicine residency standards, nor is it evaluated to any degree on either the written or the practical examinations to be board-certified. So, the use of the certification by the AOBFP is not a reasonable marker for competence in the field of OMM/NMM beyond its use as such in a family medicine practice. This limits application to teaching, research, CME, and other aspects that normally fall under osteopathic colleges' purview toward osteopathic medicine in our geographic and professional communities.
- On a very large scale, the widening/relaxation of standards is exactly what we should be avoiding if we want to have any meaning or purpose going forward through our unification with ACGME. I understand that the COCA standards only apply to predoctoral education, however, I see this approach being adopted at all levels within the osteopathic profession and have concern re: the only plausible ramifications from this. By allowing other specialties to lead the education of OMM/NMM for our medical schools can only lead to dilution and eventual dissolution of this aspect of our profession, which is truly the defining characteristic. I don't imply that an osteopathic physician cannot practice osteopathically without being NMM certified – but you certainly cannot train osteopathic physicians without seeking the highest recognized level of osteopathic knowledge and training in our schools. We are undergoing to large an all-too-rapid growth of osteopathic training, which happened exactly in such a manner a century ago and led to confusion and the attendant distrust by the public and other professions of osteopathic physicians. To repeat the same actions and expect a different outcome is one of the functioning definitions of disconnection from reality, or insanity.

If any further explanation or discussion is sought to help address any concerns or questions that might arise from what I've written, I'm certainly willing to listen and express myself more clearly.

It is difficult to see how any DO who has not been involved in extensive OMM education could be qualified to hold the position of department chair. This is a problem created by the rapid expansion of our COMs and the small number of NMM residents completing their training. Those residents just coming out of training do not have the experience needed to be in charge of training our students, but are deemed to be qualified by virtue of their certification. I feel that this issue can't be solved by establishing a one size fits all standard. Selection of department chairs should be done based on the experience of the individual. There are FPs who would be qualified, but not all are well schooled in the modalities we must cover to satisfy ECOP or NBOME. There is no easy solution!!
I am writing in support of maintaining the OMM Department Chair to be NMM/OMM certified.
I am disturbed over the prospect of an OMM Department not being run by someone boarded in OMM/NMM. Should this go through, I feel it's just another example of the professional leadership playing lip service to what should be at our core. I went out of my way to do a fellowship in OMM as I knew that my prior training was nowhere's near training or experience enough to teach or lead in that field. Although I definitely respect DOs with other backgrounds and admire they're want to teach and do OMM, for the sake of the profession, please do not move forward with this suggested change. They can be leaders in their respective fields, please allow OMM/NMM physicians to continue to lead in their field.
I serve as Department Chairman of Osteopathic Medicine at Midwestern University, Arizona College of Osteopathic Medicine(AZCOM). I am both board certified in Osteopathic Family Medicine & Neuromusculosketetal Medicine(NMM) from the AOA. I am very aware of the issue of allowing other specialists to serve as Department Chair's in Osteopathic Medicine. I am very confident that the depth of knowledge and expertise in Osteopathic Principles & Practice with OMT is far superior among NMM specialists. I have over 15 years' experience working very closely in academia with both FP & NMM specialists and dual specialist FP/NMM at our university clinic and within our department. Initially, it was proposed to us at ECOP that there was a shortage of NMM Specialists to fill the void of our expanding osteopathic colleges nationwide. As a result, I felt that it would be reasonable to open up the Chairs Position to any specialty if they had so achieved a consensus reviewed number of CME hours and could pass a OMM Academic Proficiency Exam. However, it appears that this is not accurate per the American Academy of Osteopathy. It appears that there is indeed enough current NMM Board Certified physicians as well as an adequate number of NMM graduates from our current residency pools. Based on this information, it is in the best interest of Osteopathic Education, to provide the chairperson role to the individual with the highest level of education and expertise in osteopathic principles,practice & OMT. Therefore it is my opinion that only NMM Board Certified Individuals should serve as the Department Chair of Osteopathic Medicine. Thank you for your consideration.

I would like to provide my support for revision of Element 7.5: OMM/OPP Leadership regarding the provision that the Department Chair must have the credentials of the American Osteopathic Board of Neuromusculoskeletal Medicine (AOBNMM) or a Certificate of Special Proficiency in OMM (C-SPOMM).

OMM/OPP is central to the core curriculum of all osteopathic physicians and surgeons. No single specialty owns the knowledge of osteopathic principles and practices and the osteopathic manipulative medicine modality of treatment. The American Osteopathic Board of Neuromusculoskeletal Medicine (AOBNMM) or a Certificate of Special Proficiency in OMM (C-SPOMM) boards are not the only osteopathic boards requiring a demonstration of competency in OMM and OPP. The American Osteopathic Board of Family Physicians (AOBFP) and the American Osteopathic Board of Physical Medicine and Rehabilitation (AOBPMR) require demonstrated competency in both the cognitive elements of OPP and the manual medicine component of OMM during their board certification exams. Further, AOBFP, unlike the AOBNMM and C-SPOMM, demonstrate both the cognitive and manual medicine component during their recertification process under Osteopathic Continuous Certification.

Element 7.5 specifically speaks to the Department Chair as the physician leader that provides oversight of the business operations and curricular content of the Department of OMM/OPP. The specific skill set for an individual to lead a Department within a College of Osteopathic Medicine requires a fundamental core knowledge of the specific discipline yet also requires organizational skills, in-depth knowledge of human resources, knowledge of financial management including budgets and expense line items, faculty development of specific competencies for the specialty discipline, as well as mentoring faculty for promotion and tenure. These skill sets to become a physician leader must be developed on an individual basis, and not all academic physicians are well suited to this role, regardless of their board certification.

The precedence for selection of a Department Chair with the greatest skill and attitude has already been established in Accreditation Element 7.4 addressing the Department Chair of Primary Care, where the most skilled physician leader may be board certified in the disciplines of either family medicine, internal medicine or pediatrics.
The Role of Department Chair of OMM/OPP should be the most qualified provider to lead the department, provided they have demonstrated competency in both the cognitive and manual medicine component of OMM/OPP through board certification, regardless of specialty.

As of now 7.5 still requires NMM certification to chair an OMM department. Being board certified in Internal Medicine (a general practice) and NMM, there is a difference in the depth and breadth of information that one knows with this additional training, thought process, application of NMM and greater understanding of the overall human body along with its functions in relation to the Osteopathic Principles and Practice and the body to heal itself. I support 7.5 as the way it is currently written. I do not support the request for reconsideration by ACOFP to chair the OMM dept. as the insight, knowledge base and application of NMM is less doing an overall injustice to the NMM insights and practice.
I am writing in support of standard 7.5 to leave it as is and not change it. The Chair of OMM at a COM should have advanced training in OMM via completion of an NMM/OMM residency.
I am writing to you in regards to the proposed changes of element 7.5: OMM/OPP Leadership in the COM Continuing Accreditation Standards. I am a board certified physician in family practice and OMT by the AOBFP. I am also a member of both the ACOFP and the AAO which I understand have differing opinions on this matter. While it goes without question that those board certified in neuromuscular medicine have the appropriate background to be considered candidates for the position of Department Chair of OPP there is a pool of physicians board certified in family practice across this country that are also qualified and capable of serving in this position. I believe that in time I could be one of those individuals. I have had a passion for both medicine and teaching since before I entered medical school in 2001. I had the opportunity to participate in an undergraduate OPP teaching fellowship as a 4th year medical student extending my medical school experience by an additional year. During residency I had the privilege to continue to hone my OMT knowledge and skills under many accomplished and respected D.O.s actively using OMT in their daily practices. I was in full time private practice for over eight years in a rural community in south Mississippi where all of my skills as an osteopathic physician were put to use on a daily basis. I have been involved with medical education in both the classroom and in the clinic setting in affiliation with William Carey University since the school's inception in 2010. I am now a fulltime faculty member in the Department of OPP and also serving as the course director for the second year OPP curriculum. It has not been the most direct or obvious path for me get to this point in my career. I still have a lot of personal growth and experience to be gained and I personally do not have any immediate ambitions of becoming a department chair. However, I am sure there are other physicians out there like me who could effectively fill that role. I love being an educator and I love inspiring young students that any physician in any specialty can incorporate osteopathic principles (not just OMT) into their daily practice. There is a reason it has been identified as the Department of Osteopathic Principles and Practices rather than the Department of Neuromuscular Medicine. OMT is but one beautiful component of the philosophy that distinguishes us as osteopathic physicians. Thank you for your kind

consideration.
I am in support of Element 7.5 to stand in its original form. The NMM/OMM Department Chair should be boarded in NMM/OMM through the AOBNMM or with a Special Proficiency in OMM (C-SPOMM). The NMM/OMM Chair must have sufficient knowledge, exposure and clinical practice in all modalities of NMM/OMM including but not limited to soft tissue, articulatory, muscle energy, strain counterstrain, HVLA, MFR, lymphatic techniques, BLT, Still technique, visceral, FPR and Cranial . The Chair of the OMM department must be able to effectively teach all modalities to all regions of the body. The Chair is also often responsible for ensuring that the entire curriculum is delivered within the framework of osteopathic principle and practice. The Board certified in both FP and OMT, the Family Practice Boards currently offer much less osteopathic content on their written boards. This knowledge base does not suffice to be a Chair of NMM/OMM, who must be a content expert in NMM/OMM. The NMM/OMM Board written exam includes soley Osteopathic diagnosis, clinical problem solving and techniques. To train future D.O.s to think, perceive, palpate and treat efficiently and effectively with Osteopathic principles and techniques, requires strong Chairs who bring high levels of competency and knowledge, which is best assessed in the NMM/OMM Board.
I would like to request that COCA standard 7.5 remain as originally written to require that the chair of an OMM department or division be board certified in NMM/OMM or Special Proficiency in OMM. The AOBNMM certification examination covers the greatest amount of osteopathic content among all of the specialties. This coverage gives the undergraduate student the greatest exposure to the osteopathic concepts that can be applied in his or her designated field of specialty, something that no other certification covers. Through the job task analysis and subsequent distribution of questions that spans key medical specialty subjects, department chairs who have been certified in the AOBNMM offer the most to the educational program.

Although I realize there is a shortage of qualified and willing physicians with ONMM board certification to serve as department chairs, I feel that it is important to maintain this higher standard of certification. I feel the shortage is due to lack of example. We as educators need to do a better job of encouraging and exciting our students regarding OMT and fostering those early interests. If we do a better job of showing and teaching the importance of OMT increase in the number of physicians with board certification will naturally follow. I understand that there are, of course, physicians who are not board certified and have a deep wealth of OMM/OPP Knowledge and would do well in these roles. However, I am concerned that relaxing the requirement would lead to new schools or new campuses putting people in those positions who are not well qualified thus watering down the experience of the students at those campuses. A watered down, lack luster experience with OMM during the first 2 years will further diminish/downplay the importance of BASIC osteopathic principles. This would come at a time when our profession and young physicians are feely turning away from their identity as osteopathic phsyicians.
I am in support of Element 7.5 to stand in its original form. The NMM/OMM Department Chair should be boarded in NMM/OMM through the AOBNMM or with a Special Proficiency in OMM (C-SPOMM) The training, knowledge, understanding and overall well versed depth and breadth of comprehension of NMM/OMM are necessary and provide a great deal of support and insight to the osteopathic foundation for curriculum and overall thought process at any COM.
I believe that the OMM department chair should be held to the same standards academically as any other department chair. Having said that I understand the difficulties with finding a certified NMM chair. Therefore a candidate who is proficient with a certain designated training and hours in OMM and is able to demonstrate this proficiency in a specific way should be able to hold the position as OMM chair. The guidelines should be decided by the AAO certifying board.
I am writing regarding the requirement for NMM certified Osteopathic Physicians to be department heads at Osteopathic Medical schools for the OMM course. I am a proud member of both the AAO and ACOFP. I am a FACOFP with ACOFP. I have served as a family practice residency director as well as a director of medical education. I have taught at CCOM, AZCOM and AT Still medical schools and have been a preceptor for many more schools. I feel that I come to my opinion with considerable experience. I am convinced that certified NMM physicians must lead these departments. . The testing process through AOBFP is far too superficial to qualify and doctor for this role. There are many OMT techniques to teach . Leading this course requires competence in HVLA, Myofascial release , Cranial, Counterstrain , Still technique, Muscle energy and more. We need highly trained and certified individuals to lead these courses. They do exist and the schools can find them . The American Academy of Osteopathy has lists of who is NMM certified in Osteopathic

Manipulative Medicine.
It is critical for Osteopathic Medicine to strive to have distinctiveness especially in light of the ACGME merger .
If our fine profession is going to continue we must make Osteopathic education distinctive.

This email is in support of continuing the standard of an NMM/OMM board certified physician as OMM Department Chair at COMs. It has taken me over 2 decades to achieve my current understanding of Osteopathic Practices & Principles. The first dozen years I spent primarily as a practicing physician, boarded in both Family Practice and NMM/OMM. Due to high demand in the metropolitan Detroit area, my NMM/OMM practice thrived and so my patients. In my private practice I accepted interns, externs and residents on rotation. I geared my practice towards time-efficient treatment and our professional student feedback motivated me to turn my energy towards education. They inspired me to try to share what I took me years to learn from a plethora of NMM/OMM specialists.

While moving through the ranks at many COMs to attain my current position as Chair in Joplin I found many like-minded peers. I was so pleased to see the publication of ECOP's second edition of a Teaching Guide for Osteopathic Manipulative Medicine this past year. Much of its contents was exactly why I had started on my journey seeking to standardize time efficient and easily performed OMT into medical education and practice. And, just as our OMM Curricular standards continue to evolve and change, so does our research and specialty standards.

Keeping the standard is important because it:
1. **Establishes a high bar of distinctiveness** between D.O. and M.D. schools. If an M.D. school has a D.O. Family Practice physician as Primary Care Medicine Department Chair, then they could claim that since the final pathway of residency is essentially the same, the Department Faculty is essentially the same, and basic sciences the same, then there no need for 2 professions.
2. **Establishes the standard of a specialty-level knowledge base:** OPP is what I eat, drink and sleep. While it is true that I'm dually boarded in both FP/OMM and NMM/OMM, I can't imagine truly keeping current on both. I am amazed on a regular basis by what I learn about new OPP-related research that will significantly impact our profession in the very near future.
3. **Legitimizes the Osteopathic profession:** It is truly an honor to be considered an expert in the Foundational principles of our profession and I am continually humbled by it. Removing that level of expertise and responsibility from the OMM Department Chair position would be a mistake.

To end with an analogy: I'm sure that I can still float a Swan-Ganz Catheter, but I'd prefer a cardiologist or surgeon do the procedure. Please do not change this standard.

I am in support of Element 7.5 staying in its original form. The NMM/OMM Department Chair should be boarded in NMM/OMM through the AOBNMM or with a Special Proficiency in OMM (C-SPOMM). In addition to teaching and leadership experience, the NMM/OMM Chair must have sufficient knowledge, exposure and clinical practice in all modalities of NMM/OMM including, but not limited to: soft tissue, articulatory, muscle energy, strain counterstrain, HVLA, MFR, lymphatic techniques, BLT, Still technique, visceral, FPR and Cranial Osteopathy so that if the Chair was a department of one he/she would be able to effectively teach all modalities to all regions of the body (as is appropriate). The Chair is also often responsible for ensuring that the entire curriculum is delivered within the framework of osteopathic principles and practice which includes the 4 tenets and 5 model approach along with history/background of the Osteopathic Profession. I am Board certified in both FP and NMM/OMM and have taken both boards. The Family Practice Board exam currently has from 1-7% of osteopathic content on their written boards. The practical addresses one or two body areas and one or two techniques (usually one direct technique and one indirect technique). Also, FP residencies do not usually require teaching as part of their curriculum and require a only small number of hours of documented practice of OMT. This knowledge base does not suffice to be a Chair of NMM/OMM. While I appreciate that the FP Board practical exam is sufficient for a family physician to show that they have at least some skill in hands-on treatment, it is NOT sufficient evaluation for someone who needs to be considered an “expert” in multiple forms of treatment AND in teaching those skills to others. (Or teaching others how to teach those skills and thought processes.) The current manner in which the AOBNMM runs the practical tests most of the major modalities as well as a "pot pourri" station in which a physician may choose which technique to showcase (including FPR and Still). This is a much more rigorous exam of a physician's osteopathic diagnostic and therapeutic hands-on skills. Additionally, the oral exam allows the examiner to delve into the physician's critical thinking skills and fund of knowledge. The written exam is, of course, comprised solely of osteopathic content including the history of the profession, diagnosis & the different modalities of OMT. It also evaluates use of the distinctive lens through which the osteopathic physician views clinical problems and disease states. To train future D.O.s to truly be osteopathic in thinking and "doing" we need strong Chairs who bring this level of competency and knowledge and who have been assessed on this level of competency and knowledge through the appropriate boards.
Please maintain this standard. Changing this to the suggested revision represents a failure to recognize that The NMM department requires a level of specialization not required for any other division and as such should be treated in an identical way as surgery, emergency medicine pediatrics or any other specialty area. I don’t want to see and FM boarded person in charge of OB/GYN unless they have done a fellowship in OB/GYN. I know they can still deliver babies but the responsibility in a department is to a higher standard everywhere else in medicine. We need to maintain that in our world as well. How would ACGME or LCME look at this? Are we going to lower our standards as they look on? An AOA plus one equivalent is available for those interested via ACGME approved ONMM programs, applications are being taken now.

I am in support of Element 7.5 to stand in its original form. The NMM/OMM Department Chair should be boarded in NMM/OMM through the AOBNMM or with a Special Proficiency in OMM (C-SPOMM). The NMM/OMM Chair must have sufficient knowledge, exposure and clinical practice in all modalities of NMM/OMM including but not limited to soft tissue, articulatory, muscle energy, strain counterstrain, HVLA, MFR, lymphatic techniques, BLT, Still technique, visceral, FPR and OCMM so that if the Chair was a department of one he/she would be able to effectively teach all modalities to all regions of the body (as is appropriate). The Chair is also often responsible for ensuring that the entire curriculum is delivered within the framework of osteopathic principle and practice which include the 4 tenets and 5 model approach. Being Board certified in both FP and NMM/OMM, the Family Practice Boards currently offer only about 1-7% of osteopathic content on their written boards. This knowledge base does not suffice to be a Chair of NMM/OMM. While I appreciate the manner in which the FP Boards have delivered their hands-on skills exam (I believe it is a sound practical for family practice physicians) I do not believe it to be sufficient for someone who must be a content expert in this field. The current manner in which the AOBNMM runs the practical which includes the major modalities as well as a "pot pourri" station in which a physician may choose which technique to showcase (including FPR and Still) is a much more rigorous exam of a physician's osteopathic diagnostic and therapeutic hands-on skills. Additionally, the oral exam allows the examiner to delve into the physician's critically thinking skills and fund of knowledge. The written exam is, of course, comprised solely of osteopathic content including the history of the profession, diagnosis, the different modalities of OMT but it also includes the distinctive lens through which the osteopathic physician views clinical problems and disease states. To train future D.O.s to truly be osteopathic in thinking and "doing" we need strong Chairs who bring this level of competency and knowledge and who have been assessed on this level of competency and knowledge through the appropriate boards.
I am totally in favor of those with a board certification in OPP to chair the OPP departments at our COMs and not just any other certification.
I am voicing my support for the current requirements and language such that the Chair of the OMM/OPP Department at the COM level meet the currently worded level of Board status. It is imperative in my opinion that we continue to highest standard possible for our Osteopathic Distinctiveness to be perpetuated through out our CORE training of our current students and beyond. Anyone less trained without the unique experience of this level of training (NMMOMM or AOBNMM equivalent) does not have the insight or expertise to LEAD such an integral department with in the COMs. Please continue the currently high standard of requiring the Chair of the OMM department to be NMMOMM board certified or AOBOMM equivalent as currently written.

I am board certified by the AOBFP and a Fellow in the College. I am also board certified by the AOBNMM/OMM. I have been teaching OMM and physical diagnosis to Osteopathic medical students for 27 years here in Kansas City. I have direct knowledge of what experience and knowledge is needed to design and implement an OMM curriculum as well as a physical diagnosis skills course.

I understand the issues concerning ACOFP resulting in asking for this change in the COCA standard 7.5. It is a delicate balance of not offending colleagues on both sides of the issue. Most OMM trained specialists have more training in the multiple manipulative modalities that are being recommended to teach our students based on the published ECOP Basic Curriculum and the testable somatic dysfunction list of COMLEX USA. The training of our ACOFP colleagues is excellent. However, I do not see them being fully trained in all of the modalities that we teach. Having that understanding and background is necessary for designing OMM curriculum. I have many of my family medicine colleagues come to me for advice about OMT and questions about techniques. They often do not know some of the techniques that our students are doing on our standardized patients. This brings me to the conclusion that I possess a breadth of knowledge that is over and above what they are trained to have. This is the level of specialty that should be the Chair of an OMM Department in our COM's

As an OMM Chair, I am not designing a curriculum to train all students to be a specialists. We are teaching them the basics so they can have knowledge of these multiple modalities. They can get more training. As I am seeing, attendings, residents, and students are not utilizing even the basic OMM modalities. So many of our graduates are going to ACGME programs and are not getting further training in OMT. With the move to ACGME and Osteopathic recognition we see a challenge in making sure they will be adequately trained in all OMM modalities. This is evidenced by graduates saying they do not get training in OMM and are not doing OMM in their residences. Allopathic colleagues are not comfortable in overseeing our grads and students doing OMT. We also see our students having issues in getting their DO preceptors to oversee them to treat patients with OMT . We require at least 10 OMT sessions documented and signed off by their preceptor. This is an issue for our students. This is unacceptable for me in this profession. We are seeing the AOA and the Bureau of Specialists dilute the Osteopathic certification process in allowing a pathway for Osteopathic certification without Osteopathic content in the examination. This makes absolutely no sense to me and I do not see that this will increase the numbers of members they think it will do. The AOA leadership has missed the proper conclusion of the consulting group. Our colleagues have not been held to uphold the Osteopathic standards and have not put pressure upon the programs to design real education in OMM/OPP and teach their residents these principles and practices. The NMM/OMM programs are the ones they refer to as being required to keep the content in their examinations. This obviously has caused great concern for the future of the Osteopathic profession as we know it today. Many are rightfully concerned with AOA leadership making the decision to move forward with the certification pathway change. We at the helm of OMM departments have great concerns this will have on the trickle-down effect to the COM's. We do not need any further dilution of the distinctive training of the profession. This is a real problem in the profession and is a part of why I believe that the standard should remain as it is stated. If the NMM/OMM residency is the one college that is required to maintain the OMM/OPP content in the exams, then it seems obvious to me that the head of an OMM department should be board certified in this field.

Therefore, you must deny the request from ACOFP and allow the standard to remain as it is written. The OMM specialist is the one that is qualified to be the chair of an OMM department. We must not dilute the education of our students. This is exactly why I believe that an NMM/OMM board certified

doctor be in charge of the OMM training at our COMs. The knowledge level of a specialist in this field is more in depth than our Family Medicine colleagues. I do not mean to bash on my colleagues. I have great respect for them. However, I do have a strong opinion that the standard for who is qualified to head up a OMM department be rigorous and require the certification of NMM/OMM. This is not to say that our Family Medicine Colleagues cannot be members within our departments and help teach OMT. They have great skills. However, the breadth of the knowledge necessary does not seem to be part of their skill sets. This is the delicate balance that I speak of at the beginning of my comments. Please do not bend to pressure to make this change. The challenges to this profession's distinctiveness are mounting and the foundation of our student's training is at stake in this decision. Thank you for allowing me to speak to the difficult decision that is before the COCA.

Element 7.5: OMM/OPP Leadership: (CORE)

The inclusion of the "Note" following the criteria for OMM leadership serves no purpose within the accreditation document and should be removed from the final document. As far as changing the language of Element 7.5, any changes need to be put forth for public comment.

While many physicians have been trained in osteopathic manipulative medicine throughout their training and careers, only specialists in osteopathic neuromusculoskeletal medicine/osteopathic manipulative medicine (NMM/OMM) received the required training as defined by post-graduate specialty training requirements, specialty board assessment, and recertification that included the full range of osteopathic manipulative techniques covered in the AACOM and NBOME osteopathic core competency documents. I recommend continued requirement of the OMM Leadership to have active board certification from the American Osteopathic Board of Neuromusculoskeletal Medicine (AOBNMM) or have received a Certificate of Special Proficiency in Osteopathic Manipulative Medicine (C-SPOMM) to serve as the Department Chair of OMM (or equivalent). The changes now occurring at AOA regarding the removal of OPP/OMM from all board certification exams except NMM/OMM further illustrates the importance of AOBNMM certification as the necessary prerequisite for this leadership position.

Please keep NMM department chairs NMM board certified.
It is my understanding that the standards are under review and currently a decision is likely that the leadership requirements be held as they are currently listed with NNM requirements. The following comments are mine alone, and in no way represent our COM. As a FM physician who does some OMM, and know many who make this a big part of their practice, this is somewhat offensive. There are many FM D.O.s who carry a certification for Family Medicine and OMT, and who believe in the importance of OMM/OPP in patient care. There are many who have not only performed faithfully as a D.O. in practice, but then have performed (lectured, etc) with excellence in an OMM department or as a table trainer for the OMM department. Some have done this for decades. Yet, by this standard, they are not qualified to lead the department? That is preposterous! Now, add to this the fact that NNM qualified D.O.s looking to fill the growing number of OMM departments, we are left scraping the barrel. We have chairs in our COMs that have not practiced or are new grads! They are able, due to low numbers, garner support for much higher salaries and benefits than others with similar or more advanced leadership qualities, while not providing a higher level of educational prowess. In fact, they are allowed then to give no more lectures than others in their department, including those with FM with OMT training. The fear of some that COMs will higher FM because they are "cheaper and less qualified," can occur, but should be monitored instead of leaving more qualified candidates off the table! Having a faculty member/Chair that does not practice medicine and never has leads to confusion for the students. It also allows for strictly "teaching to the boards," not encouraging an active learning that will help us promote OMM/OPP in clinical practice.
I am a board certified Family Medicine physician practicing in Colorado. I do not agree with the proposal that in order to be a chair of a department, one would need to have board certification in NMM. I say this for a few reasons but one of the most pertinent is that those that did undergraduate fellowships and are very able and passionate about teaching do not even have the opportunity to get involved on the academic side. I currently practice OMT daily in practice and 20-25% of my daily office visits are OMT visits. I feel very passionate about teaching and furthering NMM education but am very limited by what I can do based on when I did my fellowship. At the time of my undergraduate fellowship, we were essentially learning the same principles as the post graduate fellow at the time. we were involved in teaching the same material and even involved in treating patients with the same preceptors. I was just not offered the opportunity to sit for boards so am automatically ineligible to help spread education in a field I feel we desperately need additional education in. I feel that anyone that can demonstrate proficiency in NMM should have a chance at becoming chair of a department.
Not only should the chair be nmm certified but so should the dean

I agree with the stance of the AAO on the following proposed change 7.4 to 7.5. I agree that it should remain as is with physicians who are NMM certified at the helm of an OMM Dept at all the schools cross the nation. Thank you very much for your consideration of this important matter.

Element 7.4: OMM Leadership: (CORE) A COM must employ a Doctor of Osteopathic Medicine with active board certification from the American Osteopathic Board of Family Practice (AOBFP) or American Osteopathic Board of Neuromusculoskeletal Medicine (AOBNMM) to serve as the Department Chair of OMM (or equivalent).

The AAO strongly urges COCA to reconsider and remove this change. Allowing a physician certified by AOBFP to be the driver of the Osteopathic Principle and Practices departments at the COMs implies there is parity in their education and certification process which is not remotely accurate.

Currently, in order to be certified by the AOBNMM, one must complete one of four residencies in NMM. In the basic standards for all of those programs exists standards requiring training and opportunity for the residents to be involved in education, as the Post-doctoral Standards committee of the AAO has always recognized that our residencies are the source of most of our faculty and all of our department chairs. The intent to train our faculty is ingrained within our programs. There is no comparable standard within the basic standards of the FP residencies.

In addition, the curriculum of the NMM residencies emphasizes the application and integration of osteopathic principles in all of the clinical disciplines, requiring prescribed numbers of patient encounters that involve osteopathic care for pediatric, obstetric and surgical patients in addition to the numbers of encounters of patients just within NMM. This creates a deeper level of understanding of osteopathic care in every patient population unparalleled in any other specialty. These residencies also ingrain a much more detailed knowledge of anatomy with respect to osteopathic care. This is a key component in the optimal teaching of osteopathic technique to the novice learner.

The certification process itself has distinct differences as well with regard to the osteopathic component of the examination. Many of our board members are dually certified by the AOBNMM and the AOBFP and we recognize that over the last 15 years there have been significant improvements in the osteopathic components of the AOBFP certifying exam. That said, they still don't compare to the depth and rigor of the AOBNMM certification process. To become a certified specialist in NMM, the candidate must pass a detailed and diverse exam demonstrating the breadth of their knowledge in the application of osteopathic thought in all patient populations. They must also complete an oral exam demonstrating the ability to give appropriate and comprehensive medical care to all patients that present to their offices. Thirdly, they must complete a multiple station practical exam and show competence in their abilities to correctly diagnose and effectively treat somatic dysfunction in all areas of the body, using a wide variety of techniques.

Many of our current faculty became certified under the "practice pathway" which closed more than 10 years ago. The criteria they were required to meet were also extremely rigorous and their experience enabled them to still pass all of the same examination processes. Therefore, they are functionally equivalent and equally qualified to maintain that certification and provide osteopathic education at the necessary level.

To imply that there is parity in the education and certification processes of NMM specialists as compared to family physicians is not only inaccurate but potentially dangerous to the maintenance of the high standard of osteopathic education provided in our COMs, without which we lose the distinctiveness that defines our profession as training the most comprehensive physicians in the United States.

Several of our AAO board members are also faculty or department chairs at some of the COMs and have extensive experience in the pre-doctoral education process. We recognize many fine points within that

process that may have not been considered in this proposed change but which may have an untoward ripple effect that will be irreparable once instituted.
The OPP department chairs are responsible for all aspects of osteopathic education in the COMs. Not only do they oversee the curriculum in the first two years of OPP classes but they also are most often responsible for coordinating the osteopathic curriculum in years three and four. Frequently they are also tasked with assisting with the integration of osteopathic concepts into the basic science and clinical classes, as well as overseeing osteopathic research at their institution. To have this supervised by a physician who had not been deeply entrenched within the culture of OPP throughout their post-doctoral training cannot help but diminish the depth and breadth of all of those components of pre-doctoral osteopathic education.
The core of the curriculum in the pre-doctoral years is determined by the Educational Council on Osteopathic Principles (ECOP) which is composed of the department chairs or their designees from each of the COMs. The vast majority of the ECOP physicians are AOBNMM (or C-SPOMM) certified. Physicians not holding that certification will not be able to participate equally in the curriculum development process nor will they be able to oversee the delivery of said curriculum at the same level. ECOP is also responsible for the content and maintenance of the Glossary of Osteopathic Terminology, which is recognized as the official resource for osteopathic language in the US and much of the world. Again, having this work done by physicians who are not content experts risks the very foundation of our academic endeavors.
In recent years, NBOME has increased standards in all subject areas but especially in OPP/OMM. The item writers for this material are predominantly subject matter experts certified by the AOBNMM.

As an NMM/OMM and Family Medicine board certified DO I strongly support the proposed revision to COCA's Continuing Accreditation Standards requiring that the chair of any college of osteopathic medicine's OMM Department be NMM certified to ensure that undergraduate osteopathic skills training is consistent and of a quality such that osteopathic graduates can continue to provide excellent care to their patients.

kEEP THOSE who know about osteopathic manipulation as a specialty teaching our students.

You wouldn't have omm specialists teaching about family practice, would you?

This message is in support of the AAO's position on requirements for OMM department chairs - that is, the chair should be adequately trained and certified in Neuromusculoskeletal Medicine.
As a Family Physician and as boarded certified NMM physician, it is clear to me that the level of knowledge and skill required for this position demands sub-specialty training in NMM; Family Medicine training is inadequate for this position.

I am in support of the AOA requiring that the Chair of all OMM depts. at all COMs be board certified in NMM or the equivalent (ie; CSPOMM). I feel that these physicians have the broad fund of knowledge required to successfully educate and create curriculum for future Osteopathic Students. The OMM department should be encouraged to have other sub-specialists (ie; board certified/eligible physicians) who also preform manipulation, participate in lectures and labs, to add valuable experience but not to Chair the dept. Having expressly DO physicians teaching in the OMM depts. will maintain the quality and uniqueness of our profession. Please DO NOT accept Element 7>5 proposed revision.
As a practicing physician who is board certified by both the AOBFP and AOBNMM, I find myself uniquely qualified to comment on the aspect of the revision that specifically addresses the qualifications of the Department Chair of OMM/OPP. While I will admit I have met some osteopathic physicians who are board certified by the AOBFP that are quite skilled in the area of osteopathic manipulation and osteopathic principles, I would say I find them to be more the exception than the rule. Even among those who are adept in these areas, the breadth of their osteopathic skill and knowledge is still limited (e.g. great at HVLA, but not at myofascial release, balanced ligamentous tension or cranial). Additionally, the caliber to which OMM/OPP skills and knowledge are tested both by the written as well as the practical portion of the AOBFP board exam are not nearly as in depth nor as thorough as the AOBNMM exam. Quite frankly, it is rumored that no one fails the practical portion of the AOBFP exam; which, if true, certainly does not allow those who pass to demonstrate the adequacy of their skill and knowledge to be the head of a department that focuses on this material. Even if this is simply a rumor unfounded in statistical truth, it's pervasiveness alone demonstrates a severe lack of acknowledged expertise among those who do sit for, and pass, the board. Regardless, based upon the other factors alone which do bear up under statistical and factual scrutiny, I fear this will lead to those students with non-AOBNMM department chairs, getting a subpar education and further reducing the already sad rates of OMM utilization in clinical practice. Lastly, with the recent push from the AOA to allow speciality board exams to exclude OMM/OPP questions and material, now is not the time to consider expanding the use of non-AOBNMM DO's as department chairs of OMM/OPP. At present, no one clearly knows what OMM/OPP skills and knowledge will be required as the specialty boards work through the new loosening requirements set before them. Until a specially board demonstrates that its candidates have the same detailed knowledge and skill as those who are AOBNMM certified, I feel changes to this requirement should be tabled. Thank you for your time and consideration of my comments.
I am writing to give my full support that the standard requiring AOBNMM certification of any chair of a COM OMM department remain as is. While a chair may be able to staff the faculty with AOBNMM certified physicians and create a full compliment of skill and knowledge, there is risk that the lack of additional training, experience, and commitment to the full breadth of osteopathy in a chairperson would lead to a failure to recognize relative weakness in some modalities and philosophies among them. Furthermore, there is even greater risk that Osteopathic Medicine would become even more diluted, something we cannot afford in this climate of ongoing allopathocization of the profession. I am hopeful my comments reflect my own commitment to the profession and its fundamental underpinnings.

I am writing to state my strong support of keeping the established requirement that stipulates that the head of a college of osteopathy - OMM / OMT department should continue to be a NMM certified provider. Having been through the training and trained others in osteopathy as a student, fellow, and now as a practicing doctor, readily note their is a difference in the intensity of training associated with a NMM certification.
We must stand together and on both feet. If one foot is loosely placed in the shifting sands of the future then the other foot must be anchored to the sacred and unshakable foundation of experience-the fundamental constructs upon which we thrive. We cannot afford to adopt a paradigm other than one which qualifies a osteopathic program with the minimal acceptable standards. That said it is my unequivocal hope and prayer any program of this nature is led by a DO with the NMM/OMM certification credential.
In the interest of brevity, I will relay my strongly held opinion about the proposed COCA standard regarding the qualifications necessary for OMM department chairs in as few sentences as possible. Having taught both NMM/OMM and FM/ OMT residents, I can say that the exposure of the FM residents to core osteopathic principles, and their clinical application, is highly variable, and often lacking. Although I have great respect for the ACOFP, recognizing the Nelson text publication as a significant contribution to osteopathic medicine, there is no comparison of the depth and breadth of OPP/OMM training that an FM resident gets compared with NMM residents. COCA needs to keep the requirement that chairs of OMM departments be NMM board certified. Our profession is undergoing rapid change, which I'm sure will make it stronger. However, to allow FM/OMT board certified individuals to be OMM chairs, risks the quality of OPP education at the most crucial and formative point in a students education. Chairs need to be content experts who are the "go to" person in the department for their depth of understanding. This can only be true if NMM board certification is the only standard for OMM department chairs.
I do not believe that even omm departments are going to find enough qualified DO to teach in that department w the number of schools and start up schools to fill the need for teachers. As an old undergraduate teaching fellow w some secondary education back ground from over 40 years ago experience it is not easy to motive and keep students motivated when out in residencies interested enough to utilize that skills. Unfortunately w life events I was not able to have enough time to certify for FP and OMM even though I would have liked too. I have seen so many students lose their OMM desires when in residency or practice over the years. I believe part of that is due to osteopathic residencies in non-osteopathic minded centers. Then w the current changes in general reimbursement and the cost of training the numbers are more important then the patient's health which is not an osteopathic concept. I have tried influence a few students who have precepted w me over the years but since leaving Denver for financial reason's over 20 years ago except at meeting I have not influence many any more, not too many want to come to very small rural settings any more w the loans they have to pay back. As a board certified FP by grandfathering in 1995 which was a struggle w two very small children and a private solo FP I have tried to leave a small impact as an FP that utilizes OMM as much as I can w time constrains in a small medical center but computer's slow down efficiency and do not help me practice good osteopathic medicine any more.

I do not think there are enough qualified teacher's out there to keep student' doing omm in large numbers after residency even though there is a great need for it. I hope time proves me wrong but in the 40 years since graduation I have not seen it OMM is becoming more of a specialty instead of part of everyday practice as an FP.
I disagree with the AAO, that OMM department heads must be NMM certified. Osteopathic physicians who are Board certified FPs must be allowed to head OMM departments. There are already too few of us skilled in OMT, just as the profession has undergone its greatest expansion. We need a candidate pool of more DOs, not less. There is no need to further shoot ourselves in the foot!
I applaud the AOA's Commission on Osteopathic College Accreditation move to expand the pool of acceptable candidates for chairs of Departments of Osteopathic Manipulative Medicine (OMM). What is OMM? OMM is the application of osteopathic philosophy, structural diagnosis, and the use of osteopathic manipulative treatment (OMT) in the diagnosis and management of the patient. All osteopathic physicians are trained in OMM. Furthermore, OMT is a procedure that all osteopathic physicians are trained to do. You can be a great osteopathic physician and a fantastic manager without being board certified in Neuromusculoskeletal Medicine (NMM). So why should we limit the leadership of our college's Departments of OMM to one specialty area? If we hope to expand our profession it is crucial that we expand our use of OMM and OMT. We should encourage osteopathic physicians in all specialty areas to use OMM and the procedure of OMT in their practice because it is our most recognizable difference to the public and other health care professionals. We should encourage physicians who are great managers, who apply osteopathic philosophy, and who use OMM in their practices no matter what specialty area they are certified in to be department chairs of OMM departments. Limiting Department of OMM chairs to one specialty area is restricting the pool of qualified candidates and in the long run will hurt the profession.

As an osteopathic physician who is certifiedin family medicine as well as neuromuscular medicine osteopathic manipulative medicine is I feel I am qualified to make comments regarding pose revisions to accreditation standards regarding a director of a department in an osteopathic medical College. . How would a certified surgeons feel director of his department was noncertified and then there certainly sure that in most specialties there are enough qualified, certified physicians in each specialty that is capable of serving as a director of the department in osteopathic medical school. With regards to certified neuromuscular medicine specialist in osteopathic manipulative medicine there appears to be at least 800 certified physicians available with fewer department heads required In osteopathic medical schoolsin if such a shortage should emerge that there are not enough certified osteopathic neuromuscular medicine specialists then there is a failure of training in our profession. I took the certification exams neuromuscular medicine osteopathic manipulative medicine after having spent years taking numerous courses to become skilled in many forms of osteopathic manipulative techniques as possible. I have also to develop skills and of exam to make sure I was becoming proficient and that my outcomes were demonstratable I physical exam after treatment I do not see how someone elsef besides is someone certified in neuromuscular medicine could have extensive knowledge and experiencewould be capable of running the department of principles and practice in our medical schools. As maybe I need feedback from the American osteopathic Association documenting how the noncertified neuromuscular medicine – or a uncertified or a certified physician in another specialty could run the department. I am looking forward to that feedback. I expect. Hell will freeze over before that happens You cannot tell mea three-year residency in family practice
In response to comment above: xxxxx, I agree with you- suggest you post this ono the COCA site so they'll see it. This also speaks to the fact that COCA has other standards referable to experience as an administrator and team leader, in medical education, etc. that also apply to department chairs in all specialties.
Element 7.5: OMM/OPP Leadership: (CORE) A COM must employ a Doctor of Osteopathic Medicine with an active medical license and active board certification from the American Osteopathic Board of Neuromusculoskeletal Medicine (AOBNMM) or a Certificate of Special Proficiency in OMM (C-SPOMM) to serve as the Department Chair of OMM/OPP, or equivalent. Note: The COCA has received a request from the American College of Osteopathic Family Physicians (ACOFP) to revise this element to permit physicians other than those listed in this element to be eligible for chair leadership positions. Your note about considering other than those board certified in NMM seems to be in direct conflict with Element 7.3 which states "the chair must have an active medical license and active board certification in the discipline in which they serve as chair." Is there any other specialty in which you would accept a non-specialist as chair of a specialty department?

I would like to voice my opinion on the proposed changes to policies on the documents on accreditation of Colleges of Osteopathic Medicine. In particular element 7.5 of the proposed revisions, as it pertains to leadership or Department chair in the departments of Osteopathic Principles and Practice. I feel it is of utmost importance for these Department chairs to be certified by the American Osteopathic Board of Neuromusculoskeletal Medicine. These departments must be led by persons who have the highest level of education within the realm of Osteopathic principles and practice. In educating our students of Osteopathic medicine and demonstrating the highest standards within the realm of educational institutions in general, chairs of these departments should have a detailed education in Osteopathic principles and practice. These can only be obtained in a residency program certified by the AOBNMM. We must hold our standard to the highest mark thereby demonstrating to the world Dr. Still's commitment to elevating Osteopathic Medicine as a practice of medicine superior by way of its content and tenets expressed in his writings.
The reconsideration of COCA's requirement for OMM department heads to have NMM certification has caught my attention. Although now semi-retired, my ardent concern for the uniqueness of the profession, and my long view of history, asks you to leave the requirement in place. I am sure this places some logistical pressure on some departments and in some cases may exclude competent leadership. However, the position of OMM in the education of osteopathic physicians has become progressively marginalized and underappreciated. I would propose that OMM under FM supervision would easily lead to the status I see of OMM in FM in general, as well as other specialties. Despite the quite tenable associations classical OMM has with progressive science, very little research let alone scholarly pursuit is expended in valuing this dimension of our practice discipline. OMM is not an archaic token of our uniqueness. It needs to be revitalized. Family Medicine cannot or has not shown an interest in doing so.
I would like to take this opportunity to emphasize how important it is to keep the requirement that the chair of the OMM department must be NMM/OMM boarded. Could you imagine the Chair of Cardiology Department without a board certification in Cardiology? Yes, many Osteopathic physicians utilize OMT in their practice and achieve wonderful patient outcomes. In my primary field of Physical Medicine and Rehabilitation, many DOs utilize OMT without board certification. Just as many internal medicine doctors manage complex cardiology cases without much difficulty. However, we would not hire a physician who is NOT board in Cardiology to run a Cardiology Department. I understand the need to foster more educators willing to be osteopathic academic physicians as we expand our medical schools. Personally, I think it is wonderful that, as a profession, we have been expanding the numbers of our schools. However, as we expand in numbers, there are few things that we cannot forget. 1. Quality of Education. 2. Education rooted in Osteopathic Principles and Philosophy. Some may argue, not having this NMM/OMM board requirement will not affect the quality of our Osteopathic Education. I think on the surface, that could be convincing. However, consider the current environment medical education. Without the experts teaching our students we will further dilute our Osteopathic Education. With this requirement, as osteopathic educators, we will be able to work with Department Chairs who are experts in neuromusculoskeletal medicine, the experts who will understand the need to uphold the highest standards in teaching our students and residents. Let's solve our academic physician shortage by educating our students and residents with quality

medical education and inspiring them. Not by diluting the content.
I would like to comment on the proposed changes to Element 7.5. As a diplomate of both the AOBFP and the AOBNMM, I fundamentally disagree with the proposition of allowing diplomates of the AOBFP serve as the chairs of Departments of OMM at the COMs. The depth and breadth of educational and clinical experiences pertaining to the application of OPP/OMM achieved through residency training under the AAO far outweigh that delivered by the ACOFP. I applaud the ACOFPs ongoing commitment to the training, practice, and research in the field of OPP/OMM, however, the broad knowledge base required of family medicine residency programs does not permit an adequate allotment of time to a dedicated study of OPP/OMM. While family medicine physicians provide broad medical services in many communities, even involving significant obstetrical and gynecological services in medically under-served areas, it would be unwise to appoint them a chair of obstetrics & gynecology. Despite their capacity to provide many of these services in the community, they lack the depth and breadth of knowledge regarding the entirety of the field to serve as subject matter experts or develop guidelines, and therefore remain unqualified. The chair of OMM must have expertise regarding the field, capacity to identify and translate even complex OPP concepts into tenable, clinically relevant content to educate our osteopathic medical students. This responsibility demands that such a person have a deep, intimate knowledge and personal clinical experience in the incorporation of OPP into patient care in diverse medical settings and in medically complex situations. The rigors required of chairs at medical schools demand that applicants possess the highest levels of knowledge, skill and experience in the application of their specialty to deliver high-quality education to our students, support to our residents, and ongoing support to maintain our profession. Such credentials can only be obtained by way of board certification from the American Osteopathic Board of Neuromusculoskeletal Medicine (AOBNMM) or a Certificate of Special Proficiency in OMM (C-SPOMM).

The last area of distinctiveness for DOs is what is found in a single class- Osteopathic principles and practice (or whatever it is called for a given school). The quality of this course determines the quality and identity of the Osteopathic school as a whole- after all if this class was absent or minimized everyone present would rather get an MD than a DO degree. There are still those who are proud to be DOs, but to these people the degree means something. To practice and/or teach Osteopathic medicine well you need to know a tremendous amount about anatomy, pathophysiology of disease, and have thousands of hours of hands on Osteopathic training. Very few individuals qualify who are not board certified onmm, and I don't believe anyone outside the field (including those tasked with appointing someone as department chair) have the discrimination to know if they are appointing an academically qualified individual unless the individual has an ONMM board certification. The consequences of opening the door to non-ONMM department chairs will be catostrophic for the future of the profession. The schools that adopt these standards will further erode what Osteopathic distinctiveness is left. Under these circumstances an academically gifted individual that wants to learn osteopathy would be far better off going to an MD school and then doing quality Osteopathic cme than a DO school with only superficial training lead by an underqualified individual. Under the proposed rules if they pick a DO school for its Osteopathic training they have no guarantee that the school won't swap its omm department chair for an underqualified individual after they have committed. There will be truly no point in DO schools existing if the proposed legislation goes through. Whatever distinctiveness is left in the DO degree will be entirely gone.
Due to the sharp increase in numbers of COMs that are in development or have recently opened, there has been strong competition for appropriately trained OMM/OPP leadership. It is my opinion that the skill set needed to be successful in the administration of a COM department is different than the skill set demonstrated by board certification. For our COMs to be proficient in training our next generation of osteopathic physicians, a faculty of dedicated OMM/OPP faculty is necessary, but the chair, being highly administrative should not need the same credentials to be effective. I therefore request that COCA reconsider Element 7.5 while the profession develops their national cohort of trained and academically experienced OMM/OPP faculty so that in the future this goal will be attainable.
As a family medicine resident graduating in June of this year it is my opinion that department chairs of NMM departments should remain NMM trained. Training in osteopathic manipulation, although more visible in family medicine than many other specialties, remains inadequate in its depth and breadth to prepare physicians to fill the role of NMM chair.
I believe that OMM/NMM should be chaired by someone who has the appropriate qualifications, such as an NMM fellowship/certification. Similar too all other chairs, FM, Surgery, OBGYN, etc who are chaired by those with certification, OMM should follow suit. OMM is not less than any other area of practice, we are equal and should be treated as such
Element 7.5: OMM/OPP Leadership COM Comment: We support the concept of allowing an OMM Chair from any specialty provided the individual is board certified by an Osteopathic Certifying Board, inclusive of a practical examination of OMM Skills along with OPP evaluation. This broadens the pool of candidates for the OMM Chair

position, while also encouraging us to truly embrace the concept of integrated OMM for all osteopathic physicians in any speciality.
I am in support of the concept that COCA Element 7.5 must stand in its original form. The NMM/OMM Department Chair must be board certified in NMM/OMM through the AOBNMM or (C-SPOMM). The NMM/OMM Chair must have sufficient knowledge, exposure and clinical practice in all modalities of NMM/OMM. The Chair is also responsible for ensuring that the entire curriculum is delivered within the framework of osteopathic principles and practice, which include the 4 tenets of osteopathic medicine and the 5 model approach. To do this effectively, the Chair must be able to show in-depth training and experience in osteopathic principles, practice, philosophy, and all modalities of OMT. Such in-depth knowledge is only attainable through OMM/NMM residency training and board certification via the mechanisms mentioned above. Certification in OMT only is not sufficient to effectively lead an OMM/NMM department in a COM and ensure that such a department's mission can be properly accomplished.
I am emailing to comment on the proposed revision to COCA's Continuing Accreditation Standards in regards to requiring that the chair of any college of osteopathic medicine's OMM Department be NMM certified. I am board certified by both the AOBNMM and the AOBFP, having completed residencies in both family medicine and OMM/NMM. My personal and professional opinion, which has been formed from many experiences throughout my medical education and career as an osteopathic physician, is that any physician who holds the position of a chair of the OMM department at any osteopathic medical school must be board certified by the AOBNMM. Board certification by the AOBNMM is the only way to ensure an OMM department chair possesses the depth and breadth of knowledge and experience required to successfully hold this position. Board certification in any other specialty, including the AOBFP, does not provide adequate assurance of the necessary competencies to successfully run an OMM department at an osteopathic medical school.
I respectfully request that the statute not be revised and keep the standard that a department Chair of Osteopathic medicine MUST be Board Certified in NMM/OMM. This is vitally important to maintaining the dedication and commitment we hold precious to teaching all future Osteopathic Physicians.
I am board certified in both NMM/OMM and FP/OMT. I respectfully disagree with the proposed expansion of candidates to lead Osteopathic Principles and Practices courses at the Colleges and Schools of Osteopathic Medicine. Having been trained in both specialties, my NMM training m~ch better prepared me to lead an OPP course. The OMM taught during my family practice residency was taught by the NMM residents! While OMM/OMT/OPP were not originally designed to be a separate medical specialty by Dr. Still, this is what they have become and as such, must be led by someone with the highest qualifications in that specialty. The proposal would allow non-NMM or C-SPOMM certified physicians to lead the courses, and to an NMM specialist, such as myself, this would be like having cardiology taught by a radiologist. They may have the basic requirements of the topic but not all that is needed. Please do not allow non-NMM or C-SPOMM certified physicians to lead the course. They should participate in OPP courses because they can lend their valuable and unique clinical experience in their respective fields but chairing a course requires the deep study of OPP's philosophy, techniques and the application of such. Other specialists may engage in these activities secondary to their personal interests but this is not always the case; NMM/OMM certified specialists must engage in these activities to pass their boards and make a living.

(Letter submitted by several constituents)

I would like to strongly encourage COCA to revise Element 7.5: OMM/OPP Leadership regarding the provision that the Department Chair must have the credentials of the American Osteopathic Board of Neuromusculoskeletal Medicine (AOBNMM) or a Certificate of Special Proficiency in OMM (C-SPOMM). Element 7.5 specifically speaks to the Department Chair as the physician leader that provides oversight of the business operations and curricular content of the Department of OMM/OPP. The specific skill set for an individual to lead a Department within a College of Osteopathic Medicine requires a fundamental core knowledge of the specific discipline yet also requires organizational skills, in-depth knowledge of human resources, knowledge of financial management including budgets and expense line items, faculty development of specific competencies for the specialty discipline, as well as mentoring faculty for promotion and tenure.
The Role of Department Chair of OMM/OPP should be the most qualified provider to lead the department, provided they have demonstrated competency in both the cognitive and manual medicine component of OMM/OPP through board certification, regardless of specialty.
It's important to be more inclusive and allow additional specialties to meet this COCA standard. If manipulation is included in the evaluation for certification, ACOFP believes this should be an acceptable discipline that meets this qualification. The current OMM standard allows for only a small group of OMT specialists to serve as department Chairs, limiting the pool of qualified candidates.
Permitting a DO Family Physician to serve as Chair of an OMM Department would reinforce the notion of OMT as being part of family medicine and not a separate, special field. This will help promote the use of OMT and help highlight the distinct heritage of our profession. Revising the standard will expand the pool from which to choose OMM Department Chairs.

Same letter as above with added note:

Please see attached letter regarding the status of OMM department chair. As a OMS II, I believe enlarging the pool of qualified faculty will significantly improve student understand and acceptance of OMT into their physical exam and assessment.

Same letter as above with added note:

We must continue to advocate for osteopathic distinctiveness.

Same letter as above with added note:

I truly believe that having NMM specialists as the head of all NMM departments sometimes intimidates FM doctors from feeling confident performing OMT.

Same letter as above with added note: I strongly agree with this letter. We had several OMM chairs that were not as qualified to be department chairs as some of the family medicine doctors. We went through 3+ department chairs during my first 2 years because they could not find the right fit to lead the department. Family medicine doctors that have experience doing OMM full time for 30 years are better fit to be a department chair than those who are freshly out of an OMM fellowship. This should be eliminated as a requirement and the school should be able to select the best candidate with less restrictions.
Same letter as above with added note: As a student interested in the specialty of family medicine and being active in medical school education in the future, I support this proposed revision to the accreditation standard.
Same letter as above with added note: I am a board certified Family Medicine physician who also practices OMM. I teach OMM to students and teach a procedure workshop at the annual convention. I would ask that you re-evaluate the credential set that you will be imposing on the future candidates for OMM Department chair. Currently we teach OMM as an integrated part of a physical exam and treatment plan. This approach in Family Medicine allows for multiple skills to be utilized, and physicians can be proficient without an extra certificate. I fear that you will be leaving out a large group of qualified candidates if you maintain that they must be specialty certified.
Same letter as above with added note: I am writing about the proposed change request by ACOFP to article 7.5. I feel that college of osteopathic medicine's OMM Department be NMM certified. This is important as to not potentially further dilute the OMT training in our CME courses and in our DO schools.
Same letter as above with added note: After 39 years in medical practice, including over ten years in practice limited to OMT, I have yet to be convinced that an NMM degree would benefit my patients any more than decades of continuous Osteopathic focused training. I have excellent teachers and a continuous learning association. As a hospital employed teacher of OMT, I see inpatients and outpatients. I get good outcomes from directing treatment at cause rather than symptoms. I rarely need to charge for cover up medications or injections, and my patients learn how to prevent dis-ease or treat themselves rather than live with a growing problem. I do not understand the requirement of NMM residency to be a good Trainer in an Osteopathic school. Yes, I have a Health Professions Education M.A. from 2014 (Michigan State) and I was a Residency Director, still involved with GME at my hospital, so I closely follow the ACGME education directives as they follow, but on the frontline of patient care, any osteopath who has experience and knowledge, attitudes and skills that are appropriate to train osteopaths should be considered. I therefore support the ACOFP statement.

I am a proud osteopathic physician boarded in FP and NMM.I spent 18 of my 40 years as a DO involved as a teacher at COMS and NYCOM.And I was a chief resident in FP at Interboro General Hospital which was an osteopathic institution.I take exception to my fellow ACOFOP members who intuit that having a FP as chairman of an NMM Dept will increase student interest in developing their OMT skills.My experience is otherwise.While I have been delighted to share teaching in an OMT lab with a Certified FP I have been disappointed when they lectured on OMT.The basic and clinical sciences of OMT are now extensive and exacting in their complexity.Any FP can develop proficiency in OMT or proficiency in Cardiology and utilize these areas in their practice,Would you then suggest that a FP chair a Dept of cardiology because it would encourage students to do more EKGs or echos it their practice?I think not.A chairperson represents consummate knowledge and skills in their field of expertise.I remember back in the 1970's when an FP would have to substitute lecture in cardiology.They were fine attempts but never as good or inspiring as were the lectures of the experts.There is no substitute for expert knowledge and expert clinical skills in the advancing and enlarging field of Osteopathic Manipulative Medicine.The citeria for Chairperson in OMM/NMM should be Certication in NMM and not FP..
I would like to strongly encourage COCA to NOT revise Element 7.5: OMM/OPP Leadership regarding the provision that the Department Chair must have the credentials of the American Osteopathic Board of Neuromusculoskeletal Medicine (AOBNMM) or a Certificate of Special Proficiency in OMM (C-SPOMM). Element 7.5 specifically speaks to the Department Chair as the physician leader that provides oversight of the business operations and curricular content of the Department of OMM/OPP. The specific skill set for an individual to lead a Department within a College of Osteopathic Medicine requires a fundamental core knowledge of the specific discipline yet also requires organizational skills, in-depth knowledge of human resources, knowledge of financial management including budgets and expense line items, faculty development of specific competencies for the specialty discipline, as well as mentoring faculty for promotion and tenure. The Role of Department Chair of OMM/OPP should be the most qualified provider to lead the department, provided they have demonstrated competency in both the cognitive and manual medicine component of OMM. I feel that to ensure these Chairs have the best and most uniform competency they should be boarded in AOBNMM or have obtained C-SPOMM. While I understand there is a shortage in qualified individuals I do feel that broadening the qualifying criteria for the chair position is potentially doing a disservice to future learners and the future of Osteopathy. OMT/OPP, ideally is and, should continue to be an integral part of every Osteopath's practice regardless of specialty. To ensure every Osteopathic learner obtains the best training I strongly encourage the commission to continue to reserve the Chair position for those who have completed the rigorurous training requirements of the AOBNMM or C-SPOMM.

You have probably received numerous copies of the ACOFP request allowing a family physician head an OMM/OMT/OPP department. As the profession moves forward and Osteopathic Residents can sit for Osteopathic Boards that do not have an Osteopathic component, why are we even having this discussion. We are forced to have a single entity GME because our Osteopathic Educators (sic) did not understand that you can't train more graduates that you have actual post-graduate training spots for (I refer you to the A T Still lecture the same year as the vote for the single entity GME). Please stop wasting our time with your perceived self-importance.
I would like to strongly encourage COCA to continue the current Element 7.5 OMM/OPP Leadership provision. As a FM/NMM integrated resident, I have first-hand knowledge in the differences in training between my OMM colleagues and my FM colleagues. While I am not disparaging my FM colleagues for their level of osteopathic knowledge, there is a significant difference in the amount of knowledge, history, and passion for OMT that my C-NMM colleagues possess that the FM faculty just does not have. They have undergone specialty training, and it shows in their depth of knowledge and nuanced approach to diagnosis, treatment, and management. As a member of both AAO and ACOFP, I can see the stark differences between the family physicians and the C-NMM providers. ACOFP colleagues argue in the form letter that they have asked all ACOFP members to forward to you that the role of the Department Chair of OMM/OPP should be the most qualified provider to lead the department. I agree, This means that they should be the most qualified representative and provider of OMM in the department, a C-NMM physician. While ACOFP representatives may argue that board certification through ACOFP's OMM certification would demonstrate competency in OMM and OPP, I can attest, as the tutor for many family medicine residents who have prepared for the ACOFP OMM certification examination, that the level of difficulty in the board certification cannot even match that of the in-service examination NMM residents undertake, much less the C-NMM board examination. Again and again, we have seen ACOFP dilute the founding osteopathic principles. Permitting a DO Family Physician to serve as chair of an OMM Department would show that we no longer value OMM as the foundation of osteopathic education, and instead have chosen the easy path to creating schools that diverge from the tradition that AT Still instilled into the American School of Osteopathy.

I am writing in support of Element 7.5, that an OMM Department Chair must be boarded by the ABONMM or have a C-SPOMM. I am double boarded in FM/OMM and NMM/OMM and I have been teaching in an osteopathic college of medicine for 4.5 years. There are many FP doctors who do OMM, at varying levels of proficiency, and I am glad they are able to serve their patients in their practices the way that they do. However, teaching and organizing a curriculum in OMM requires both a broad and deep knowledge of NMM/OMM and it is my opinion that only those who have demonstrated their proficiency in many areas of OMM and NMM (and not just a relatively few set of techniques) can adequately fulfill this role. An analogy is pediatrics—there are a lot of FP doctors who see children and have varying levels of proficiency at it. Yet we would not ask a FP doctor to be the chair of a pediatrics department because there is specialized knowledge to a breadth and depth that only physicians who have spent 3 years studying and seeing patients, would know. I have been working part time in a pediatrics clinic for the past 4.5 years, but I definitely do not call myself a pediatrician.
I'm writing with regard to the COCA standard Element 7.5: OMM/OPP Leadership provision that the Department Chair must have the credentials of the American Osteopathic Board of Neuromusculoskeletal Medicine (AOBNMM) or a Certificate of Special Proficiency in OMM (C-SPOMM). I believe it is imperative that COCA retain this standard. No other specialty would allow such a deviation as to let another specialty oversee the leadership of their work. I'm am board certified in NMM/OMM and Family Medicine. My OPP training from those two specialities are worlds apart. While any DO may know the fundamentals of all fields, they are no more qualified to oversee the OMM department as they are to oversee OB/Gyn. They have no standard training in Cranial, BLT or visceral techniques which are standard in our specialty and our residencies. We are seeing the OPP stripped from our profession further and further. OMM departments are core to our schools. Show the profession that you value this and keep the standards as high as you would for any specialty. Otherwise perhaps our next step is that Deans of Osteopathic schools don't need to be DOs. Wouldn't that be easier as well? Easier is not right. Keep the legitimate and appropriate standards that you have set. Keep the OMM Department Chairs as having the credentials of the American Osteopathic Board of Neuromusculoskeletal Medicine (AOBNMM) or a Certificate of Special Proficiency in OMM (C-SPOMM).

I encourage COCA to revise Element 7.5: OMM/OPP Leadership regarding Department Chair credentials, to explicitly allow osteopathic physicians with AOBNMM or C-SPOMM, and preferably also with FP/OMT board certifications, to be Department Chairs. OMM/OPP is more than a specialty, it is a core element of our osteopathic identity. Department Chairs must have expertise in a whole range of areas--practical medical skills, expertise in OMM/OPP, business organization and management, finance, among others. Limiting the pool of candidates to just AOBNMM candidates diminishes the contributions that others, including board certified osteopathic family physicians, can bring to an OMM/OPP department. As the osteopathic profession continues to grow, we must ensure that we have access to the best qualified physicians to act in leadership positions in our schools.
I ask COCA to revise Element 7.5 OMM/OPP Leadership regarding the provision that the department chair must have credentials of American Osteopathic Board of Neuromusculoskeletal medicine or certification of special proficiency in OMM. The department chair of OMM/OPP should be the most qualified physician leader to provide oversight of business operations and curricular content, provided he or she is deemed competent in both cognitive and manual medicine components of OMM/OPP through board certification, regardless of specialty. The current standard limits the pool qualified candidates whereas permitting a DO family physician to serve as chair of an OMM/OPP department would reinforce the notion of OMT as being part of family medicine, promoting the use of OMT and highlighting the distinct heritage of our profession.
I am an ACOFP member and an AAO member. ACOFP is pushing hard to get the NMM certified doctors out of the chairmanships. This is a horrible move in my opinion. OMT is more complex than it used to be. Techniques like cranial, still, counterstrain, FPR etc and more complex than ever. We need experts to teach these courses. There are plenty of NMM certified physicians to fill these jobs. The schools just need to do a better job to seek them out'

I wanted to take this opportunity to lend my support to the current consideration to allow FM-OMT certified osteopathic physicians to serve as OPP Department Chair persons. We have many great providers of OMT within the profession, both those formally trained in post-graduate programs and those who were trained in other residencies as part of their programs. And to a lesser degree, those who were grandfathered. Thus, to be very frank, I cannot understand why we are needing to even have this conversation. Please allow those with FM-OMT certifications to also serve as Department chair persons. It is only right and just to do so.
I would like to discourage COCA to even consider a revision to Element 7.5: OPP/OPP Leadership regarding the provision that the Department Chair required to have an AOBNMM or C-SPOMM certification. I am both a family physician and a NMM specialist. I have been teaching future family physicians for years. I have kept in touch with several of them. In my experience, very few of them have kept up with their skills enough to lead a department in OMM. Before I started teaching at xxxx, I did not either. Using their "passing" of the OMM portion of the family practice boards is, frankly, a joke. Most family physicians who do not practice an ounce of manipulation, can pass those boards. Where I do not believe that they should be restricted in practicing OMT; I do not think that portion of the board certification is enough for teaching the future DO's. I would not suggest that a family physician be head of the cardiology department just because they had cardiology on their board exam. You need a specialist in that position. There are many OMM specialists being trained that more than keeps up with the demand. Please do not allow people who have only the family physician certification to head the OMM departments in our schools.
I am in support of Element 7.5 to stand in its original form. The NMM/OMM Department Chair should be boarded in NMM/OMM through the AOBNMM or with a Special Proficiency in OMM (C-SPOMM). The NMM/OMM Chair must have sufficient knowledge, exposure and clinical practice in all modalities of NMM/OMM including but not limited to soft tissue, articulatory, muscle energy, strain counterstrain, HVLA, MFR, lymphatic techniques, BLT, Still technique, visceral, FPR and OCMM so that if the Chair was a department of one he/she would be able to effectively teach all modalities to all regions of the body (as is appropriate). The Chair is also often responsible for ensuring that the entire curriculum is delivered within the framework of osteopathic principle and practice which include the 4 tenets and 5 model approach. Being Board certified in both FP and NMM/OMM, the Family Practice Boards currently offer only about 1-7% of osteopathic content on their written boards. This knowledge base does not suffice to be a Chair of NMM/OMM. While I appreciate the manner in which the FP Boards have delivered their hands-on skills exam (I believe it is a sound practical for family practice physicians) I do not believe it to be sufficient for someone who must be a content expert in this field. The current manner in which the AOBNMM runs the practical which includes the major modalities as well as a "pot pourri" station in which a physician may choose which technique to showcase (including FPR and Still) is a much more rigorous exam of a physician's osteopathic diagnostic and therapeutic hands-on skills. Additionally, the oral exam allows the examiner to delve into the physician's critically thinking skills and fund of knowledge. The written exam is, of course, comprised solely of osteopathic content including

the history of the profession, diagnosis, the different modalities of OMT but it also includes the distinctive lens through which the osteopathic physician views clinical problems and disease states. To train future D.O.s to truly be osteopathic in thinking and "doing" we need strong Chairs who bring this level of competency and knowledge and who have been assessed on this level of competency and knowledge through the appropriate boards.
I strongly support retaining the requirement that chairs of departments of Osteopathic Principles and Practice at Osteopathic College be Board certified in OMMNMM. Given the changes in board certification allowing DO's to avoid examinations including osteopathic content, it is important that osteopathic students get the firmest possible grounding in osteopathic principles. Board certification in OMMNMM (as in other specialties) involves mastering a depth of knowledge that is essential in the academic/predoctoral setting both for training students and mentoring junior faculty. We require other departments to be led by specialists (surgery, pediatrics) and OMMNMM is no different.
I recommend to leave it how it is currently and that the chair should be NMM.

Regarding Element 7.5. It is opinion that the OMM/OPP Leadership be required to have active board certification from the AOBNMM or C-SPOMM. I do not think that this leadership should come from physicians board certified only in Family Medicine and OMM.
I am writing to voice my concerns regarding this requirement for NMM certification in order to serve as OMM department chair. I feel that this policy is exclusionary at best, and that it attempts to discredit and devalues any Osteopathic Physician who is currently specializing in Osteopathic Manipulation. To have this requirement, you are sending out the message that if a student/resident/physician should want to incorporate Osteopathic Manipulation into their practice, that they need to only do OMM, or as you like to refer to it as NMM. This is symantics. I am an Osteopathic Family Medicine Doctor with a focus on Interventional Pain and OMT. It was not long ago that for a physician to be certified in pain, that they had to have their certification through Neurology, PMR or Anesthesiology. Any other specialty, regardless of their scope of practice, was not allowed to be certified in pain. This was changed several years ago when the Conjoint Board for Pain was created which allowed and allows essentially any specialty to become certified in pain. This just makes sense as pain is a part of every scope of medicine. To say to a family medicine doc that they can treat pain but cannot be certified in its management is an injustice to those physicians, just as much as it would be an injustice to tell someone who practices OMT daily that they are not qualified to oversee or chair an OMM department. It is my opinion that a clinician who is dedicated to practicing OMM in addition to their primary specialty is more qualified to chair an OMM department than someone who solely specializes in NMM. A Chair of an OMM department should be more well rounded and all encompassing. Making the OMM Chair strictly NMM is alienating students who want to explore other specialties such as Pain, Neurology, PMR, where having Osteopathic skills makes these people so much more qualified to treat the patient as a whole. If NMM only can lead an OMM department, you are sending an exclusionary message and you are discouraging so many young minds who want to use OMM as part of their treatement realm for their patients.

Please do not change standard 7.5
I am writing to comment on the DRAFT COM Continuing Accreditation standards document. I am in favor of keeping Element 7.5: OMM/OPP Leadership written as is, such that any and all OMM/OPP Chairs will need to be board certified by the AOBNMM (or have the C-SPOMM credentialing). I believe that the requirement as it is currently written will lead to the strongest COM education, specifically with regard to our unique hands-on work, for our future osteopathic physicians.
I'm writing in vehement support of maintaining the standard that only NMM/OMM or C-SPOMM certified physicians be qualified to chair departments of OMM/OPP. Completion of a family medicine residency prepares someone to chair an OPP department to the same extent that it qualifies them to chair a pathology, anatomy, or obstetric department. Particularly in light of the recent changes in board certification exams to remove OPP content, NMM certification is our only means of assessing that physicians possess the depth and breadth of training and expertise to serve in these important roles. If members of the ACOFP are passionate about OMT and would like to serve as OMM/OPP department chairs, I encourage them to join many of their colleagues in completing "+1" trainings to become OMM board certified.

I am writing to comment on the proposed revisions to standard 7.5.

I can understand the predicament of there not being enough NMM-boarded physicians to adequately staff all the COMs. However, that is not a valid reason for lowering the standard for the OMM department chair.

While I'm sure there are physicians of all specialties that are highly skilled in OMM, currently none of other osteopathic boards adequately assess the level of expertise that the AOBNMM does. I appreciate that the AOBFP continues to strive to include a practical exam, but as a physician boarded in FP/OMT and NMM, I can attest that the exams are not equivalent. Even this week, I had residents in our combined FP/NMM residency that took the AOBFP exam, and described it as rudimentary at best. No diagnosis or treatment was performed. It was "going through the motions". The AOBNMM exam, in contrast, demands accurate evaluation and diagnosis of multiple body regions along with the performance of a variety of techniques, and leading to a change in the somatic dysfunction.

As such, with our board exams being the common minimum standard, being certified by the AOBFP and the AOBNMM are not reflective of the same level of expertise. They do not represent the same depth or breadth of knowledge of osteopathic treatment. Therefore, if we want our students to have the OMM curriculum designed by someone with the highest level of expertise, then the standard must continue to require AOBNMM certification.

With all the changes ongoing in board certification, the current proposal is to make the AOBFP practical exam optional for initial certification. As such, if this standard were to change, it could be easy to have a scenario where a department chair had not demonstrated any OMM proficiency and yet was in charge of OMM curricular decisions. Even the Board of Deans' proposal, requiring an NMM-certified physician in the department, would be insufficient, as how could a member of the department have full jurisdiction over the curriculum if the chair disagreed?

I would encourage the COCA to instead turn its attention to the root of this issue: COM growth that has far outstripped the osteopathic profession's capacity to furnish all of our COMs with excellent leadership and OMM faculty. This rapid growth is already not sustainable, and if unchecked, will only weaken our profession through the reduction of quality.

In closing, I want to thank the COCA for its thoroughness in investigating all aspects of this issue. I believe that all sides have felt heard, and your thoughtful consideration has been apparent.

The proposed new standard expands who may be considered acceptable to lead and educate in osteopathic manipulative medicine to include board certifications other than AOBNMM.

ECOP believes that the leadership in Osteopathic Manipulative Medicine should be provided by physicians specially trained in that field. While physicians in other fields can take additional training to become more expert than their residencies provided, training directed specifically to OMM provides an expertise and worldview that we expect students to appreciate and understand.

Control of curriculum should be under the leadership of someone who has trained in that curriculum, and appreciates the approach, philosophy and practice of osteopathic manipulative medicine. Continuing the distinctive culture of osteopathic medicine requires that those steeped in the culture are a necessary part of the educational process.

The real danger in saying that a non-NMM/OMM boarded physician is qualified to run an OMM Department isn't their competence, it is whether the removal of a required NMM certification will reduce the distinctiveness of the profession as a whole. With the merging of the GME pathways, a scenario could develop where an MD with little to no OMM training could become the chair of the OMM department. In such a situation, how could COCA guarantee a quality OMM curriculum?

The argument that there are simply not enough NMM/OMM boarded physicians to supply all the current and in development schools is not accurate. There are currently over 800 NMM/OMM certified physicians in practice. With adequate salary and conditions, that should be enough to allow for at least one such physician in each of the current 48 teaching locations. If a prospective school cannot find a qualified physician, then COCA will be faced with the decision to allow for a lower quality curriculum, or to deny accreditation. If our goal as a profession is to produce the highest quality physicians, then the choice is simple. If the growth of new schools is progressing more rapidly than our assurances of quality, then perhaps it is time to slow the growth in order to ensure the maintenance of the highest educational standards. As a profession, we would not want to repeat the errors of the early days of osteopathic medicine, where the rapid growth led to declining standards, the Flexner report, and the closing of schools.

While other specialty residencies may have strong osteopathic components or distinction, the depth of understanding and experience is far greater in an NMM/OMM residency, and therefore qualifies an NMM/OMM certified physician to be better equipped to lead that portion of the curriculum.
ECOP acknowledges and appreciates that many non-NMM/OMM certified DOs perform OMM clinically, teach OMM to trainees, and have authored texts on OMM. We do not wish to diminish their contribution or skill. However, NMM/OMM certification designates the recipient to be a content expert in OMM, which is a designation not guaranteed by any other current certification. Therefore, if we wish to set a standard requiring our most expert physicians to be leading our educational programs, then we must keep the requirement that the OMM department chair must be certified by the AOBNMM.

ECOP appreciates the opportunity to respond to the proposed changes.

As a dual-boarded physician in both FM/OMT and NMM/OMM, I feel that I can state the differences, both in training and in certification exams, of the two residencies are vast. I have met and worked with FM physicians that are capable of chairing an OMM department, but many more who are not. Please do not dilute the standards for osteopathy further by changing this requirement.
I am writing to ask that you retain the current requirement that chair person of OMM training programs be board certified in NMM/OMM. Once OMM was designated a specialty, it took on a higher professional standard that can not be reasonably filled by some one with out the additional training to meet specialty level requirements. It would be ridiculous to assume that a physician trained in family practice could be proficient in training physicians in specialty fields such as surgery or radiology. By the same reasoning, they are not qualified to train in the specialty of OMM. Not long ago, before OMM was a specialty, the family practice doctors were certainly the majority of physicians training OMM. Long before that, family practice physicians provided the care and training for patients and physicians in the areas of surgery, pediatrics, ob/gyn, cardiology, and other areas. As the amount of knowledge grew, specialty training and specialties became necessary. We reached the point of needing a separate specialty in OMM over 10 years ago. Please do not denigrate the specialty of OMM by designating it as a trivial specialty that can be taught by those without demonstrated qualifications. We, as a profession either believe and respect the additional training and qualifications we test for, or we do not. If we do not, than we have no room for complaint when organizations outside of medicine declare their PTs, PAs, and nurse practitioners to have the same qualifications and the capacity to provide the same quality of care as our physicians. Please support and honor our profession by maintaining OMM board certified physicians as the leaders in OMM training programs.

I support keeping the current standards for teaching OP&P. “A COM must employ a Doctor of Osteopathic Medicine with an active medical license and active board certification from the American Osteopathic Board of Neuromusculoskeletal Medicine (AOBNMM) or a Certificate of Special Proficiency in OMM (C-SPOMM) to serve as the Department Chair of OMM/OPP, or equivalent.”
I am boarded by the ABFM in Family Medicine, by the AOBFP in Family Practice and OMT, and by the AOBNMM in NMM/OMM. I feel strongly, as a practicing osteopathic family physician with a strong OMT component to my practice, that the chairs of OMM/OPP departments at our COMs be NMM/OMM or C-SPOM certified. Based on my experience, I feel that the training in osteopathic family medicine residencies - while important to include!!!! - is NOT to the same depth, nor provides the same experience, as an NMM/OMM residency. This is not a discredit to osteopathic family medicine residencies...how could anyone expect them to include ALL of family medicine and ALL of an NMM/OMM residency in 3 years? This is impossible. Additionally, (based on my experience) I feel that the osteopathic content in osteopathic family medicine residency training is quite variable, and is not "equal across the board." Thus, while one resident could have excellent osteopathic training in their FM residency, another resident might not. I fully support continuing to have osteopathic education in family medicine residencies. However, for those candidates that are interested in also chairing an OMM/OPP department at a COM, I feel they should pursue an NMM/OMM plus-one fellowship to round out their osteopathic experience (& ability to teach OMM/OPP), as well as to provide a common baseline for all OMM/OPP chairs.
I feel the statute should remain as it is. NMM certified physicians should teach and lead NMM students and departments.

The Family Medicine - OMT Boards have a very small percentage of the requirements and exam being OMM or OPP. The NMM/OMM boards are certainly more than half OMM/OPP, and likely closer to 90%. Thus the requirement for knowledge in OMM/OPP is many times greater in the NMM/OMM board as compared with the FP-OMT board. Therefore, to have the best - strongest - OMM/OPP departments, we need to keep the NMM/OMM requirement as it. Of course there are always certain individuals who will have strong skills without the certification, but the standards are there to protect and preserve the profession, and needs must remain strict for the good of our professional future.
The AAO represents students, OMM faculty and private practice specialists as well as many dually certified physicians – predominantly, though not exclusively, FP/OMM. The AAO continues to support Element 7.5 as written (i.e., OMM/OPP department chairs should be AOBNMM certified) and continues to stand by its original position on the matter. We appreciate the challenges faced by the colleges of osteopathic medicine in finding qualified faculty. Still, we support the high standard set forth by COCA for leadership of OMM departments at colleges of osteopathic medicine to be NMM board-certified. We advocate against changing our standard on the basis of numbers alone. We applaud the ACOFP's commitment to osteopathic education. They consistently produce welltrained family practitioners who are committed to osteopathic principles and practice, and they have created a much more robust practical exam. With that, I am dually boarded, as are many of our members: The two exams are not the same. Both support the use of osteopathic manipulative medicine but from different perspectives. The NMM board is broader and has much more comprehensive osteopathic content. FP/OMM is family practice–centric, as it should be, with strong support of osteopathic curriculum. NMM training includes the education of residents to help them teach. It focuses on integration of OPP/OMM in all disciplines. Medical school students will go to a variety of specialties, not just family practice. Their training also includes a deeply ingrained knowledge of anatomy. Family practice is a shining example of the incorporation of OPP in their certification exam. Still, the NMM exam is a detailed, diverse written exam demonstrating a breadth of knowledge of osteopathic principles as well as 0MM. There is an oral exam that demonstrates appropriate and comprehensive osteopathic care to all patients, and there is a multi-station practical exam demonstrating correct diagnosis and diverse treatment modalities. The OPP/OMM chairs' job is to oversee curriculum for first- and second-year students regardless of their specialty intent. They coordinate the curriculum for third- and fourth-year medical students. They assist in the integration of osteopathic concepts in basic sciences and clinical classes. They oversee research and potentially oversee fellows in OMM. Per AOA's standards, an NMM specialist is required to be a subject matter expert in matters pertaining to osteopathic principles and practice. For these reasons, we continue to support the COCA standard 7.5 as it stands, continuing the NMM certification requirement to chair OPP/OMM departments.

As a recent graduate, and dually board certified osteopathic physician by both ACOFP and AOBNMM, I can understand the concern and need for more people to hold positions of leadership for osteopathic education. There are growing concerns about the ability of the profession at every level, especially the educational level to continue to teach osteopathy as a unique and separate medical art and science with relation to allopathic medicine. I DO NOT think that the solution to this is to open up positions of leadership to under-qualified physicians. there is SIGNIFICANTLY more education, testing and dedication that goes into the holding of a AOBNMM or C-SPOMM board. It is imperative for the future of the profession for brand new osteopathic medical students to have experience with AOBNMM certified Osteopathic Physicians demonstrating the full breath of osteopathic knowledge to experience the osteopathic difference and advantage. I truly believe that if OMM/OPP departments are chaired by ACOFP boarded physicians, there is a much greater risk that osteopathic education will continue to be enveloped and overtaken by the allopathic forces already in motion. there are other options that should be considered, such as separating the ACOFP "family medicine" and "OMT" components of the board certification rather than defaulting everyone to have both. by requiring that every ACOFP candidate takes the OMT practical, it has turned into a completely watered down practical that does not require the candidate to demonstrate much proficiency in osteopathic manual technique. it is a waste of time, money and effort and does not mean anything to 90% of the candidates since everyone has it and most do not use it. if the OMT portion was elective, it could be made more comprehensive and actually hold some meaning when people obtain that portion of their board. this could be a middle ground between being ACOFP boarded and being AOBNMM or dual boarded. my main comment is that OMM/OPP chairs should continue to be required to hold an AOBNMM or C-SPOMM board certification. Quoting A.T. Still, we need to ensure that osteopathy continues to be taught by "persons who understand the science thoroughly, and know how to teach it"
I would like to strongly encourage COCA to NOT revise Element 7.5: OMM/OPP Leadership regarding the provision that the Department Chair must have the credentials of the American Osteopathic Board of Neuromusculoskeletal Medicine (AOBNMM) or a Certificate of Special Proficiency in OMM (C-SPOMM). Element 7.5 specifically speaks to the Department Chair as the physician leader that provides oversight of the business operations and curricular content of the Department of OMM/OPP. The specific skill set for an individual to lead a Department within a College of Osteopathic Medicine requires a fundamental core knowledge of the specific discipline yet also requires organizational skills, in-depth knowledge of human resources, knowledge of financial management including budgets and expense line items, faculty development of specific competencies for the specialty discipline, as well as mentoring faculty for promotion and tenure. The Role of Department Chair of OMM/OPP should be the most qualified provider to lead the department, provided they have demonstrated competency in both the cognitive and manual medicine component of OMM. I feel that to ensure these Chairs have the best and most uniform competency they should be boarded in AOBNMM or have obtained C-SPOMM. While I understand there is a shortage in qualified individuals I do feel that broadening the qualifying criteria for the chair position is potentially doing a disservice to future learners and the future of Osteopathy. OMT/OPP, ideally is and, should continue to be an integral part of every Osteopath's practice regardless

of specialty. To ensure every Osteopathic learner obtains the best training I strongly encourage the commission to continue to reserve the Chair position for those who have completed the rigorurous training requirements of the AOBNMM or C-SPOMM.
I would like to strongly encourage COCA to revise Element 7.5: OMM/OPP Leadership regarding the provision that the Department Chair must have the credentials of the American Osteopathic Board of Neuromusculoskeletal Medicine (AOBNMM) or a Certificate of Special Proficiency in OMM (C-SPOMM). Element 7.5 specifically speaks to the Department Chair as the physician leader that provides oversight of the business operations and curricular content of the Department of OMM/OPP. The specific skill set for an individual to lead a Department within a College of Osteopathic Medicine requires a fundamental core knowledge of the specific discipline yet also requires organizational skills, in-depth knowledge of human resources, knowledge of financial management including budgets and expense line items, faculty development of specific competencies for the specialty discipline, as well as mentoring faculty for promotion and tenure. The Role of Department Chair of OMM/OPP should be the most qualified provider to lead the department, provided they have demonstrated competency in both the cognitive and manual medicine component of OMM/OPP through board certification, regardless of specialty. It's important to be more inclusive and allow additional specialties to meet this COCA standard. If manipulation is included in the evaluation for certification, ACOFP believes this should be an acceptable discipline that meets this qualification. The current OMM standard allows for only a small group of OMT specialists to serve as department Chairs, limiting the pool of qualified candidates. Permitting a DO Family Physician to serve as Chair of an OMM Department would reinforce the notion of OMT as being part of family medicine and not a separate, special field. This will help promote the use of OMT and help highlight the distinct heritage of our profession. Revising the standard will expand the pool from which to choose OMM Department Chairs.

It is absolutely ludicrous that any department in a medical school would allow a non board certified physician to chair a department. Why is ONMM being singled out this way? As a retired ONMM program director, I was tasked with training residents who could become faculty, clinicians, program directors and department chairs. Why would they then serve under a non-certified doctor? This idea should be soundly rejected.
It baffles me that the subject of chair for NMM/ OMM department at the colleges of osteopathic medicine continues to be controversial. Each specialty has it's own unique aspects, that's why they are considered specialties. For family medicine to argue that they are qualified to be department chair of the NMM department because they also perform OMT is a false equivalency . family medicine plus OMT does not equal NMM. You would not allow a family medicine DO to chair the cardiology department because they can read an EKG or the OB/GYN department because they do PAP smears, or even deliver babies. OMT is only one aspect of Neuromusculoskeletal Medicine.
The proposed revision to COCA's Continuing Accreditation Standards includes requiring that the chair of any college of osteopathic medicine's OMM Department be NMM certified (see Element 7.5, previously 7.4). It remains the strongly held opinion of the leadership at the AAO that this requirement remain as is. COCA was petitioned by the American College of Osteopathic Family Physicians to have this requirement changed. We applaud the ACOFP's commitment to OMM and OPP, and we continue to feel that NMM leadership of OMM departments at COMs creates the most in-depth and broadest representation of the osteopathic content of our profession. I am AOA Board Certified in both Family Medicine and NMM/OMM and a Fellow in both

I would encourage you to postpone making any changes to the current standard 7.5 as it relates to the leadership of the OPP curriculum in our COMs. I do not believe that the particular board certification held by a physician will by default make them an excellent department chair. However, in many of our schools (especially the new ones) the number of people serving as faculty and teaching our students in this subject area is quite small. I think that for the benefit of our students and their potential ability to perpetuate osteopathic medicine into the next generation it is essential for that portion of the curriculum to be led by someone who has been tested and demonstrated expertise in both palpatory diagnosis and appropriate application of the many different treatment modalities that ECOP lists as their minimum standard curriculum (along with others that are part of what they consider a comprehensive OPP/OMM curriculum). If changes are to be made allowing for people who have not successfully passed such an examination (currently the AOBNMM exam is the only national standard exam that approximates such an examination of a physician's skills), then additional standards must be put in place in order to insure that the students will have that portion of their curriculum directed by someone who has demonstrated that level of excellence over a broad spectrum of treatment approaches as they apply to any area of the body. Another reason to postpone making any changes at this time is related to all of the ongoing changes that are occurring in the realm of AOA board certification. The examination processes and standards for certification by AOBNMM have been fairly stable for almost 2 decades, and have no proposed changes in the foreseeable future. On the other hand, my colleagues who are certified by AOBFP tell me that the clinical practical OMT examination administered by that board has seen significant change and progressive improvement over the past 12 to 15 years. Recent changes have been approved and additional changes have been proposed regarding a candidate or diplomat taking this examination, and the nature of the exam itself. If the exam has been notably changed (even if the change is for it's overall improvement) then the label attached to that board certification is not necessarily a stable reliable representation of similar expertise and what is meant by that certification becomes somewhat dependent on when the person successfully passed the exam. A dramatically different structure of AOA board certifications is being rolled out and I think it would be to the benefit of the schools and their students to make sure that we understand what a particular board certification will be representing prior to changing the criteria for someone to be directing the OPP/OMM aspect of their curricula.
I feel very strongly that NMM departments have the requirement to have NMM certified department heads, I think that even teaching faculty under 45 should be boarded as well. There is not other specialty that we would allow a department head to not have commited a full residency and board testing in order to head that department. There are committed and talented physicians that are not boarded, I understand this. However, the field of manipulative medicine needs to advance into the future, and having leaders who are trained with more depth and precision, ones that are taught research modalities and better teaching practices. Please plan for the future, and hold this field to a high standard that is deserves as the foundation of our profession.

As one who chaired two departments and started two residencies it is AAO certification to chair or NO DEAL!!!
I am writing to the proposed changes to the COCA standard the the Chair of a Department of OMM/OPP to be board certified in NMM/OMM or ONMM (as the residency is now known in the ACGME world). I DO NOT believe that a certification other than NMM/OMM or ONMM requires a substantial breath of knowledge in Osteopathic Principles and Practice. I am dually board certified in NMM/OMM as well as Family Medicine and OMT. I have taken both initial and OCC recertification exams for both. The NMM/OMM exam sets a standard for excellence in the knowledge and practice of NMM/OMM. Candidates and diplomates need to be well versed in multiple osteopathic treatment techniques as well as examined in a rigorous practical examination to test their skill in OMT. The oral examination administered by the AOBNMM during the initial certification process rigorously assessed the candidates critical thinking abilities in the practice of osteopathic principles and manual techniques (both indications and contraindications in a case based manner). I have sat for the OMT practical exam for family medicine and it is NOT as rigorous a process. I was in Chicago this past weekend for my OCC recertification of the OMT practical exam for Family Medicine and a candidate could pass the exam by demonstrating only one technique. This exam does NOT require a diverse knowledge of OMT techniques. According to ECOP, Osteopathic students should have a knowledge base of muscle energy, HVLA, myofascial/soft tissue technique, Balanced ligamentous tension, Still Technique, Facilitated Positional Release, Osteopathic Cranial Manipulation, and Visceral technique. Chair persons of OMM departments should be knowledgeable in all these areas which is demonstrated by being certified in NMM/OMM. Chair persons not only need to know who to apply the techniques but they should know when NOT to apply the techniques. These are the people in our profession that represent excellence in the profession and who can vet their own faculty for OMM knowledge and skill in various OMT techniques. I view a Chair of the Department of OMM/OPP as a person who could serve as an expert witness in the field of NMM/OMM- who has excellent knowledge in the application of various OMT techniques. They should have enough expertise and knowledge in this field to successfully defend the appropriate us of OMT and should be able to effectively debunk those who do not practice this in an appropriate and safe manner. That being said I do not believe anyone who graduates an Osteopathic School and utilizes only one or two techniques in a few regions on patients qualifies as an expert in the field of OMM/OPP. While they may be qualified for a leadership roll they are lacking in the full breadth of knowledge and skill level required to appropriately and safely supervise other faculty and students performing OMT.

WE have a responsibility to the public, our patients, to educate students who have been trained by qualified faculty and have been taught how to SAFELY perform OMT by the time they graduate. As a profession we can not tolerate any other physicians behaving in an inappropriate manner under the guise of an OMT technique, nor can we allow students to be taught inappropriately how to perform thrusting maneuvers (or any OMT Technique) that have the potential to cause harm in their patients.
I am STRONGLY OPPOSED to COCA revising the wording of Element 7.5 to include ACOFP OMM certified family physicians as appropriate candidates to become OPP Department Chairs at COMs. As Course Director for the xxxxx OPP program and member of ECOP for the past 14 years, it is my opinion that the in-depth knowledge, experience and practical skills needed for this position are not attained by family physicians who solely take the ACOFP boards and practice OMT sparingly, if at all. It would be a great disservice to the COMs and particularly osteopathic medical students to place an FP who is not NMM or CSPOMM certified in the Chair/Course Director position. This position requires an in-depth knowledge of gross anatomy and physiology, especially related to the neuromusculoskeletal system. It requires knowledge and mature evaluation/GMT skills in a variety of osteopathic models for the whole body, including, but not limited to soft tissue, myofascial release, muscle-energy, counterstrain, HVLA, facilitated positional release, Still Technique, balanced ligamentous tension and cranial OMM. It requires that the Chair know how and when to apply osteopathic principles to the treatment of a wide variety of patient health issues in the outpatient clinic, as well as the hospital setting. In addition to academic knowledge and skills, it requires the ability to communicate effectively to students, faculty and peers. Permitting a DO family physician (not certified in NMM or CSPOMM) to serve as Chair of an OMM Department would not reinforce the notion of OMT being a part of family medicine, as most DOs in Family Medicine do not do OMT. Since the AOA hasn't promoted OMT to any significant extent since I have been in practice over 30 years, I don't see how having an FP as a chair of OPP would make any contribution to brand recognition or highlighting the heritage of the profession. As an ACOFP-certified member of this profession, I remember my OMT practical which was very basic. In talking with recent graduates and colleagues who have taken the certification exam, it doesn't sound like much has changed with respect to what is tested and expected from family physicians.

I am board certified by both AOBFP and AOBNMM.
I have taught in the medical schools for almost 20 years both in the FP department and OMM department.
If ACOFP feels like the head of the OMM department should be an AOBFP physician then they should be advocating for the head of Surgery, Ob-Gyn, Pediatrics, and Internal Medicine should be AOBFP physicians since Family Medicine encompasses all these disciplines and medical students should only rotate with family physicians since their training encompasses all these areas as well.

While ACOFP physicians do OMT, they do not perform it at the level as a specialist.

I am an osteopathic physician in practice for 36 years.

Please maintain the standard that the head of the OMM department be properly certified in NMM.

Historically the Osteopathic Profession has had a dicotomy of distress balancing "Broad Osteopathy" and "Narrow Osteopathy" for almost a hundred years. The present situation would disallow my OMM teachers, my Osteopathic mentors which include Byron Laycock, Martin Bielke, Wesley B. Larsen, the entire collection at MSU-COM in the 70's Drs. Johnston, Hoover, Mitchell, Upledger, Beal and many others. The concept of Osteopathy, as stated by Dr. Still, was to teach principles that could be applied by the individual DO to their patients. We do need to keep digging for progress and realize that the chokepoint that the small number of AOBNMM approved directors is a restriction on COMs and also affects the ACGME residency pathways.

I would like to strongly encourage COCA to revise Element 7.5: OMM/OPP Leadership regarding the provision that the Department Chair must have the credentials of the American Osteopathic Board of Neuromusculoskeletal Medicine (AOBNMM) or a Certificate of Special Proficiency in OMM (C-SPOMM).

Element 7.5 specifically speaks to the Department Chair as the physician leader that provides oversight of the business operations and curricular content of the Department of OMM/OPP. The specific skill set for an individual to lead a Department within a College of Osteopathic Medicine requires a fundamental core knowledge of the specific discipline, yet also requires organizational skills, in-depth knowledge of human resources, knowledge of financial management including budgets and expense line items, faculty development of specific competencies for the specialty discipline, as well as mentoring faculty for promotion and tenure. The Role of Department Chair of OMM/OPP should be the most

qualified provider to lead the department, provided they have demonstrated competency in both the cognitive and manual medicine component of OMM/OPP through board certification, regardless of specialty.

It's important to be more inclusive and allow additional specialties to meet this COCA standard. If manipulation is included in the evaluation for certification, ACOFP believes this should be an acceptable discipline that meets this qualification. The current OMM standard allows for only a small group of OMT specialists to serve as department Chairs, limiting the pool of qualified candidates.

Permitting a DO Family Physician to serve as Chair of an OMM Department would reinforce the notion of OMT as being part of family medicine and not a separate, special field. This will help promote the use of OMT and help highlight the distinct heritage of our profession in the "Broad Osteopathy" tradition. Revising the standard will expand the "Narrow Osteopathy" pool from which to choose OMM Department Chairs.

Program chairs need NMM/OMM board certification, this is proper and logical. I understand that there are some from the other specialties proficient in OMM who desire to fill these positions. It is completely reasonable to ask that a chair of a department, such as surgery, hold board certification in that specialty. There should be no double standard for the OMM department.

Given the rapid growth of schools, I assume this push to change the standards is out of a shortage of qualified (board certified) candidates. If that is the case, it is likely that gap will close in a few years as the shear number of DOs in practice grows and more seek NMM/OMM board certification. If we are deciding to change the rules to adapt to this unique (and temporary) environment we are in, there need not be a drastic change.

What is the practical problem you are trying to solve with this revision? How many program chair positions do we need to fill as a profession? It can't be more than 30, and I assume its much less. Who are the interested candidates? What are their specific qualifications? I'm sure they must be exceptional at OMM or they wouldn't apply. Perhaps these physicians have been practicing for years and missed the opportunity to sit for the NMM/OMM boards through the practice track? Certainly, COCA wouldn't be proposing a rule change to dilute the quality of the educators, right?

The program chairs need to be qualified first and foremost. A board certified NMM/OMM physician who is out in practice for one year compared to Larry Jones (if he were still with us) would not bring as much to an osteopathic department in the way of clinical experience. However, the new graduate would have a well rounded training with applications in multiple settings and be able to teach from a solid broad foundation of OPP. They are both valuable, not interchangeable, and both candidates have areas where they are strong and areas where they lack. Both would be appropriate to lead a department as the newer candidate's experience would grow with time, and Dr. Jones (as an example) would be capable of rounding out his foundation through exposure from other faculty or filling in holes through CME as all physicians do.

The ideal is to have every chair board certified. Honestly though, if I had my choice I'd want to learn from Larry Jones, and I see why COCA would want to allow for physicians of that caliber clinically to teach if they are passionate about serving as a OMM department chair. If that is what COCA has in mind by allowing other specialty physicians to serve as chair, I'm all for it.

However, we as a profession need, now more than ever, to raise the bar. This revision will be seen by

many, most notably the osteopathic medical students, as lowering the bar and discounting OMM as a specialty. We must stick with the standard that is present for all other specialities, that the chair is board certified in the specialty they oversee. The question is not how to lower standards, but rather how do we get this handful of interested and very qualified physicians the one piece they are missing. I assume that all candidates a school is considering would have experience commensurate to the requirements of practice track for NMM/OMM prior to that track being closed. Instead of a revision to lower the bar, can COCA establish a plan for these physicians (recognizing their unique position) to prepare them to sit for the NMM/OMM boards? Effectively, a "program director's track" that will serve to close this temporary gap and ensure that every chair is NMM/OMM board certified? Program chairs need NMM/OMM board certification. This should be the goal, and it is the right direction to go as it shows the future generations of DOs that our standards are consistent for every specialty they may be interested in. Again, the concern of filling program director positions has every indication of being temporary. Why lower our standards?
I am writing to encourage the COCA to keep this standard as it is, as was wisely done two years ago when this issue last arose. Allowing a physician certified by AOBFP to be the driver of the Osteopathic Principle and Practices departments at the COMs implies there is parity in their education and certification process which is not at all accurate. But before delving into that part of the discussion, it appears to me that the change proposed by AOBFP would be in direct contradiction to Element 7.3 which states that "For clinical department chairs, the chair must have an active medical license and active board certification in the discipline in which they serve as chair." If that standard is appropriate for every other discipline, why should it be different for something as fundamental as OPP/NMM? Up until very recently, the only pathway be certified by the AOBNMM was to complete one of four AOA residencies in NMM. In the basic standards for all those programs there were standards requiring training and opportunity for the residents to be involved in education, in recognition that our residencies are the source of most of our faculty and all our department chairs. The intent to train our faculty has been ingrained within our programs. There is no comparable standard within the basic standards of the FP residencies. Within the ACGME ONMM programs there is still the ability to require longitudinal teaching experiences which most residencies associated with the COM's do. In addition, the curriculum of the NMM residencies emphasizes the application and integration of osteopathic principles in all the clinical disciplines, requiring prescribed numbers of patient encounters that involve osteopathic care for pediatric, obstetric and surgical patients in addition to the numbers of encounters of patients just within NMM. This creates a deeper level of understanding of osteopathic care in every patient population unparalleled in any other specialty. These residencies also ingrain a much more detailed knowledge of anatomy with respect to osteopathic care. This is a key component in the optimal teaching of osteopathic technique to the novice learner. The certification process itself has distinct differences as well with regard to the osteopathic component of the examination. Being personally dually certified by the AOBNMM and the AOBFP, I recognize that over the last many years there have been significant improvements in the osteopathic components of the AOBFP certifying exam. That said, it still doesn't compare to the depth and rigor of the AOBNMM certification process. To become a certified specialist in NMM, the candidate must pass a detailed and diverse exam demonstrating the breadth of their knowledge in the application of osteopathic thought in all patient populations. They must also complete an oral exam demonstrating the ability to give appropriate and comprehensive medical care to all patients that present to their offices. Thirdly, they

must complete a multiple station practical exam and show competence in their abilities to correctly diagnose and effectively treat somatic dysfunction in all areas of the body, using a wide variety of techniques.

So, to imply that there is parity in the education and certification processes of NMM specialists as compared to family physicians is not only inaccurate but potentially dangerous to the maintenance of the high standard of osteopathic education provided in our COMs, without which we lose the distinctiveness that defines our profession as training the most comprehensive physicians in the United States. Amid the coming changes in AOA certification, it feels premature to make any requirement changes based on a certification that may look entirely different within a few years.

Many of our current faculty became certified under the "practice pathway" which closed many years ago. The criteria they were required to meet were also extremely rigorous and their experience enabled them to still pass all of the same examination processes. Therefore, they are functionally equivalent and equally qualified to maintain that certification and provide osteopathic education at the necessary level. There have been proposals put forth to re-open the practice pathway but those have not come to fruition. However, the current ONMM 2 residency slots which are the equivalent to the AOA Plus One programs, can be completed over a longer period which creates new possibilities for people to go back and earn ONMM board certification on a part-time basis without giving up everything they are currently doing. This could go a long way toward increasing the numbers of qualified candidates for the chair of OPP/OMM departments at the COMs.

The OPP department chairs are responsible for all aspects of osteopathic education in the COMs. Not only do they oversee the curriculum in the first two years of OPP classes but they also are most often responsible for coordinating the osteopathic curriculum in years three and four. Frequently they are also tasked with assisting with the integration of osteopathic concepts into the basic science and clinical classes, as well as overseeing osteopathic research at their institution. To have this supervised by a physician who had not been deeply entrenched within the culture of OPP throughout their post-doctoral training cannot help but diminish the depth and breadth of all those components of pre-doctoral osteopathic education.

The proposal by the Board of Deans to just have an NMM boarded person in the department as opposed to the chair having that qualification does not guarantee that oversight of all department activities would be overseen from the perspective of that level of expertise. It would be inappropriate and set up potential for conflict if the NMM boarded faculty member was trying in institute curriculum the chair didn't approve.

The core of the curriculum in the pre-doctoral years is determined by the Educational Council on Osteopathic Principles (ECOP) which is composed of the department chairs or their designees from each of the COMs. The vast majority of the ECOP physicians are AOBNMM (or C-SPOMM) certified. Physicians not holding that certification will not be able to participate equally in the curriculum development process nor will they be able to oversee the delivery of said curriculum at the same level. ECOP is also responsible for the content and maintenance of the Glossary of Osteopathic Terminology, which is recognized as the official resource for osteopathic language in the US and much of the world. Again, having this work done by physicians who are not content experts risks the very foundation of our academic endeavors.

In recent years, NBOME has increased standards in all subject areas but especially in OPP/OMM. The item writers for this material are predominantly subject matter experts certified by the AOBNMM. Having the curriculum of an OPP department overseen by someone who is not a subject matter expert puts the students at that institution at serious disadvantage with regards to their licensing examination.

With the advent of the Single Accreditation System, osteopathic education will be on the biggest national stage in its history. This would be the worst possible moment to dilute or diminish in any way

the one part of osteopathic education that is truly osteopathic. It is regrettable that the first two years are the only truly osteopathic education that many DOs ever receive. To put it at risk by allowing it to be directed by anyone other than the most comprehensively trained content expert would be a big mistake. It has been reported that the reason cited for this proposed standard change is the lack of availability of NMM boarded physicians to fill the department chaired positions. This simply can't be true. Not only are there close to 1000 NMM board certified physicians, we are graduating more all the time. As of this writing, there are 26 ACGME ONMM residency programs currently at some level of the accreditation process and more list on the AOA site that are planning to transfer over so there should be minimal interruption to the process of producing physicians who will be the ultimate subject matter experts in the field of NMM/OMM. If all of these doctors are choosing to go into private practice or other clinical settings rather than pursue a career in academia, the question must be asked why that is. It is conventional wisdom that in the specialty of NMM, private practice pays significantly more than academia and that the people who teach at COMs do so "out of love". Regardless of specialty, academic physicians need to be paid appropriately to ensure that the best qualified people are teaching the physicians of the future. I know that the COCA's goal is to ensure excellence in all facets of osteopathic education, so we should be raising standards, not lowering them. I absolutely understand that there are physicians who are superb practitioners of NMM/OMM despite not having specialty certification. I in no way wish to diminish the importance of their achievements or their value to our profession. I simply believe that the osteopathic physicians of the future must receive the best education available anywhere in the world and the only means to guarantee that is to have that education exclusively developed, delivered and overseen by the only physicians with the proven ability to do so.

I'm writing in vehement support of maintaining the standard that only NMM/OMM or C-SPOMM certified physicians be qualified to chair departments of OMM/OPP. Completion of a family medicine residency prepares someone to chair an OPP department to the same extent that it qualifies them to chair a pathology, anatomy, or obstetric department. Particularly in light of the recent changes in board certification exams to remove OPP content, NMM certification is our only means of assessing that physicians possess the depth and breadth of training and expertise to serve in these important roles. If members of the ACOFP are passionate about OMT and would like to serve as OMM/OPP department chairs, I encourage them to join many of their colleagues in completing "+1" trainings to become OMM board certified.
I am very much in favor of keeping the requirement for NMM board certification to for any Osteopathic Manipulation teaching positions. Physicians without Residency training and certification in NMM will not have the knowledge or experience comparable to an NMM Board Certified Physician. The importance of this designation should not be ignored.
I am writing to you today in response to the American College of Osteopathic Family Physician's proposal for changes to the credential requirements for OMM department chairs in colleges of osteopathic medicine. I strongly oppose the proposal that would allow chairs in OMM departments to be board certified by the American Osteopathic Board of Family Physicians (AOBFP) without board certification by the American Osteopathic Board of Neuromusculoskeletal Medicine (AOBNMM) or its precursor Certification of Special Proficiency in Osteopathic Manipulative Medicine (C-SPOMM). I am dual board certified by the AOBFP and the AOBNMM. I practice both osteopathic family medicine and osteopathic neuromusculoskeletal medicine. I teach osteopathic medical students in the family medicine clinic and in the OMM specialty clinic. I am a clinical assistant professor in my college's OMM Department, and I am a guest lecturer for workshops delivered by my college's Family Medicine Department. I am also Assistant Program Director for my college's Osteopathic Neuromusculoskeletal Medicine Plus One Residency. I can honestly state that I love practicing both osteopathic family medicine and osteopathic neuromusculoskeletal medicine. I can also honestly share that I love teaching both osteopathic family medicine and neuromusculoskeletal medicine. The two specialties complement each other very well. Patients need the care provided by both specialties. Osteopathic Family Medicine physicians deliver comprehensive expertise and care for their patients, and Osteopathic Neuromusculoskeletal Medicine physicians deliver specialty expertise and care for their patients. These

specialties are my two favorite medical specialties in the whole world, but they are not one and the same.

Osteopathic Medicine cannot afford to be diluted any more. The ACOFP's proposal to eliminate the requirement for OMM department chairs to be board certified by the AOBNMM or C-SPOMM would do just that. With that being said, I want to make this clear: physicians in the ACOFP are my people, and I am one of them. I love the ACOFP, and I believe that osteopathic family medicine physicians are the best primary care physicians on the planet. ACOFP physicians possess more skills to treat patients in the primary care setting than any other health professionals around the world. It is their care of the patient as a whole, their helping the patient find health rather than just treating disease, and their skills in osteopathic manipulative medicine that distinguish them from other primary care health professionals.

Some ACOFP physicians have developed a large repertoire of OMM skills akin to specialists in AOBNMM and C-SPOMM, but that is not usually the case. A physician boarded by the AOBFP with a OMM skill set and knowledge on par with the OMM skill set and knowledge of a physician boarded by the AOBNMM is the exception and not the standard. The specialty of Osteopathic Neuromusculoskeletal Medicine sets the standard for the osteopathic profession when it comes to OMM skills and knowledge. An opposing argument to this statement carries no foundation. An opposing argument would be the equivalent of saying that family medicine physicians receive training in neurology and obstetrics during residency and, therefore, are the authority on neurological and obstetric conditions. Even the layperson knows that a neurologist is the authority on neurological issues and an obstetrician is the authority on obstetric conditions. The neurologist undertook a residency devoted to training in neurologic conditions, and the obstetrician undertook a residency devoted to training in obstetric conditions. Similarly, a specialist in Osteopathic Neuromusculoskeletal Medicine undertook a residency devoted to training in OMM skills and knowledge in osteopathic principles and practices.

Back to my point: the profession of Osteopathic Medicine cannot afford to be diluted any further. There have already been too many decisions in the profession of Osteopathic Medicine that have done just that: the relinquishing of osteopathic residencies to the single accreditation system, the removal of osteopathic principles and practices as a foundational component of osteopathic board certification examinations for all osteopathic physicians, and the selection of professional leadership that does not always value the distinctiveness of Osteopathic Medicine. Osteopathic Medicine seems to be slowly fading away as a result of choices such as these, and allowing physicians who are not experts in OMM skills and knowledge to be chairs of OMM departments would further exacerbate the problem by diluting the knowledge and skill base of those departments.

I strongly urge COCA to oppose the ACOFP's proposal to eliminate AOBNMM or C-SPOMM certification as a credentialing requirement for OMM department chairs. A decision to support this proposal would dilute osteopathic knowledge and skills in osteopathic medical schools further, and this ultimately would lead to osteopathic medical schools creating a product (DO's) with skills and knowledge inferior to the current standard. Ultimately, the general population would suffer because a unique and effective set of skills and knowledge would be at best diluted and at worst lost altogether over time.

I wish to continue support of the COCA Standard 7.5, page 17, requiring that a NMM OMM Certified physician be the Chair of an OMM Department or Division. I oppose any change of the standard. I do not support that a Family Practice physician teach a family practice approach to our future DOs. We need a more scientific approach showing the rational of osteopathy. With the principles that can be applied to all specialties incline for example Dermatology, Radiology and Pathology. OMT is only part of the reason for having an NMM OMM person the chair. I am a longstanding certified member of the AOCFP and of the AOBNMM and OMM. I have been teaching postgraduate education since 1974, and gave the first lecture at xxxxx. I teach OMM to all four years of students at xxxxx and ALL of the xxxxx OPTI residents. I teach hospital applications of OMMJ to general surgery, orthopedic surgery, dermatology, emergency medicine and family medicine. OPP is stressed and practical applications of OMT are given with the research evidence of its use in tissue healing, infections, circulatory, endocrine, autonomic nervous system problems, lymphatic circulation, but also the 5 models of Osteopathic Care. For example dermatology residents are getting good response to wound healing as well as the general and ortho surgeons by using some OMT with the 5 Models. .Internal medicine is treating post ventilator pneumonia, etc. Thank you for allowing me to give my opinion,

OMT in Primary care applications is economically a benefit as it builds practices, and helps diagnostic and therapeutic approaches. They realize its effectiveness now while as students they did not see how valuable OPP is. OMT is only part of it.

The lecture I gave the first class and now, 21 years later, is about the history and philosophy of osteopathic medicine, the Science of osteopathic medicine and the reason for our existence as a separate entitiy. I mentioned that OMT is the basic concept that will help diagnostic skills, and understanding of the pathophysiology of disease. OMT by itself in the hospital and the clinic is useful, but having the confidence to physically examine a patient with a basic understanding of functional anatomy and physiology is the major advantage our DO residents have. OMT knowledge is a basic training and its applications are very valuable to ALL DOs regardless of skill level or future OMT use. The knowledge of OPP with its diagnostic history and physical examination skill make for a better clinician.

To have just a FP as Chair is diminishing the training of OMM as part of OPP in our schools is a disservice to our residents and their later practice regardless of specialty. The3r4e is no specialty including radiology that does not need the concepts that properly taught OPP can give. The actual ability to do OMT its not the point, but the techniques that we are now teaching are safe and require skills beyond just doing manual treatment.

When a student asks me or any other NMM OMM certified DO a question, a full and scientific ,factual - not anecdotal- answer will be given. Will a medical school FP be trained to answer and keep the DO student interested in the science and philosophy Osteopathy? Not all DO students will be Fps, but NMM OMM address ALL aspects of OPP for all specialties.

The teaching of OMT is just part of the art of OPP. If we have a weak OMM Department or Division, it will affect the medical student's desire to learn more and STAY with our profession with Single Accreditation System. They will go to the ACGME program and certify with the MDs. The AOA will permanently loose another to the AMA banner.

I can not understand why any lessening of OPP skills by just a FP chair would be an advantage to the longevity of our profession. We need to best to teach our students regardless of their choices in later specialties. We have to have well trained, strong and enthusiastic OMM Chairs to keep our students in our profession. Respect is to be earned and it requires a person who will teach not just a Family practice approach to OMT, but one who will teach the scientific and evidence models that will encourage them to stay with Osteopathy.

My opinion is respectfully submitted in support of continuing COCA Standard7.5 to preserve our profession.

I am writing to you today in response to the American College of Osteopathic Family Physician's proposal for changes to the credential requirements for OMM department chairs in colleges of osteopathic medicine. I strongly oppose the proposal that would allow chairs in OMM departments to be board certified by the American Osteopathic Board of Family Physicians (AOBFP) without board certification by the American Osteopathic Board of Neuromusculoskeletal Medicine (AOBNMM) or its precursor Certification of Special Proficiency in Osteopathic Manipulative Medicine (C-SPOMM). I am dual board certified by the AOBFP and the AOBNMM with Special Proficiency in Osteopathy in the Cranial Field. After 6 years of practicing Family Medicine and Obstetrics in private practice, I completed the practice track Board Certification in NMM/OMM. I had my own private practice OMM/NMM practice for an additional 13 years in xxxx. I was part of the inaugural faculty in the Integrated Medicine Program at the xxxxx founded by xxxxxx. During this time I was blessed to teach postgraduate OMM courses with xxxxxx for 18 years. 15 years ago I left private practice and became part of the teaching and clinical faculty at the xxxxxx COM. I have taught OPP & OMM to medical students and residents of all specialties including NMM for 35 years. I have had a number of publication in the field of OMM and serve as the COM OMM Department Research Advisor, doing our part to enhance the culture of research in Osteopathic Medicine. I helped start an NMM+1 residency program that is now flourishing in its 6th year. I continue to see patients in the OMM/NMM Clinic of our COM Clinic. teach osteopathic medical students in the family medicine clinic and in the OMM specialty clinic. I am a Clinical Professor in OMM and Director of our OMM Undergraduate Fellows Program which incorporates clinical, teaching, and research experience in the field of OMM. The two specialties of Osteopathic Family Medicine and Osteopathic Neuromusculoskeletal Medicine complement each other very well. Patients need the care provided by both specialties. Osteopathic Family Medicine physicians deliver comprehensive expertise and care for their patients, and Osteopathic Neuromusculoskeletal Medicine physicians deliver specialty expertise and care for their patients, but they are not one and the same. But Osteopathic Medicine cannot afford to be diluted any more. The ACOFP's proposal to eliminate the requirement for OMM department chairs to be board certified by the AOBNMM or C-SPOMM would do just that. I love the ACOFP, and I believe that osteopathic family medicine physicians are the best primary care physicians on the planet. ACOFP physicians possess more skills to treat patients in the primary care setting than any other health professionals around the world. It is their care of the patient as a whole, their helping the patient find health rather than just treating disease, and their skills in osteopathic manipulative medicine that distinguish them from other primary care health professionals.

Some ACOFP physicians have developed a large repertoire of OMM skills akin to specialists in AOBNMM and C-SPOMM, but that is not usually the case. A physician boarded by the AOBFP with a OMM skill set and knowledge on par with the OMM skill set and knowledge of a physician boarded by the AOBNMM is the exception and not the standard. The specialty of Osteopathic Neuromusculoskeletal Medicine sets the standard for the osteopathic profession when it comes to OMM skills and knowledge. An opposing argument to this statement carries no foundation. An opposing argument would be the equivalent of saying that family medicine physicians receive training in neurology and obstetrics during residency and, therefore, are the authority on neurological and obstetric conditions. Even the layperson knows that a neurologist is the authority on neurological issues and an obstetrician is the authority on obstetric conditions. The neurologist undertook a residency devoted to training in neurologic conditions, and the obstetrician undertook a residency devoted to training in obstetric conditions. Similarly, a specialist in Osteopathic Neuromusculoskeletal Medicine undertook a residency devoted to training in OMM skills and knowledge in osteopathic principles and practices.

Again, the profession of Osteopathic Medicine cannot afford to be diluted any further. There have already been too many decisions in the profession of Osteopathic Medicine that have done just that: the relinquishing of osteopathic residencies to the single accreditation system, the removal of osteopathic principles and practices as a foundational component of osteopathic board certification examinations for all osteopathic physicians, and the selection of professional leadership that does not always value the distinctiveness of Osteopathic Medicine. Osteopathic Medicine seems to be in danger of slowly fading away as a result of choices such as these, and allowing physicians who are not experts in OMM skills and knowledge to be chairs of OMM departments would further exacerbate the problem by diluting the knowledge and skill base of those departments.

I strongly urge COCA to oppose the ACOFP's proposal to eliminate AOBNMM or C-SPOMM certification as a credentialing requirement for OMM department chairs. A decision to support this proposal would dilute osteopathic knowledge and skills in osteopathic medical schools further, and this ultimately would lead to osteopathic medical schools creating a product (DO's) with skills and knowledge inferior to the current standard. Ultimately, the general population would suffer because a unique and effective set of skills and knowledge would be at best diluted and at worst lost altogether over time.

Thank you for the opportunity to provide my thoughts to the Commission on Osteopathic College Accreditation (COCA) regarding the Proposed Revisions to the Continuing Accreditation Standards (effective July 2019). I am limiting my comments to only Standard 7, Element 7.5.

Element 7.5 requires that a COM "must employ a Doctor of Osteopathic Medicine with an active medical license and active board certification from the American Osteopathic Board of Neuromusculoskeletal Medicine (AOBNMM) or a Certificate of Special Proficiency in OMM (C SPOMM) to serve as the Department Chair of OMM/OPP, or equivalent."

Irequest that the COCA please revise Standard 7, Element 7.5 to allow any osteopathic physician:

a) with the expertise and experience as determined by the Dean of each COM to fulfill the unique roles and responsibilities of a Chair for her/his institution and mission/vision; and
b) certified by the American Osteopathic Association (AOA) Bureau of Osteopathic Specialists (BOS) through a psychometrically-validated examination that assesses both cognitive and practical skills, and includes Osteopathic Principles and Practice (OPP) as an integral component. Subsequent to a resolution approved by the AOA Board of Trustees (reported in the Journal of the American Osteopathic Association (JAOA) published online1 , only those osteopathic physicians certified by examinations that include OPP should be qualified.

The COCA, I am confident, is aware that at any given time there are generally multiple COMs actively searching for Chairs of OMM/OPP as well as additional qualified faculty with expertise in both OMM and OPP. Some COMs have conducted multiple searches for Chairs as qualified individuals have many career options and move frequently. I am aware of a COM that matriculated its first class less than six years ago that is searching for its fourth Chair, Department ofOMM.

It is notable that the students at most COMs perform well on all levels of the NBOME's COMLEX Examinations and frequently receive very positive feedback from preceptors and residency directors that students are very well-versed in the concepts of OPP and application of osteopathic manipulative medicine (OMM). This is not surprising as the focus of the training osteopathic medical students is to prepare competent graduates to begin residency training. The focus of residency training is to produce well-qualified clinicians, not individuals with administrative expertise or experience.

Flaherty (2016)2 reported that Chairs of Departments have ten "top responsibilities" which can be arranged under three major roles3
1) Leadership
2) Management
3) Curricular Oversight I Scholarly Endeavors

While Curricular Oversight I Scholarly Endeavors (Quality of Teaching [#5) and Teaching I Advising Students [#10]) are an important role, the two important responsibilities that align with this role account for only 20% of the top responsibilities of a Chair.

The other 80% of the top responsibilities are within the roles of Leadership (Representing the Department to Higher Administration [#1], Creating a Conducive Work Climate [#2], Developing Long-Range Goals [#3], Recruiting Faculty [#4], and Soliciting Ideas to Improve the Department [#7]) and Management (Resource Allocation [#6], Evaluating Faculty Performance [#8], Informing Faculty of

Institutional Concerns [#9]). These roles are not priority areas of development for residents-in-training as they develop clinical competence. In fact, leadership and management skills are commonly not even mentioned in residency training protocols.

At this time, the COCA includes Department Chairs [Element 7.3], Primary Care Leadership [Element 7.4]. and OMMIOPP Leadership [Element 7.5] within Standard 7: Faculty and Staff. Ibelieve that Chairs and Department Leaders should be included in Standard 2: Leadership and Administration to strengthen the importance of the position in each COM. Gmlech (2015)3 reported that "professors that become department chairs spend, on average, 16 years in their discipline" before venturing into leadership positions. Is it reasonable to expect newly minted residents or clinicians with experience and expertise in OMM and OPP to become Chairs of Departments without gaining the prerequisite skills needed to lead and manage?

As our profession continues to endorse and encourage the establishment of ACGME residency programs with Osteopathic Recognition, we need to judiciously allocate the time and energy of our most-qualified OMM educators (those certified by the AOBNMM or holding the designation C-SPOMM) to focus on educating our learners across the curricular continuum, OMS1 through PGY1-7. It is imperative that Deans be permitted to hire qualified osteopathic physicians that have the experience and credentials that each COM needs (as allowed by the COCA) to serve as leaders and administrators; focusing the efforts of their best OMM educators on the design and delivery of the pre-doctoral and post-doctoral curriculum.

During the past six months, I attended multiple COCA Meetings on the topic of Revisions of the Standards; reviewed a significant number of documents publically available (including the Basic Standards for Residency Training in Neuromusculoskeletal Medicine and Osteopathic Manipulative Medicine [AOA-BOT, amended 612012], AOA Policies and Procedures of the American Osteopathic Board of Neuromusculoskeletal Medicine [amended 813112016], the Educational Council on Osteopathic Principles [ECOP] website and documents; the American

Academy of Osteopathy [AAO] website and documents); listened to the testimony presented to the COCA by Drs. Kendi Hensel, Stephen Shannon, Michael Wieting, and Duane Koehler; engaged in several lively discussions with COM Deans; attended and participated in the ACOFP's Residency Program Directors' Workshop; reviewed the emails from the leadership of both the AAO and ACOFP calling for their members to contact the COCA and make their stance on this matter known; discussed concerns with faculty, staff, and students from more than a few COMs; engaged in dialogue with other osteopathic physicians and colleagues at several organizations that partner with COM and ACGME residency programs; and reflected on what I've read and heard.

I am confident that it is through due diligence that I arrived upon my conclusion that now is the time for the COCA to revise Element 7.5.

1. Williams D. (2019). The Evolution of Osteopathic Board Certification. Accessed March 18, 2019: doi:10.7556/jaoa.2019.037
2. Flaherty C. Forgotten Chairs. Inside Higher Education; December 1, 2016
3. Gmlech W. The Calf for Leadership: Why Chairs Serve, What They Do, and How Long Should They Serve.
AKA Monographs: Leading and Managing the Kinesiology Department 1(10): 1-12.

I'm writing in vehement support of maintaining the standard that only NMM/OMM or C-SPOMM certified physicians be qualified to chair departments of OMM/OPP. Completion of a family medicine residency prepares someone to chair an OPP department to the same extent that it qualifies them to chair a pathology, anatomy, or obstetric department. Particularly in light of the recent changes in board certification exams to remove OPP content, NMM certification is our only means of assessing that physicians possess the depth and breadth of training and expertise to serve in these important roles. If members of the ACOFP are passionate about OMT and would like to serve as OMM/OPP department chairs, I encourage them to join many of their colleagues in completing "+1" trainings to become OMM board certified.
I am board certified in both FM-OMT and NMM/OMM. I respectfully disagree with the proposed changes to COCA Standard 7.5 by the ACOFP. (Please note that I will use NMM/OMM when referring to both NMM/OMM and C-SPOMM) My comments and opinion are based on my professional experiences. I graduated from COMP (Now Western U. of Health Sciences) in 1991. My initial board cert was in Family Medicine-OMT. Ten years after graduating from medical school, I took my NMM/OMM boards, then had an OMM private practice for the next eleven years. For the past seven years, I have been teaching Osteopathic Principles and Practice to Osteopathic medical students. Despite practicing a LOT of OMT in the US Navy, emergency departments and private practice family medicine settings, I know, in retrospect, that I did not have the clinical or academic breadth of OPP or OMT to be the chair of an OPP department. As a Family Medicine physician, I treated a lot of patients with skin and psychiatric disorders, but I know that I did not have the depth of training or experience to chair the Department of Dermatology, Psychiatry (or fill in the specialty of your choice) in any medical school. As an NMM specialist, I took referrals from DO Family physicians who did OMT, but their patients needed more in-depth work. When studying for my NMM boards, I realized that my scope of OPP/OMT knowledge was generalized and limited in the family medicine realm, vs. what I needed. The Osteopathic principles, philosophy, breadth of OMT modalities, and the depth within each of those modalities that are required for the NMM boards are significantly more rigorous and in-depth than anything I had encountered in my ten years of military

and family medicine. The ACOFP sent out a sample letter that they were encouraging us to sign and send to you. It states: The Role of Department Chair of OMM/OPP should be the most qualified provider to lead the department, provided they have demonstrated competency in both the cognitive and manual medicine component of OMM/OPP through board certification, regardless of specialty. The NMM/OMM and FM-OMT exams are very different. I have copied and pasted the outlines of both exams below for comparison. If you read through the differences in the board certification content, you will see that the board certification for FP-OMT does not have anywhere close to the same OPP/OMT depth of competency in either cognitive OR manual medicine components as compared with the NMM/OMM boards. Even if we only compared the manual medicine components, there is a radical difference. As for the written examinations, I remember the first time that I recertified my FM-OMT boards. I walked out, shocked at the errors that I found in several of the very basic OMT questions. How could this exam test my competency of OPP/OMT when the exam questions had multiple correct answers? The individuals who wrote them did not even know the correct information. I have recertified for both exams (FP-OMT twice), and I can vouch that the Family Medicine-OMT board certification alone does not test to the depth needed for a physician to chair an OMM/OPP department. There are a few family medicine doctors who have had dedicated a large portion of their careers to practicing AND teaching OMT/OPP and might be adequately prepared to be an OPP department chair, but they are the rarity, not the norm. I have worked/taught with several colleagues who are boarded in only in FP-OMT. They are very good, but there is a lot that they do not even realize that they do not know. How can you teach what you do not know? How can you direct a department in the creation and improvement of an OPP curriculum if you don't even realize that you don't know key concepts that need to be taught? We are giving our students and future colleagues a subpar education if we do not have the most qualified in the field leading the team (as stated by the ACOFP). Our students deserve to have the chair of the OPP department to be the NMM/OMM specialist, to have a deeper understanding of the subject, just like any other specialty department. I cannot emphasize enough how strongly I feel that we will seriously jeopardize the education of our future DOs if we lower the standard for the Chair of the OPP/OMM departments in our COMs.

I am writing in response to your invitation to participate in a comment period regarding the proposed changes to element 7.5 of the COM Continuing Accreditation Standards. I do not support the current proposal as it stands and believe that COCA should decline the ACOFP's request to revise this element. Department Chairs should have adequate training and experience to supervise a program that will deliver upon the high educational standards that COMs have always sought to maintain. A physician without primary board certification in a specialty they chair does not have an expert level knowledge In the subject, and therefore, would be providing a disservice to the education of the osteopathic students they teach and the future of a profession which wishes to maintain its distinctive difference. One could hardly have the tools and experience to explain that difference (OPP) if they received only an introductory training with which to understand it themselves. I also recognize that there is a critical shortage of qualified physicians with primary OMM/NMM/C-SPOMM certification to fill the chair positions at our COMs which are rapidly multiplying, and something must be done to satisfy this need and fill these positions so that our students receive an education worthy of bearing the osteopathic distinction. I offer a few suggestions for this. Faculty at COMs should educate students that primary OMM/NMM board certification is an option and should provide education on the routes available for achieving this primary certification much as they do for other specialties. They should encourage interested students to pursue primary OMM board certification as a respectable specialty of choice, not attempt to dissuade them, as I experienced as a student. And finally, a two or four week required rotation in in-patient or out-patient OMT during the third or fourth year of school would allow students to continue developing their skills and understanding of OPP and to decide if a career in OMM is for them. Many DOs that I talk to, had no idea that OMM is available as a primary board certification. Increasing awareness would certainly increase the applicant pool.
I am an AOA member, board-certified OMM/NMM specialist in private practice for nearly a decade, and an adjunct faculty member at Touro College of Osteopathic Medicine in Harlem, NY for the past seven years. I have recently been made aware of the proposition to change the standards for OMM/OPP Leadership at COMs to include physicians certified by the ACOFP, and I am writing to voice my concerns about that proposed change. I feel that in order to maintain the highest standards of expertise in OMM taught in our schools, the current standard that requires OMM Chairs to be either NMM/OMM or C-SPOMM certified should be maintained. I did my residency training at St. Barnabas Hospital in the Bronx, as well as over 1 year of my medical school rotations there amongst FP residents. There I was able to compare the quality and depth of training in OMM for both the NMM/OMM residents versus that for the FP residents. Due to the relative lack of depth of knowledge and training in OMM, and lack of time devoted to OMM in the FP track, I chose to specialize in NMM/OMM. From my experience, I am certain that only NMM/OMM or C-SPOMM certified physicians possess the depth and breadth of training and expertise necessary to chair departments of OMM/OPP. Please continue the highest standards for osteopathic education by maintaining the current standard. The future of osteopathic medicine depends upon the best possible training for our physicians. Our future physicians should have their training designed by those with the most expertise.

I have worked at a few different institutions and I can guarantee you the requirement for having a Board Certified neuro musculoskeletal medicine specialist running the department of OMM is critical. Frequently when interacting with other departments that do not have specialty training In NMM, The emphasis of specific critical items required In the curriculum are just missed completely.
Maintain the requirement for Dept. Chairs in OMM to be Board Certified in OMM.

Being board certified in both family medicine & OMT with the AOBFP and in NMM/OMM with AOBNMM, I can say with certainty that the training to become board certified in NMM is substantially more than that required to become certified in FM & OMT. I think it's important to maintain the high standard that OMM/OPP department chairs should only be boarded specialists in NMM/OMM or C-SPOMM certified, so that the education in that field that is passed on also meets that standard.

I am NOT in favor of the revision.

I would like to make a comment in support of maintaining the standard that only NMM/OMM or C-SPOMM certified physicians possess the depth and breadth of training and expertise to chair departments of OMM/OPP.

I am a family physician, certified by both ACOFP and AAFP, practicing both family medicine and osteopathic manipulation in my outpatient practice. I have also completed a Plus-One program in NMM/OMM and obtained board certification from the AOBNMM. I previously worked as a faculty member at a college of osteopathic medicine and have seen first hand the demands of teaching OMM/OPP to our next generation of medical students. In my personal and professional experience, I have repeatedly seen a large difference between the level of OMM/OPP knowledge obtained by physicians certified by ACOFP versus AOBNMM.

The amount of OMM/OPP skill and expertise required by the ACOFP may be sufficient for a physician employing OMT in his/her private practice, but the depth of knowledge required of an OMM Department Chair goes well beyond that level. It is imperative that department chairs have a complete understanding of osteopathic history, philosophy, and multiple treatment modalities in order to be effective educators. It is their role to maintain the standard of OMM/OPP teaching in their respective schools, and no benefit will come of lowering the standards to allow OMM/OPP department

chairpersons with less than adequate background in osteopathic knowledge.

Now I realize that family physicians are very knowledgeable, well trained, good leaders, and many have good OMM/OPP skills. But even the cream of that crop have considerably less training and background knowledge in OMM/OPP when compared to their NMM/OMM and C-SPOMM peers. Only the highest standards of leadership qualification should be acceptable for our osteopathic medical students. The AOA is already hemorrhaging DO members who actually think and treat osteopathically; a great many of them practice identically to MDs. Why would we want to accept an even lesser standard during the core training years of osteopathic medical school?

I support maintaining the standard that only NMM/OMM or C-SPOMM certified physicians possess the depth and breadth of training and expertise to chair departments of OMM/OPP. NMM leadership of OMM departments at COMs creates the most in-depth and broadest representation of the osteopathic content of our profession.

I am writing to emphatically urge the AOA and COCA to maintain Element 7.5 as is.

That is, keep in place the requirement for ABONMM certification as prerequisite to serve as the Department Chair of OMM/OPP at osteopathic medicals.

I greatly esteem ACOFP-certified friends and colleagues. I applaud the great work of osteopathic family physicians.

At the same time, physicians who do added training in ten-fingered osteopathy deserve the utmost support. Their special qualifications rightly qualify them for department leadership.

Further, a parallel situation in an allopathic school would be nearly untenable. Would an M.D. school content itself if an internist without dual certification chaired a Neurology Department, or Vascular Surgery training? Dozens of similar analogies would not reflect well.

Ten-fingered osteopathy has been the core of osteopathy, since its inception. Please keep in place the highest regard for certified ONMM practitioners as faculty leaders in their OMM/OPP field. That is, KEEP IN PLACE the requirement of ONMM certification to chair OMM/OPP departments.

I believe that the chair of Osteopathic principles and practice at our medical schools should be those physicians that meet the highest level of training and breadth of knowledge. I have had the fortune to pursue training and am board certified in ONMM and FM. There is a definite difference in level of training and minimum knowledge base in OPP between FM and ONMM.
I propose that Chairs of OPP departments continue to be board certified in ONMM or C-SPOMM.

I am certification in both Family Practice and OMM. Family physicians do Not have the knowledge base or skills to teach or Chair the OMM departments. If the AOA feels this is acceptable than I trust that Family Physicians can be chairs of the Cardiology department, obstetrics, ENT departments. FP's perform in all these areas. When this happens then I will reconsider the current change.
I support the proposed change to COCA standards - Element 7.5: OMM/OPP Leadership - to allow physicians other than those boarded as NMM or SPOMM, to serve as chair of OMM departments. My rationale is that there are not enough NMM boarded physicians to serve the plethora of osteopathic colleges. Moreover, the AAO does not hold a monopoly on the practice of osteopathic principles. It may, one day, but for now, I accept the proposed changes. I would also request that the COCA to stop accrediting new COM's where the increased number of graduating students exceeds the available postgraduate slots. I am a dual Board Certified (FP & NMM) practicing osteopathic physician.
With regard to the change in 7.5; In addition to the comments above about the inappropriateness of one specialty influencing the COCA standards in a way to devalue another specialty group, I'm sure that there are osteopathic family practitioners who have quite adequate OMM knowledge and skills. Is adequate going to be the new osteopathic standard at this time of AGCME/SAS consolidation? I can read an ECG but that does not qualify me to teach or perform a cardiac catheterization. We should not be going into this consolidation devaluing the very aspects of why we are being included in the deal in the first place. I assure you it is not because we have shown that we can prescribe medications and take multiple choice tests as well as any allopathic physicians.

It is important to maintain the current standard that the chair of OMM department is certified in OMM. The FP have their own credentials for Dept of family Medicine and are welcome to be dual certified like I am. Do not lower the bar!
I submitted comments the last time there was debate as to whether an OMM chair at a COM ought to be NMM certified and/or C-SPOMM or if a lesser amount of OPP and OMM knowledge will do (standard 7.5). I don't recall exactly what I wrote last time, but it likely went something like this... A medical school departmental chair ought to be a content expert. Family medicine/OMT doctors know a good amount of cardiology, but should not be cardiology department chairs. Family medicine/OMT doctors know a good amount of anatomy, but should not be anatomy department chairs. Family medicine/OMT doctors (should) know a good amount of OMT, but should not be OMM chairs. OMT is not the same thing as OMM or OPP. It used to be that the major DO organization in the US claimed that all, or at least near-all DOs had a working knowledge of OMM. Now that that same organization has finally admitted that is not the case we should all be able to agree that having the initials DO after your name does not indicate adequate enough OPP and OMM knowledge to be an OMM departmental chair. While I know some FM/OMT DOs would like to believe that having the name of a procedure category tacked on to the end of their specialty indicates that they all use those procedures and are experts in how to perform them in a clinically relevant manner, we all know that is not the case. To quote a colleague of mine who recently took his FM/OMT boards, "The bar for the FM/OMT practical is set just high enough so you don't trip over it." Having never taken it myself, I cannot actually attest to having first-hand knowledge of their practical, but having trained with and practiced with many an AOA certified in FM/OMT DO, I can confidently state that the vast majority of them did not demonstrate an expert knowledge of OPP, OMM, or even OMT. I am not an NMM/OMM snob. I understand that there are DOs that did not do an NMM/OMM residency or are not C-SPOMM who do have a working knowledge of OPP and OMM and OMT, but there is not currently any other certification that actually demonstrates proficiency in OPP and OMM as well as OMT. If there is a shortage of properly credentialed OMM chairs: 1. please consider putting a moratorium on accepting new COM applications, and 2. push for DOs that want to be able to demonstrate their proficiency to be eligible to attain C-SPOMM. If the AOBNMM or the AAO can be in charge of the proficiency exam, then they can assure the exam/practical meets an expert-level OPP/OMM knowledge base for being an OMM chair.

I strongly oppose the proposed changes to Element 7.5 (p. 18). Osteopathic manipulative medicine is a specialty of our profession.

It requires a deep understanding of the principles, anatomy, and physiology of the various manipulative methods, the deep practice of hands-on treatment that comes from doing it many many times a day (e.g., the rule of 10000 hours to achieve mastery). FP doctors are pulled in too many directions during their training to effectively achieve this mastery.

While I greatly admire family practitioners -- and I believe that the breadth they bring to medicine as a "jack-of-all-trades" is hugely important to patient care -- they are NOT trained in the specialties of OMM. If they were, the profession would never have needed to create a "Plus-One" program to do that very training.

I understand that NMM/OMM or C-SPOMM Boarded physicians are difficult to find and hire for the COMs, but that is not a good argument to lower the standards for teaching. I think it's reasonable not to require ALL OMM faculty to be Board-certified, but the Chair needs to be well-versed in the specific knowledge of OMM that comes with dedicated training.

Now is NOT the time to water down the critical differences that make us DOs.

I have to state that IF a DO Boarded FP/OMM without a dual Board in NMM/OMM and without a Cranial Certification Presumes that he/she is Qualified to Chair the Department of OMM/NMM oat one of our osteopathic medical Schools, It would be a I Would have to State he is a Pale comparison to The Alternative, Someone who is Dual boarded in FP/OMM and NMM/OMM and Cranial Certified and who actively practiced in both fields with teaching experience. Make No Mistake the Role of a OMM/OPP Department chairperson in this Day and age is crucial to the Depth and Breath and Very Essence of Osteopathic Diagnosis and Technique and Osteopathic Treatment, Osteopathic medicine, Osteopathic Research, Osteopathic Conduct and Coding.

In the current world, where ALL of medicine has strayed and is now Controlled By Government Policies, Regimented by Insurance Coverage Reimbursements and Reductions, Compressed by Corporate Medicine Fast Track Models, and Globalized by Impersonalization, It is Time to Stand up For Standards. It is time to Recognize that Osteopathic Medical Uniqueness and Expertise has been Compressin into the First two Clinical years of osteopathic Medical School Training as the Two 3rd and 4th years of clinical Experience is often Devoid of any Formal Training in OMT and Wholistic medicine in Clinics or Hospitals. This is also true in Residency and Intern Years, Since many of the Osteopathic Graduates are now going to Combined or Allopathic Residency Programs. Therefore osteopathic students are loosing opportunities for Osteopathic education and loosing Mentors of Osteopathic practice, At an alarming rate. Leaving them to develop into Backdoor MDs and Poor representations of Complete Osteopathic Physicians, It is sad enough that those Osteopathic physicians who go into Surgical and Internal medicine Specialties have NO opportunities in their specialty training to continue developing their Osteopathic skills as they relate to those specialties.

The two most Honored and Sought after Osteopathic Physical Medicine and Osteopathic Skills, Unique to an Osteopathic physician are the Wholistic approach and the Physical Medicine Diagnostic and Therapeutic Skill Edge. Now in the Era of Interventional Medicine and We are threatened by Naturopathic MDs, Allopathic DOs (MDs who have sought and grasped our techniques through CME post graduate Studies), Aspiring Chiropractors, Massage therapists, Physical therapists, sports trainers,

and Kinesiologists who have also sought out Sutherland Cranial Courses and are now utilizing a Fractured version in their Practices. By Lowering our Standards and Giving Away our Knowledge to less schooled individuals we are Quickly Moving to the Elimination of our Profession as Osteopathic Physicians. Mid level Providers are stealing our livelihood in rural areas in both Osteopathic and Allopathic market shares of Clinics and Hospitals who have convinced innocent and ignorant individuals that a therapist and a Mid Level can Equal A Physician. But When A Knowledgeable individual seeks a Complete DO Physician they expect a complete evaluation Head to Toe, Pathogen and Physical Restriction, Answers to the Environmental and their Individual/Personal Cause for the DISEASE and Dysfunction. That Patient Expects to Be Educated and Treated completely for his illness. This Is What is Expected of a Complete Osteopathic Physician. An Osteopathic Surgeon should know how to do Lymphatic pump and Rib raising for post op complications and how to release muscle strains from Retractors used during surgery with Fascial release techniques. An ENT should know how to relax a eustachian tube with and without surgery and how to correct a lateral cranial strain or a temporal strain to improve Ear function. An Osteopathic Pediatrician and Allergist should have knowledge of how to Promote lymphatic flow and adrenal balancing. AN Osteopathic Internist should understand how to interpret Travel's trigger points and how to Calm a Phrenic nerve and Recruit the Sympathetic Nervous System response.

We are Forfeiting our Forefathers Foundations and all they represented to us and our Profession, Andrew Taylor Still, MD/DO, Wm. Garner Sutherland, DO, Edna Lay, DO, Tom Schooley, DO, Herbert C. Miller, DO, Richard Van Buskirk, DO, Nicholas Nicholas, DO, Fred Mitchel, DO, Steven Blood, DO, Colin Dove, DO, Robert Fulford, DO, Rollin Becker, DO, Allan Becker, DO, Ed Stiles, DO, Larry Jones, DO, Philip Greenman, DO, Paula Esthruth, DO, J Martin Little John, PhD, DO, MD, Dennis Dowling, DO, Charles Hazzard, DO, Raymond Perrin, Viola Fryman, Karen Steele, DO…….May they not Rock the Foundations of the Profession as their Standard was to Up lift learning and Carry the Message that the human body has the inherent capability of self healing given the optimal opportunity and release of physical restrictions from day to day trauma from Birth and life itself.

The Multitude of Osteopathic Techniques and Diagnostics Deserve the Expertise of NM/OMM and/or C-SPOMM Certified Physicians.

Now ASK yourselves at COCA, Do you Prefer to have the next generation of our Osteopathic Profession taught or treated by The Best of our Qualified NMM/OMM Professionals Or does a Pediatrician make a skilled Gerontologist, or does a Proctologist make a Great Neurologist? MY FP/OMM Practical was certainly pale in comparison to the NMM/OMM Practical. If you Strive to Be the Best Osteopathic Physician you Can Be you must Double Board in NMM/OMM Plus any other Specialty and must be Cranial Certified as well Anything else is HALF WAY THERE.

So, Are We To Strive for Half of a Complete OPP Chairman or do we Accept the Hard Decision of Maintaining the Whole Complete Osteopathic Chairperson for the established First 2 Academic years of Osteopathic Medical School Exposure, Acceptance, Infusion and integration of Thought, Understanding and Incorporation of Principles and Practice of our Osteopathic profession.

Let Us Grow the Tree of Osteopathic Medicine and Stop the further creation of BackDoor Allopathic DOs and the Loss of our Knowledge and heritage for all those Persons who look far and wide for the one DO who can Diagnose their restrictions and Free them of their chronic strains, which multiple others have Miss-diagnosed, Miss- treated, and eventually abandoned for failure or ignorance. Osteopathy is often

the Last Hope for Relief and Light in the Lives of many. Make a Conscious Generational Decision For the Longevity of our Osteopathic Profession.
I am writing as a third generation D.O. board certified by the ACOFP , SPOMM, with a certificate of proficiency in Cranial Osteopathy to urge the commission to maintain its current requirement that OMM department heads be NMM/OMM or SPOMM certified. As a physician who for 15 years practiced the full scope of Osteopathic family medicine ranging from newborn exams in the nursery , to end of life care in nursing homes , ICU patients and everything in between before limiting my practice to OMM, I believe I have a unique perspective on the issue. Simply put, the demands of family medicine make it impossible to develop the high level skills and true understanding of the potential of the Osteopathic approach to restoring health. Without this, one cannot be expected lead others to learn what they have not.
I graduated from PCOM in 2010 & completed both a Family Medicine Residency and NMM Plus One after. I am Certified in both Osteopathically. I am writing to support of maintaining the standard that only NMM/OMM or C-SPOMM certified physicians possess the depth and breadth of training and expertise to chair departments of OMM/OPP. Osteopathic Family Medicine training is simply not adequate to hold the position of department chair in an OMM department. NMM residency and Plus One Residency is much more in depth training on OMM. It is understandable that many Osteopathic Physicians go into OMT practices, without additional residency training, but these individuals should not have the option of becoming a department chair. Allowing, those who are not NMM certified or C-SPOMM to become a department chair discounts the additional work that these individuals put in. As AOA argues value of Osteopathic certification, NMM should not be disregarded!

I am Certified in both FP by the ACOFP, and in NMM/OMM, and I disagree with the ACOFP proposal that FP physicians have the same training in OMT and same test rigors as presented by the NMM/OMM Examination, and should be able to chair OPP Departments at our COMs - the certificates are not similar in intensity of subject matter or degree of practice, and providing less for our COM Students is not what is required at this or any time in our students' academic experiences.
I recently passed my family medicine boards through the ACOFP, and will take my ONMM boards this fall. I also completed an undergraduate OMM fellowship through my medical school at xxxx College of Osteopathic Medicine, and will join the faculty in the OMM department at xxxx COM this coming summer. OMM education has been my career goal and focus for the majority of my medical school education, and the entirety of my time as a resident physician. The proposed changes to COCA standards concern me greatly. To allow non-OMM specialists to chair OMM/ONMM/OPP departments would allow individuals without any sort of standardized ONMM qualifications to determine the level of education of our osteopathic students, and runs the risk of further diluting the quality of osteopathic principles and practices education that our students receive. To my knowledge, the only osteopathic certifying board exam that contains any practical OMT component is the ACOFP exam; having just taken that exam, I can assert that one's ability to pass it is woefully insufficient to determine whether an individual can develop, implement, and deliver quality osteopathic care to patients, much less teach students how to do so. And, especially at a time when more integration of osteopathic students with allopathic physicians in training is occurring under the single accreditation system, if we wish our profession to stand the test of time, we cannot afford the luxury of questionably qualified OMM department leadership. We must insist on high standards for our department chairs, regardless of their specialty. While certainly some individuals without ONMM board certification may be qualified to chair departments, without requiring board certification, there will be no standardization of qualifications for department chairs' OMM experience. The minimum standard for an OMM department chair should be board certification in ONMM. Accepting anything less is a disservice to our students, their future patients, and the profession as a whole.

Element 7.5 should remain with physicians who are board certified in NMM/OMM specialty through AOBNMM. As a physician who is board certified in FP and NMM, I can say without a doubt that there is a difference in the level of knowledge and understanding between the two specialties. It is important to have this increased knowledge base to adequately teach our students the appropriate practices and principles that guide this aspect of our profression. While there are many FP doctors who have a firm knowledge and understanding, my experience is that the majority of FP doctors don't have this depth and breadth of knowledge. I would encourage individuals in areas outside NMM/OMM board certification who wish to hold his chair position to complete the second residency to make them board eligible or board certified as I have done.

I urge you to maintain the current requirement that all OMM/OPP Department Chairs maintain AOBNMM or C-SPOMM certification.
While there certainly may be very skilled and knowledgeable Family Practitioners in our profession, ACOFP board certification alone is insufficient to ensure that a DO has been properly trained with the depth and breadth of knowledge and skills to oversee the teaching of OPP/OMM to our students. The very existence of "Plus One" residency programs is a testament to the fact that the typical family practice residency does not meet the needs of DO's interested in optimizing their skills and knowledge base in this area.
As someone who teaches osteopathic skills to other DO's, it is very evident to me that my NMM residency prepared me differently than my non-AOBNMM-certified colleagues.
Our students deserve the highest qualified teachers, especially in the one distinctively osteopathic department in our COMs. Please uphold the current standards to ensure that the teaching of OMM/OPP is overseen by those DO's who are uniquely and most thoroughly trained to implement it.

I have reviewed the new proposed COCA standards for certification of COMs. Although I have already sent a letter with my opinions about the proposed changes in 7.4 of the prior COCA standards, specifically the proposal to make a change to the qualifications of department chairs for OMM departments, I am prompted to make sure my point has been received.

Filling the position of OMM department chairs may seem easier if the pool of applicants included board certified Osteopathic Family Physicians, rather than just Board Certified NMM specialist. However, the COM is where the essentials are laid for a good foundation in OMM with our students. Osteopathic Family physicians (OFPs) may be good at OMM, but not all OFPs will be. On the other hand, all NMM specialists have proven that they ARE good at OMM. The focus of their teaching will be different. They will be more likely to keep the students in touch with the roots of Osteopathy. The only exception that might be made would be an OFP who has special certification in Cranial Osteopathy.

Thank you for your attention, and for the ongoing endeavor to keep the purpose and intent of Osteopathic education alive.

I'm writing in vehement support of maintaining the standard that only NMM/OMM or C-SPOMM certified physicians be qualified to chair departments of OMM/OPP. Completion of a family medicine residency prepares someone to chair an OPP department to the same extent that it qualifies them to chair a pathology, anatomy, or obstetric department. Particularly in light of the recent changes in board certification exams to remove OPP content, NMM certification is our only means of assessing that physicians possess the depth and breadth of training and expertise to serve in these important roles. If members of the ACOFP are passionate about OMT and would like to serve as OMM/OPP department chairs, I encourage them to join many of their colleagues in completing "+1" trainings to become OMM board certified.
I am writing in support of maintaining the requirement that the chair of any college of osteopathic medicine's OMM Department be NMM certified. I feel it entirely appropriate that anyone heading such a department be fluent in its practical applications.
As a third generation DO, ACGME trained (AOA approved internship, residency and fellowship), AOA Certified Family and Sports Medicine Physician I do Not support the proposed change to the continuing accreditation standards element 7.5. While I understand the ACOFP's position that the Chair of the OPP department is primarily an administrative position and that it could be managed by a DO with administrative experience of any background, I must also acknowledge the reality that the chair of OPP is the focal point of Osteopathy at the COMs. Changing the requirement from a specialty trained physician (focused, depth of training on OPP) to a generalist trained physician (broad, width of training including OMM) is not in keeping with the current view of the chair of OPP as the focus of Osteopathy in the COM. This is especially true today. The recent AOA board of directors adoption of a plan to create a dual path to board certification, one to separate out osteopathic content and one to keep it created the appearance of a profession not committed to the Osteopathic Philosophy. A move that appears to further erode the bedrock of Osteopathy would be very inappropriate and potentially damming to the future of Osteopathic Medicine. If for no other reason, the optics created by such a move could be the end of our professions distinctiveness. Now is not the time to make a change that would be seen by our competitors as the death of Osteopathic Medicine and it will adversely affect future patient care. I implore you to not make a change to this standard. We need to continue to be strong in our

commitment to the core of our osteopathic education by maintain the highest level of training possible in OPP as the Department Cahir of OPP in or COMS. If in the future the concerns about availability of NMM certified faculty remain, a more robust plan should be developed to ensure an equivalent level of training and experience is maintained in the Chair position and or the course director positions.
Thank you for allowing comment on this proposal. I am currently an assistant professor of OMM at xxxx COM. Our current chair of the department is FM/OMM trained and certified in both. From my past dealings with FM trained and certified individuals that teach and assist in the OMM curriculum at several college and universities is that the FM only physician approaches the patient as a FM doctor first and then adds some degree of OMT (more often, very little and limited to direct techniques) to the encounter (or not as time is often a significant issue). However, the FM/OMM or NMM/OMM certified physician will often approach the patient in a more osteopathic way in that they consider how the OMT can benefit the patient's condition and not necessarily the pharmacologic or surgical management. In other words, the residency trained board certified NMM/OMM physician has a totally different and more inclusive approach than the FM/OMM physician. This has to do with the additional training. There is often little to no additional training in OMM in most FM residencies and that will be decreasing significantly with the ACGME take-over. Did you know that the American Association of Medical Colleges does not even consider NMM/OMM a specialty? Neither does the largest insurer in the US – UnitedHealth Care. Sad, but true. Even more disturbing is that there are very few FM residencies that include OMM at all. This can be witnessed by the number of them not seeking osteopathic recognition and the loss of a significant number of DO FM residencies that occurred with the merger. Should we allow FM physicians to be the chair of a department of cardiology or radiology? They were trained in both, but lack the additional credentials to claim cardiology or radiology specialties. This is the same with NMM/OMM. In conclusion, only NMM/OMM board certified physicians should chair any Department of OMM. They have received the additional training to insure that the education and continuation of the practice of OMM is both thorough and broad.

I believe that OMM department directors of COM should be NMM tained
The specific skill set for an individual to lead a Department within a College of Osteopathic Medicine requires a fundamental core knowledge of the specific discipline yet also requires organizational skills, knowledge of human resources, knowledge of financial management including budgets and expense line items, faculty development of specific competencies for the specialty discipline, as well as mentoring faculty for promotion and tenure. It is very important to be more inclusive and allow additional specialties to meet this COCA standard . If manipulation is included in the evaluation for certification, I believe this should be an acceptable discipline that meets this qualification. The current OMM standard allows for only a small group of OMT specialists to serve as department Chairs, limiting the pool of qualified candidates. Accepting a family physician board certified by the AOA in Family Medicine and Osteopathic Manipulative Medicine to serve as Chair of an OMM Department would reinforce the notion to our students that a primary care physician is qualified to perform OMT. This will help promote the use of OMT by many more DOs. Personally, I perform effective OMT on patients and I have taught many residents OMT during my time as a residency program director. I further have the administrative experience to chair a COM department and I strongly believe that someone like me would be competent in chairing an OMM department. However, the current standard discriminates against DOs like me. I respectfully ask the COCA to revise Element 7.5 to be more inclusive of other qualified DOs and not be exclusive to a small subset of DOs.

As a practicing NMM specialist, I have a responsibility to comment on several proposed changes to our educational system, the composition of our faculty, and our certifying examinations.

In response to the COCA proposal that the requirement for NMM board certification be removed for those serving in the role of NMM department chairs at COM's:
As a physician certified in both FM and NMM, and as a teacher within our profession, I have two major concerns. The first is regarding the educational impact on students if they have no role models that are board certified in NMM. The second is the impact to our profession as a whole if the distinct practice of NMM slowly goes extinct.

Nationwide, many of our students, and unfortunately many of our colleagues, suffer from the misconception that NMM and OMT consists of what they learned in OPP lab in medical school, repeated over several years of clinical practice. Not at my hospital, where they can learn at the bedside from an NMM specialist. Not at our school, where NMM certified faculty teach in the labs, and an NMM certified physician serves as Dean. I was taught to read an ECG in medical school, but I am no board certified cardiologist.
I was taught to suture and tie knots, but I am no surgeon. I am a dually board certified FM and NMM specialist, and what I learned in OMS years 1 and 2 was only the beginning of my training. What I learned in the required OMT parts of my FM residency did not equal or even approach the full scope of the specialty of NMM.

At the time I was training, an NMM residency was not available to me, and my board certification in NMM was by "practice track" after a residency and certification in family medicine. I knew that I needed real training in NMM, and the process of preparing for my NMM boards, not accidentally, consisted of many, if not all of the elements now required for NMM residencies. I completed 12 months of NMM specific rotations, a two year longitudinal continuity of care NMM clinic, and several years of a full time NMM practice. I completed a series of thirty five OMT courses, including Muscle Energy, HVLA, Exercise Prescription, FPR, Fulford Percussion, Functional Methods, Counterstrain, MFR, Still Method, Visceral OMT and Osteopathy in the Cranial Field, prior to passing my NMM specialty board examinations. This training changed my practice model from that of a family medicine (plus some omt) focus to that of a specialist in NMM. I now know what it means to help my patients find health. I am no longer a generalist. I specialize in the distinctive practice of Neuromusculoskeletal Medicine.

I have been teaching OMS3 and OMS4 students, interns and residents in my roles as clinical faculty at several schools, and as the program director for FM/NMM and plus one NMM residency, at my hospital for 19 years. What I teach, how I teach, and what the students learn, is profoundly impacted by my board certification in NMM. It has made a profound difference in educational outcomes at our school and at our hospital. Instead of Osteopathic students losing their OMM thought process and skills in years 3 and 4 and becoming MD look alikes, we have been motivating many of them to integrate OMT into their practices, apply it to their many specialty fields once they graduate, and for some, to choose the specialty of NMM.

My NMM certified faculty at my COM were there to show me what was possible beyond the basic skills, and I am so grateful. It is noteworthy that my first choice of school was deliberately a COM that had several such specialists actively working with the students. They inspired me to "dig on" because they were trained and practicing at a specialist level. From their example I try to convey to my students and residents the full scope of what is possible in Osteopathic medicine.

Month after month I review material written by generalists intended for OMS 3 and OMS 4 OMT labs, and find myself needing to add red flags, pitfalls, clinical pearls, and real cases I have seen, to take the material from theoretical to practical, and from repetitive to challenging. The misconception of OMT as a limited modality is perpetuated by our choice of faculty. Without NMM specialists, our schools end up teaching only what palpatory diagnosis and OMT material is easy to teach, and only what a generalist is able to accomplish, not what the practitioner will really need to be effective. The treatments that inspired my students were outside the scope of a family physician's practice. They wanted to see how to diagnose a gallbladder dysmotility by palpation, relieve the pain of interstitial cystitis to make weekly lidocaine infusions un-necessary, confound plastic surgeons by treating babies with plagiocephaly that corrected to "below threshold for helmet treatment" between the helmet fitting and the arrival of the helmet.

The educational impact of role models at a specialist level in NMM cannot be overstated. The loss of such role models would be a profound loss to any COM, and the profession as a whole.

Regarding my second concern, the many recent administrative changes to all levels of our educational system risk having the effect of a self-fulfilling prophesy:
We say we don't have enough NMM specialists to teach NMM, although 1000 practicing NMM certified specialists is the current estimate. Instead of making NMM residency more available, thereby meeting the need and creating more qualified faculty, first we closed the very accessible and effective practice track to NMM certification. Then we agreed to oversight of NMM programs, and all of our residency programs, by MDs. Their rule changes made combined FM/NMM and IM/NMM residencies more expensive and more challenging, perhaps almost impossible, to run, requiring full time faculty when previously part time faculty could meet the needs of the NMM portion of a combined residency. In all, we are subjecting every NMM training program to obstacle after obstacle just to stay open.

Now we are contemplating removing one reason many DO's seek NMM board certification in the first place - namely to be able to chair a department or teach at a school. We continue to open more schools, without ensuring we have the faculty we need to make them truly Osteopathic. We are considering having faculty without NMM certification head our NMM departments. Instead of valuing and rewarding the skills of the NMM certified faculty we do have, we look for ways to get those services for less, taught by generalists, or for free, taught by students.

In response to the proposal that osteopathic content be removed from our individual certifying exams in non-NMM specialties, it is worth remembering that our most successful trainees study at least partly to prepare for the exam itself. Removal of osteopathic exam content both reflects and causes a lack of osteopathic content in training overall. Eventually we have removal of the reason many sought osteopathic education in the first place –which is an actually osteopathic education-altogether. And then, why apply to osteopathic schools at all? Now, are we setting such a low bar for "equivalency" of training for MD applicants that desire our Osteopathically Recognized residencies that there would really be no reason to choose an osteopathic school over an allopathic program?

We need reinforcements in our battle for survival, not surrender. We need robust inclusion of osteopathic principles and practices in all of our residency training programs and certification exams. We need Osteopathic Recognition, which is being pursued by many previously allopathic programs, to be a goal of all of our previously osteopathic residencies. We need more opportunities for talented DO's

who want to re-enter training and be board certified in NMM, to grow our faculty base.

We have the opportunity to realize AT Still's dream of transforming the practice of medicine. The most surprising reason we must not run up a white flag of surrender next to the banner of osteopathy is the strong interest our MD trainees have shown. They value Osteopathy. Do we? They are willing to work to prove they are prepared with the philosophy of osteopathy, the structural exam skills, the understanding of anatomy, to join osteopathic trainees in learning the science and art. Are we? Or will the greatest threat to the survival of our osteopathic profession, as Still predicted, come not from MDs, but from osteopathic physicians themselves?

These decisions need to be reviewed and discussed by all stakeholders. The future of our profession hangs in the balance. There are many red flags that these changes are not in the best interest of the Osteopathic profession, osteopathic trainees, and our patients. These proposed changes could deplete our pool of osteopathically minded applicants, remove the distinctiveness of all of our residencies, and write the NMM specialists out of the future of Osteopathic medical education, limiting our entire profession's understanding of what is possible with the work of our hands.

Element 8.1 and 8.2

Element 8.1: Research and Scholarly Activity: (CORE)

A COM must have a strategic plan and scholarly activities that document how the COM will contribute to the advancement of knowledge through research and scholarly contributions.

Proposed Revision:

A COM must have a strategic plan and scholarly activities that document how the COM will contribute to the advancement of knowledge through research and scholarly contributions that are characteristics of an institution of higher learning.

Submission 8.1: Research and Scholarly Activity

1. *Provide a copy of the research and scholarly activity plan.*
2. *Provide a public link to where the research and scholarly activity plan may be accessed.*
3. *Complete and submit Table 8 to identify the activity of the COM's faculty (and staff, if applicable) over the past year. (Tables are located within the electronic accreditation system)*

Proposed Revision:

1. *Provide a copy of the research and scholarly activity plan.*
2. *Provide a public link to where the research and scholarly activity plan may be accessed.*
3. *Complete Table 8 to identify the activity of the COM's faculty over the past three years.*

Note: Revise Table 8

Element 8.2: Student Participation:

A COM must publish and follow policies and procedures to support student driven research and scholarly activity, as well as student participation in the research and scholarly activities of the faculty.

Proposed Revision:

A COM must demonstrate a commitment to research and scholarly activity through its budgetary processes, support of faculty research (including the establishment of a research facility at the COM), and inclusion of its students in research throughout all four years of the osteopathic medical education.

Submission 8.2: Student Participation

1. *Provide a copy of all student research and scholarly activity policies.*
2. *Provide a link to where the policies are published.*
3. *Complete and submit Table 8 to document student research and scholarly activity. (Tables are located within the electronic accreditation system)*

Comment

Standard 8: Scholarly Activity
3. Complete Table 8 to identify the activity of the COM's faculty over the past three years.
3. Complete and submit Table 8 to document student research and scholarly activity.
Note: Revise Table 8

Should include a time frame for student research and scholarly activity similar to what is stated for faculty – over the past three years.
Table 8 has been very difficult to use because it is not in any form that makes sense for tracking research/scholarly activity. The column titles don't make sense at the level of the COM. Rather than a table for this, would it work to request a list of grants submitted/funded, faculty peer-reviewed publications, student peer-reviewed publication, faculty podium/poster presentations, student podium/poster presentations, etc. In your Table 8 now, column 2 asks if something is research or scholarly activity and then column 3 asks number of research activities ongoing or completed – those two columns are asking for things that don't line up in a database/spreadsheet format.

Element 8.1: Research and Scholarly Activity:

A COM must have a strategic plan and scholarly activities that document how the COM ~~will~~ contribute**s** to the advancement of knowledge through research and scholarly contributions that are characteristics of an institution of higher learning.

Explanation: Requiring a strategic plan and documentation of how the COM *will* do something creates a situation of where a COM seeking continuing accreditation does not have to actually accomplish anything.

Table 8- Scholarly Activity: This could be made into one table, instead of the four sections. The first column could capture all four academic years with a drop down menu- which would make data collection easier.
Change "oral" in the drop down options for column two to "conference" presentation.
Suggest adding a sixth column to include the full citation and/or grant number- if/as appropriate.

Scholarly Activity				
Academic Year (1) State the academic year the research or scholarly activity was conducted.	Types of Research and/or Scholarly Activity	Number of Research or Scholarly Activities Completed	Number of Faculty Participants	Number of Student Participants
	Peer Reviewed Publication			
	Poster Presentation			
	Oral Presentation			
	Non Peer Reviewed Grants			
	Ongoing Projects			
	Other (specify)			
Academic Year (2) State the academic year the research or scholarly activity was conducted.	Types of Research and/or Scholarly Activity	Number of Research or Scholarly Activities Completed	Number of Faculty Participants	Number of Student Participants
	Peer Reviewed Publication			
	Poster Presentation			
	Oral Presentation			

Element 8.2: Student Participation:

A COM must demonstrate a commitment to research and scholarly activity through its budgetary processes, support of faculty research (including the establishment of a research facility at the COM), and inclusion of its students in research throughout all four years of the osteopathic medical education.

We are very concerned about the misguided expectation that every medical university should have a wet lab. We have clearly examined the future of medical education and the role and responsibility we have for containing tuition growth, educating primary care physicians and contributing to the body of knowledge in support of those objectives. We clearly engage in multiple areas of pedagogical, clinical and community based research and support. We have MOUs with wet labs for the few faculty and students who choose to pursue the partnership with sister institutions which indeed helps them keep their fledgling labs open.

The future predicts 50 major research Universities well support for their unique skill and ability. The vast majority of medical schools will and already are focused on community based missions. In our case primary care and rural medicine outreach.

I look forward to your review of the enclosed document and your reaction. If you agree, I would enjoy and appreciate your voice at COCA in avoiding a Flexner knee jerk response by the COCA. The medical education community has reexamined the tenets of Flexner at the 100 year point and found the need to update and reexamine. Additionally, the release of the third leg of medical education text book by the AMA, Systems Based Practice provides a multitude of important opportunities for scholarly activity.

Response to above comment

Well said! I find most of the standard change recommendations to be solutions without problems.

Element 8.1: Research and Scholarly Activity: (CORE)

The proposed revision needs to acknowledge that the primary mission of COMs is to produce osteopathic physicians. To reflect this mission I recommend the following revision.

Element 8.1: Research and Scholarly Activity: (CORE) A COM must have a strategic plan and scholarly activities that document how the COM will contribute to the advancement of knowledge *and development of osteopathic medicine* through research and scholarly contributions that are characteristics of an *osteopathic* institution of higher learning.

I would like to provide the following comments regarding Standard 8 of the COCA COM Continuing Accreditation Standards proposed revisions:

- COM Continuing Accreditation Standards, Element 8.2: Student Participation: I am unclear as to what is meant by "establishment of a research facility at the COM," in the proposed revision. Clarification would be appreciated.
- Table 8, General Comments:
  - Being the college representative who completes this table, I do appreciate that an effort has been made to simplify data input by not requiring citations, etc. for the reported activities. That said, ideally, the information and the format required for this report would be somewhat consistent to what we are required to gather for our many other reports, both internally and for other agencies. With that in mind, I would recommend requiring citations for publications; authorship lists, project/presentation titles, and possibly conference names for presentations; and investigator names, project titles, and possibly funding agencies and project periods for grants. This information will also assist with reporting the total number of faculty and student participants in each activity.
  - Presumably we would only be required to complete these tables every three years since the proposed revision requires three years information. If that presumption is not correct, please consider the rationale of requiring the past three year's information each year.
- Table 8, Types of Research and/or Scholarly Activity:
  - Peer-Reviewed Publications: It is sometimes difficult for a third party (e.g. a research office) to determine whether or not a publication is peer-reviewed and faculty do not always include this information in their CVs/other reporting. Potentially at better way of capturing publications may be to use the criteria of PubMed cited publications. Most of the journals in PubMed are peer-reviewed, so this criteria for capturing the information would simplify the process and allow a third party to pull this information directly from PubMed without being reliant upon self-reporting by faculty or students.
  - Non-Peer Reviewed: I am not clear on what is meant by this category. Is it referencing publications? Is it referencing abstracts? All of the above? More clarity would be appreciated. Additionally, I would recommend considering removing the non-peer reviewed category entirely, as non-peer reviewed activities are not generally valued at the same level as those that are peer-reviewed.
  - Ongoing Projects: Clarification would be appreciated in the category. Is this referring to funded projects? Non-funded projects (which would be almost impossible for a third party to track)? What criteria should be used? Is this category necessary with a switch to three year's activities being reported?
- Table 8, Number of Research or Scholarly Activities Completed: If information recommended in the general comments above (particularly related to project periods for grants) would be implemented, I don't believe this column would be necessary; however, at minimum, clarity around the meaning/desired information for this category would be appreciated.
- Table 8, Number of Student Participants: Clarity surrounding what type of students (medical students only or undergraduate, graduate, and medical students) should be included in these calculations. This becomes somewhat murky when a COM has students at all levels working with the COM's faculty.

Standard 8.2: Student Participation- A COM must demonstrate a commitment to research and scholarly activity through its budgetary processes, support of faculty research (including the establishment of a research facility at the COM), and inclusion of its students in research throughout all four years of the osteopathic medical education

We support the commitment to research within COMs and advocate for student involvement throughout their medical education. However, we believe the proposed language limits our conception and definition of research, and should be revised to be more encompassing of all research disciplines related to the practice of medicine and patient-care. The term facility brings to mind a physical space or entity, and research facility is often envisioned as a laboratory. While basic science research is tremendously valuable, we believe osteopathic institutions are uniquely suited to engage in research and scholarly activity not only in natural sciences but also humanities, social, and applied sciences. Collaboration is natural in osteopathic medicine, it is embedded in our history of community involvement, exemplified by the tenants of osteopathy, and distinctive even in modern day osteopathic education. We create communities of practice between departments, between schools, and between continents, and narrowing the scope of research limits those valuable and fruitful opportunities. We argue that research in osteopathic medicine should be inclusive of multiple disciplines and our collaborations should be recognized.

A.T. Still said “To know all of the bone in its entirety would close both ends of an eternity”. We interpret his words as a call for continued investigation into the intricacies of the human body, of which we only know a fraction. However, when considering the sustainability of basic science research, it is necessary to acknowledge the challenges. Creation, construction, development, and maintenance of wet lab facilities are vastly expensive undertakings, financially cumbersome, and likely prohibitive for a great many osteopathic medical institutions1. Grant receipt is a vastly more difficult endeavor in the current funding environment 2 and increasing scarcity of public and governmental funding opportunities3 further reduces the realization of successful basic science research programs at all COMs. Consequently, the burden falls on our ethical and moral responsibility not to pass these extreme costs on to students with rising tuition and fees.

There is also a perspective driven more by osteopathic philosophy, a broader point of view to consider: osteopathic medicine is not solely concerned with the anatomy and physiology of the body; it also involves the mind and spirit. We, as osteopathic medical institutions, have a deep responsibility to investigate questions that delve not only into the workings of the body but also the mind and environment. We take an oath to help restore our patients to health; body, mind, and spirit – not just physical health, but emotional and mental health and we do this by learning how those concepts interact and how social factors can affect and determine health. By involving disciplines such as psychology, sociology, public health, social work, ethics, and others, we can thoroughly examine all aspects of the practice of medicine. We do not need wet labs or basic science research facilities to accomplish that mission and to make significant contributions to the world’s collective body of knowledge. We need to not have the scope of research narrowed, to not have the notion of educational, epistemological, and pedagogical research devalued by marking it as outside the definition of research and scholarly activity. We fully support basic and translational science in COM’s but what sets osteopathic research apart may very well be our orientation towards the whole patient.

To that end we propose that research facility be defined as the requirement that all COMs should be engaged in research which produces peer-reviewed publications, and other evidence of scholarly work, to support the development of new knowledge for practice of osteopathic medicine in healthcare delivery, education, and wellbeing. Furthermore, we support development of the Office of Research focused on the support of faculty and students as they pursue relevant research for the COM as part of

this standard. This will allow the faculty and students of the COMs to fulfill our investigative potential, a possibility that is severely limited by applying stringent definitions or artificial constructs.
A final recommendation is to include a more definite definition of the word inclusion. Student involvement in research should be tailored to each student based on their needs and interests. While all students should receive instruction in the fundamentals of research and practice in research methodologies, not all students should be expected to graduate with peer reviewed publications of enter into research-focused residencies. We do not feel this is necessarily implied in the proposed revision but we would like to take this opportunity to advocate for individualized outcomes based on student interests and needs.

References
1. Johnson, Judith. NIH Funding: FYI: 1994-FY2016. Edited by by Congressional Research Survey; 2016.
2. Office of Management and Budget. Budget of the U.S. Government: A New Foundation for American Greatness. Washington DC: CLAITORS Publishing; 2018.
3. Alberts B, Kirschner MW, Tilghmanc S, Varmus H. Rescuing US biomedical research from its systemic flaws. Proceedings of the National Academy of Sciences of the United States of America. 2014; 111(16):5773-5777.

Element 8.1: Proposed Revision:
A COM must have a strategic plan and scholarly activities that document how the COM will contribute to the advancement of knowledge through research and scholarly contributions that are characteristics of an institution of higher learning.

COM Comment: By adding the words, “characteristic of an institution of higher learning”, we create an implication that schools must have basic science/bench lab research. As grant dollars for basic science research have become more challenging to access, numerous articles and editorials have been published documenting that the true bench research will most likely be limited to a few specific research institutions. This allows our COMs, many of which have strong community training opportunities and community ties to focus on clinical research, community and population health, and translational research. Additionally, as institutions committed to teaching and training student physicians, many of our COMs have developed robust medical education research programs. We are confident that the COCA does not intend to suggest that basic science research must be funded and occur; however, we would encourage consideration of wording in this element to support all types of research within the COMs strategic research plan.

Element 8.2: Proposed Revision
A COM must demonstrate a commitment to research and scholarly activity through its budgetary processes, support of faculty research (including the establishment of a research facility at the COM), and inclusion of its students in research throughout all four years of the osteopathic medical education.

COM Comment: By adding the words, “including the establishment of a research facility at the COM”, we create an implication that schools must have a basic science/bench lab facility and research. As grant dollars for basic science research have become more challenging to access, numerous articles and editorials have been published documenting that the true bench research will most likely be limited to a few specific research institutions. This allows our COMs, many of which have strong community training opportunities and community ties to focus on clinical research, community and population health, and translational research. Additionally, as institutions committed to teaching and training student

physicians, many of our COMs have developed robust medical education research programs. We are confident that the COCA does not intend to suggest that basic science research must be funded and occur; however, we would encourage consideration of wording in this element to support all types of research within the COMs strategic research plan.

Element 9.2

Element 9.2: Academic Standards: (CORE)

A COM must publish and follow policies and procedures on academic standards that include grading, class attendance, tuition and fees, refunds, student promotion, retention, graduation, students' rights and responsibilities, and the filing of grievances and appeals.

Submission 9.2: Academic Standards

1. *Provide copies of policies and procedures on academic standards.*
2. *Provide a public link to where the documents are published.*

Comment
Evidence requested demonstrated policies in place – consider requesting evidence that demonstrates procedures followed.

Element 9.5

Element 9.5: Academic Counseling: (CORE)

A COM must provide academic counseling to assist its students in study skills, learning styles, learning resources, and other assistance for academic success.

Submission 9.5: Academic Counseling

1. *Describe the process for academic counseling provided to students.*
2. *Complete Table 9.5. (Tables are located within the electronic accreditation system)*

Proposed Revision:

Revise Table 9.5

Comment

Submission 9.5: Academic Counseling
2. Complete Table 9.5. (Tables are located within the electronic accreditation system)
Proposed Revision: Revise Table 9.5

Need to see what Table 9.5 is asking for in order to comment on this change…

Table 9.5 The proposed table and the current table are extremely difficult to complete unless all counseling activities are centered in one location. Will there be definitions provided so a COM can differentiate between for example learning styles, study skills, and use of learning resources? All might occur within a single

session. For a COM where this counseling often occurs one-on-one between faculty advisor and student and the session may include a multitude of advice given this would mean recording each session with each student across the entire year and in multiple entries to include all the topics covered. The concept of such a table and reporting seems to assume COMS have one central place/person that handles all of this counseling. The fact is for any COM where this is not the case this will be very difficult to report all the counseling that is occurring on a continual basis. The burden is then placed on faculty to account for all categories whenever they meet with a student. This is an onerous task to place on faculty and staff members.

Table 9.5- Academic Counseling: From a data collection perspective the medical school year could be captured by adding an additional column to this table containing a drop down menu of OMS1, OMS2, OMS3, OMS4.
Please allow for multiple selections from the drop down menu in column two.
Consider adding a column for title and credentials for the person providing the counseling.
In the last column- Is the number supposed to reflect the approximate number of students involved in that particular type of counseling throughout the (current/last) academic year? Might need some clarification around the wording here.

Academic Counseling		
OMS I		
Academic Counseling Type	Person(s) Providing the Counseling	Approximate number of students involved in the academic year
Tutoring	**Drop Down:** Faculty Staff Administration Peers Other	
Study skills	**Drop Down:** Faculty Staff	

Element 9.6

Element 9.6: Career Counseling: (CORE)

A COM must provide career counseling to assist its students in evaluating career options and applying to graduate medical education training programs.

Submission 9.6: Career Counseling

1. *Describe the process for career counseling, including GME Readiness, provided to students.*
2. *Complete Table 9.6. (Tables are located within the electronic accreditation system)*

Proposed Revision:

Revise Table 9.6

Comment

Submission 9.6: Career Counseling
2. Complete Table 9.6. (Tables are located within the electronic accreditation system)
Proposed Revision: Revise Table 9.6

Need to see what Table 9.6 is asking for in order to comment on this change…

Table 9.6 The current table should supply sufficient information. As stated in the response to Table 9.5, this places an onerous amount of work on the faculty to record interactions with students discussing these topics. Clinical faculty will also need to keep accurate records of any interactions with students where discussion of career options, personal statement advice, etc. occurs. The response to Submission 9.6 should provide adequate description of what is being done at the COM. The current Table 9.6 collects sufficient data to show the COM is following through with the Standard. Addition of multiple layers of complexity makes it a burden to complete the requested information in the proposed Table 9.6

Table 9.6- Career Counseling: Again, from a data collection perspective the medical school year could be captured by adding an additional column to this table containing a drop down menu of OMS1, OMS2, OMS3, OMS4.
Please allow for multiple selections from the drop down menu in column two.
Consider adding a column for title and credentials for the person providing the counseling.
In the last column- Is the number supposed to reflect the approximate number of students involved in that particular type of counseling throughout the (current/last) academic year? Might need some clarification around the wording here.

Career Counseling

OMS I		
Career Counseling Type	Person(s) Providing the Counseling	Approximate number of students involved in the academic year
Choice of residency	**Drop Down:** Faculty Staff Administration Peers Other	
Preparation for interviews	**Drop Down:** Faculty	

Element 9.7

Element 9.7: Financial Aid and Debt Management Counseling:

A COM must provide its students with counseling to assist them with financial aid applications and debt management.

Submission 9.7: Financial Aid and Debt Management Counseling

1. *Provide a list of financial aid and debt counseling sessions offered to students.*
2. *Provide an attendance list documenting that each student who received financial aid under Title IV of the Higher Education Act participated in a minimum of two counseling sessions while enrolled in the COM.*

Proposed Revision:

1. *The COM must provide a description of all financial aid and debt counseling sessions provided to its students. This description must include:*

   a. *When the financial aid and debt counseling sessions are/were provided to the students; and*

   b. *The OMS year during which students are required to receive these sessions.*

Comment

Element 9.7: Financial Aid and Debt Management Counseling:
A COM must provide its students with counseling to assist them with financial aid applications and debt management.
Proposed Revision: 1. The COM must provide a description of all financial aid and debt counseling sessions provided to its students.
Submission 9.7: Financial Aid and Debt Management Counseling
This description must include:
a. When the financial aid and debt counseling sessions are/were provided to the students; and
b. The OMS year during which students are required to receive these sessions.

Since the submission is asking only for financial aid and debt counseling "sessions", you should include the word "sessions" in the standard too. May need to define "sessions" as well. Does that include completion of on-line modules or other electronic means or is it only referring to face-to-face sessions. The use of the word "sessions" makes it sound like only "face-to-face" counts here.

Element 9.11

Element 9.10: Non-Academic Health Professionals:

A COM must ensure that any health professional providing health services, through ~~via~~ a therapeutic relationship, must recuse him/herself from the academic assessment or promotion of the student receiving those services.

Submission 9.10: Non-Academic Health Professionals

1. *Provide the policies and procedures on recusal from student assessment and promotion for health professionals providing services to students.*

Comment
1. We recommend a limit to the recusal period - if therapeutic relationship was within last 2 years.

Element 9.11

Element 9.11: Health Insurance:

A COM must require that all students have health insurance.

Submission 9.11: Health Insurance

1. *Provide the policies and procedures regarding health insurance for students.*
2. *Provide a link to where the documents are published.*

Comment
Evidence requested does not align with standard. Suggest requesting a report that verifies students are in compliance with having health insurance.

Element 10.1

Element 10.1: Osteopathic Educational Continuum:

The COM must demonstrate policy, structure and procedures to support the continuum of osteopathic education - including predoctoral education, graduate medical education, and continuing medical education. The COM must provide a copy of its policies and procedures demonstrating its support of the continuum of osteopathic education.

Proposed Revision:

The COM must demonstrate its policies, procedures, personnel and budgetary resources to support the continuum of osteopathic education in both undergraduate and graduate medical education (GME), as well as in continuing medical education (for all GME faculty). A COM must demonstrate and publicly evidence the placement of its students in graduate medical education programs, including through the publication of match rates of its students in the National Residency Match Program.

Submission 10.1: Osteopathic Educational Continuum

1. *Complete and submit Table 10.1. (Tables are located within the electronic accreditation system)*
2. *Submit the COM's policy (policies) and describe the COM's structure and procedures to support the continuum of osteopathic education.*

Proposed Revision:

1. *Submit the COM's policies and describe the COM's structure and procedures to support the continuum of osteopathic education.*
2. *Provide a public link indicating the COM's average match rate for the last four academic years in the National Residency Match Program. The match rate must be calculated by dividing the number of students who matched into a PGY1 position by the number of students who attempted to match.*
3. *The COM must also provide evidence of its support (exclusive of policies and procedures required under elements 10.2 and 10.3) of residency programs affiliated with the COM in their ACGME accreditation process, including obtaining osteopathic recognition, as well as providing support for other milestones. This demonstration of support may include the financial support, faculty support, or other assistance.*

   Editor's Note: This requirement has been moved from Element 6.6.

   Eliminate Tables 10.1 and 10.2.

Comment

Element 10.1: Osteopathic Educational Continuum:
Proposed Revision: The COM must demonstrate its policies, procedures, personnel and budgetary resources to support the continuum of osteopathic education in both undergraduate and graduate medical education (GME), as well as in continuing medical education (for all GME faculty). A COM must demonstrate and publicly evidence the placement of its students in graduate medical education programs, including through the publication of match rates of its students in the National Residency Match Program.
Standard 10: Graduate Medical Education (GME)
Submission 10.1: Osteopathic Educational Continuum
Proposed Revision:
1. Submit the COM's policies and describe the COM's structure and procedures to support the continuum of osteopathic education.
2. Provide a public link indicating the COM's average match rate for the last four academic years in the National Residency Match Program. The match rate must be calculated by dividing the number of students who matched into a PGY1 position by the number of students who attempted to match.
3. The COM must also provide evidence of its support (exclusive of policies and procedures required under elements 10.2 and 10.3) of residency programs affiliated with the COM in their ACGME accreditation process, including obtaining osteopathic recognition, as well as providing support for other milestones. This demonstration of support may include the financial support, faculty support, or other assistance.

Recommend removal of the words "in both undergraduate and" in the first sentence of the standard. All of the other COCA standards are addressing the policies, procedures, personnel and budgetary resources to support the undergraduate medical education at a COM. Nothing in the submissions for 10.1 addresses undergraduate in this way.

Recommend changing item #1 to Submit the COM's policies and describe the COM's structure and procedures to support (1) the transition of its students into graduate medical education, and (2) to support graduate medical education programs and faculty.

This is the only place that CME is mentioned but it is limited here to only GME faculty. Would recommend extending the CME to include both GME and UME faculty and perhaps moving that portion of this standard/element to Element 7.6 Faculty Development. COM's should be assisting all physician faculty, UME and GME faculty, with their CME needs but no where is that addressed or investigated in the standards.

Element 10.1: Proposed Revision
The COM must demonstrate its policies, procedures, personnel and budgetary resources to support the continuum of osteopathic education in both undergraduate and graduate medical education (GME), as well as in continuing medical education (for all GME faculty). A COM must demonstrate and publicly evidence the placement of its students in graduate medical education programs, including through the publication of match rates of its students in the National Residency Match Program.

COM Comment: While the NMS Match no longer exists, there are other matches besides the NRMP, including the Military and San Francisco matches. Is the intent that this element includes publishing of match rates in all matches? Also, for further clarification, is this primary match only, or all placements (including SOAP/scramble) that must be published? Will match and placement rates be considered separately?

Element 10.1: As noted in the comments above, can the COCA please clarify the collection of data regarding match versus placement rates and NRMP only versus all match programs?

I am an osteopathic physician currently in residency training. Regarding the revision of Element 10.1, I agree with the current proposed change, but would also recommend a GME placement requirement of 93% or 95%.

I would like to strongly appeal for the committee to reestablish a previous proposal for a Graduate Medical Education (GME) placement requirement. GME placement of osteopathic graduates is an essential element to training successful osteopathic physicians. These graduates spend a great deal of time and take great financial expense to attend COMs, and without GME training, much of that is wasted.

With the expansion of COMs, US MD schools, MD school seat expansion, and the merger without clear efforts for large scale GME expansion, osteopathic graduates are at an increased risk of not placing into GME. This makes understanding the application process, the NRMP match, and the SOAP very important. I am sorry to say that many COMs inadequately counsel and train their students for this process, and ultimately GME placement suffers.

In the past, COCA has made proposals for a strict placement requirement (98% and 95% averaged across 3 years) of all graduates seeking GME. A requirement (95% or 93% averaged over multiple years are reasonable) is the only way to ensure that COMs are putting in significant effort to guarantee placement of their graduates.

In summary, I strongly recommend establishing a GME placement requirement (such as 93% or 95% averaged across multiple years as appropriate) to ensure that osteopathic graduates continue to place and become successful physicians.

I am a 3rd year medical student at LMU-DCOM. I am writing to you in support of changing certain provisions in the accreditation standard:
1. Reinstate the GME placement requirement for DO schools at 98% over a rolling 3 year period as it was proposed several years ago. At the minimum I believe 95% placement should be required. It is important that we hold our profession to the highest of standards, and our educational facilities should be no exception.
2. Force any new school opening to produce GME at a 1:1 rate with any new seats, and if they do not follow through with development of these GME by the firsts class graduation, do not allow them to fill

any of the new seats till GME is open. 3. Transparency in match results. Require schools to publish the match rate by the Friday after Match, and the placement rate by 2nd week of April. 4. Place programs on probation with a higher than 10% attrition rate. While some attrition is expected, students are told repeatedly prior to matriculating that 'if you are here, your smart enough.' Its important for the future of our degree that admissions continues to be the gaitkeeper rather than DO school or residency placement. I greatly appreciate you taking the time to consider my suggestions, and hope they can be discussed further. I believe these are ways in which Osteopathic Medical Education can become leaders rather than simply matching others accreditation standards. We can distinguish our Doctor Of Osteopathic Medicine as being the premier degree in medical education by taking these steps.
Submission item 10.1: Provide a public link indicating the COM's average match rate for the last four academic years in the National Residency Match Program. a. The term "National Residency Match Program" is used. I am unclear if this will then exclude match information and rates for other match processes (i.e., AOA match, San Francisco, and the military). I would be concerned if it excluded the other match processes as we would want to be inclusive in this reporting.

Element 10.3

Element 10.3: Osteopathic Recognition GME:

A COM must provide a mechanism to assist graduate medical education programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) in meeting the requirements of osteopathic recognition.

Submission 10.3: Osteopathic Recognition GME

1. *Complete and submit Table 10.2. (Tables are located within the electronic accreditation system)*
2. *Submit the COM's policy (policies) and description of its mechanism to assist GME programs.*

Proposed Revision:

1. *Submit the COM's policy (policies) and description of its mechanism to assist GME programs to achieve osteopathic recognition.*

   Eliminate Table 10.2

Comment

Element 10.3: Osteopathic Recognition GME:
A COM must provide a mechanism to assist graduate medical education programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) in meeting the requirements of osteopathic recognition.

Is this referring to all ACGME residencies or just DO programs seeking the new recognition? And what are "the requirements of osteopathic recognition"?

Element 11.1

Element 11.1: Program Assessment: (CORE)

A COM must connect its learning outcomes assessment to its program mission, goals, and objectives to continuously improve the educational quality of its osteopathic medical education program.

Submission 11.1: Program Assessment

1. *Submit a copy of the COM's assessment plan.*

Proposed Revision:

1. *Provide the guiding documents which govern how the COM conducts systematic program review. This may be in the form of a program review manual or guide that has been adopted by the faculty. This should include the manner in which the core osteopathic competencies are embedded in the curriculum and assessed as an aspect of the review.*
2. *Provide a calendar which specifies the most recent and scheduled program reviews for the past three academic years preceding a site visit or any submission to the COCA for any monitoring purposes (e.g., annual report, mid-cycle report, supplemental report, etc.).*
3. *Provide examples of changes in curriculum, pedagogy, counseling, or other aspects of the student experience that have been made as a result of recent program reviews in order to more fully support the learning of the core competencies.*

Comment
As an OMM boarded physician and an FAAO, I am appalled, but not surprised by the proposed changes. Since I started osteopathic medical school in 1999 the number of OMM residency slots has stayed pretty much the same, while the number of DO graduates yearly has more than doubled. I stated to the staff at the AAO when I was a student that that fact did not bode well. Now we are in a place where we can't turn out enough OMM boarded docs to both go into private practice and also have enough to teach with the number of new schools opening and the turnover. Thus I am not surprised by the proposed change. This change does not bode well for our profession. It waters down the level of teaching. As pointed out below, it also violates a few of your own other mandates. Element 11.1 If the students are not learning OMM, not being tested on it sufficiently and it is not applied in the residencies (this is the current uproar in the osteopathic profession and the driving force behind some other proposed changes). Are you not violating your own mandate? If we aren't teaching it enough and making it applicable in EVERY specialty, (and thus the students and physicians don't see its applicability and don't want to learn it or be tested on it) how is watering down the education even more going to help at all?
Evidentiary documentation should ask for a copy/evidence of the curriculum map and/or program outcomes chart that demonstrates connection between learning outcomes assessment with program mission, goals, and objectives to continuously improve…..(if not contained in Assessment Plan).
Element 11.1: The evidentiary requirements for Element 11.1 now focus solely on learning assessments. Is the COCA interested in looking at how COMs assess and improve items such as IT, facilities, faculty adequacy, etc? If so, will that be included in each of those elements, or will the assessment plan, as submitted for Element 11.1 need to be all inclusive?

Element 12.1

Element 12.1: Incorporation of the Institution: (CORE)

A COM that is not affiliated with a parent institution must demonstrate incorporation as a non-profit or for-profit corporation with bylaws consistent with the COCA accreditation standards. The COM must have an autonomous appointed, functioning governing body that is broad in representation of education, finance, legal, health policy, and osteopathic medical expertise. The governing board must be responsible for appointing the Chief Executive Officer.

Proposed Revision:

A COM must demonstrate its incorporation as a non-profit or for-profit entity (e.g., corporation, limited liability company, etc.) with governing bylaws that are consistent with the COCA accreditation standards. The COM must have an autonomously appointed functioning governing body that is broad in representation of expertise in education, finance, law, health policy, and osteopathic medicine.

Submission 12.1: Incorporation of the Institution

1. *Provide the annual registration documents for ongoing incorporation for the COM.*
2. *Provide a copy of the bylaws of the governing body.*
3. *Provide a list of members of the governing body and their titles.*

Proposed Revision:

1. *Provide the annual registration documents for ongoing incorporation for the COM.*
2. *Provide a copy of the bylaws of the governing body.*
3. *Provide a list of members of the governing body and their titles.*
4. *Provide evidence of an annual assessment of the governing body's conflicts of interest.*

Comment

Element 12.1
If you are beginning to accept FP boarded faculty as your OMM chairs, are you not narrowing your base osteopathically? FP training in OMM is NOT the same as an OMM residency training. There is no FP on the planet that has the OMM training that I have - this is not a ding against anyone, but the fact that an FP doc ALSO needs FP CME, thus they are pulled in more than one direction. With only so much CME time and funds available, they cannot get the same level of education that I receive (and this gets compounded yearly as we gain knowledge based on the collective of what we know). Thus, bringing in FP docs as chairs for OMM goes against your mandate. It narrows your knowledge base.

So, I ask you, how can you support your own mandates of growing the profession and supporting the things that set us apart, osteopathic thinking and osteopathic manipulation, when you are trying to water down the department heads? It would seem to me that, if anything else, we should be RAISING the bar rather than lowering it. With the merging of our residency programs, this is our time to step up and not down.

Element 12.8

Element 12.8: Public Information

All public information published by a COM in its catalogs, student handbooks, advertising literature, or any other publicly available information must be presented in an accurate, fair, and complete manner.

Submission 12.8: Public Information

1. *Provide all documentation that demonstrates the institution's calendar, as well as its policies on grading, admissions, academic program requirements, tuition and fees, and refund.*

2. *In all COM publications, the COM must accurately represent its accreditation status and must include information on how to contact COCA.*

Comment

Element 12.8: Public Information (Proposed New Text):

~~All public information published by a COM in its catalogs, student handbooks, advertising literature, or any other publicly available information must be presented in an accurate, fair, and complete manner.~~

Explanation: There is no clear way to demonstrate compliance with this proposed standard. The COCA can only verify *the absence of compliance*. It is also not clear what the standard of accuracy should be. For example, almost every organization has outdated webpage content somewhere on its site. I believe the intent of this standard is to create a strong stance against dissemination of misleading information that may cause harm to the reader, the profession, or the public. That is a laudable goal.

Suggestion: The adjudication should be addressed by revising the *Complaint Procedures* and/or as part of routine review and inspection of documents, reports, and site visits. COCA should make the consequences of disseminating misleading information transparent and appropriately severe.

I would like to thank the COCA for the opportunity to comment on these proposed standards and for the tremendous amount of work the entire commission has accomplished. You continue to be a great service to the profession.

Element 12.10

Element 12.10: Academic Freedom

A COM must include in its publications policies regarding academic freedom. All such policies must be approved by the COM's governing board.

Submission 12.10: Academic Freedom

1. *Provide the institution's policies regarding academic freedom evidencing a commitment to academic freedom, intellectual freedom, freedom of expression, and respect for intellectual property rights.*

Comment

Element 12.10: Academic Freedom

The language of the following new element is inconsistent with the required documentation. I recommend the following revision:

A COM must include in its publications policies regarding academic freedom evidencing a commitment to academic freedom, intellectual freedom, freedom of expression, and respect for intellectual property rights. All such policies must be approved by the COM's governing board.