



AMERICAN OSTEOPATHIC ASSOCIATION

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**Basic Standards for
Residency Training in
Osteopathic Family Medicine
and Manipulative Treatment
(Includes Rural Training Standards in Appendix III)**

**American Osteopathic Association
and
American College of Osteopathic Family Physicians**

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1 **Basic Standards for Residency Training in**
2 **Osteopathic Training for Family Medicine and Manipulative Treatment**

3 **I. INTRODUCTION**

4 Residency training programs in Osteopathic Family Medicine and Manipulative Treatment
5 are designed to provide the osteopathic physician with advanced and concentrated training
6 in the specialty of osteopathic family medicine.

7 **II. MISSION**

8 Upon the successful completion of a residency in osteopathic family medicine and
9 manipulative treatment, the physician will be prepared to provide comprehensive
10 osteopathic health care to diverse populations and will be prepared for certification by the
11 American Board of Osteopathic Family Physicians (AOBFP).

12 **III. EDUCATIONAL PROGRAM GOALS**

13 The goal of osteopathic family medicine residency training is to provide instruction and
14 evaluation in the integration of osteopathic principles and osteopathic manipulative
15 treatment into the daily practice of family medicine. The program must document that
16 residents achieve all core competencies as described in the *AOA Basic Documents* and Core
17 Competency Compliance Program.

18 3.1 Osteopathic Philosophy and Osteopathic Manipulative Medicine

- 19 a. The Integration of Osteopathic Principles into the daily practice of family medicine.
20 b. The appropriate application of OMM to patient management.

21 3.2 Medical Knowledge

- 22 a. Maintain current knowledge of clinical medicine that reflects the majority of patient care
23 issues that present to osteopathic family medicine settings.
24 b. Maintain current knowledge of behavioral medicine that reflects the majority of patient
25 care issues that present to osteopathic family medicine settings.

26 3.3 Patient Care

- 27 a. Provide osteopathic family medicine patient care service in ambulatory continuity,
28 hospital, and extended care sites.
29 b. Provide acute care, chronic care, and preventative care across the full spectrum of ages
30 and genders.
31 c. Accurately gather information from all sources including patients, care givers, other
32 professionals, electronic sources, and paper sources.

33 3.4 Interpersonal & Communication Skills

- 34 a. Develop appropriate doctor-patient relationships in all family medicine settings.
35 b. Develop effective listening, written, oral and electronic communication skills in
36 professional interactions with patients, families and other health professionals.

- 1 3.5 Professionalism
- 2 a. Demonstrate respect for patients and families and advocate for the primacy of patient’s
- 3 welfare and autonomy.
- 4 b. Adhere to ethical principles in the practice of family medicine.
- 5 c. Demonstrate awareness and proper attention to issues of culture, religion, age, gender,
- 6 sexual orientation, and mental and physical disabilities.

7 3.6 Practice-Based Learning and Improvement

- 8 a. Apply the principles of evidence-based medicine to osteopathic family medicine.
- 9 b. Participate in practice based objective performance improvement projects in osteopathic
- 10 family medicine settings.

11 3.7 System-Based Practice

- 12 a. Effectively function within local and national health care delivery systems to provide
- 13 high quality osteopathic family medicine services.
- 14 b. Effectively function within a family medicine group to provide care to diverse
- 15 populations.

16 **IV. INSTITUTIONAL REQUIREMENTS**

17 4.1 The institution must have an organized department or section of Family Medicine.

18 4.2 The institution shall maintain a minimum program size of six filled Family Medicine

19 residents. This will be calculated as a five year rolling average.

20 a. Residencies operating in conjunction with an ACGME family medicine residency must

21 maintain a minimum program size of at least six filled total Family Medicine residents

22 (D.O. and M.D.)

23 b. Residencies operating in conjunction with combined programs in integrated family

24 medicine/ neuromusculoskeletal medicine or family medicine/ emergency medicine must

25 maintain a minimum number of six filled total family medicine residents (family medicine

26 plus integrated family medicine/neuromusculoskeletal medicine plus family

27 medicine/emergency medicine).

28 c. Residencies must utilize electronic health records (EHR) for the inpatient and outpatient

29 sites, or a plan in place with a target date for the implementation of an EHR system.

30 A. Facilities

31 4.1 The institution shall ensure that training facilities are organized to support patient care

32 activities by family medicine faculty and family medicine residents.

33 4.2 The primary training facilities shall be located in geographic proximity so as to allow for

34 efficient functioning of the educational program.

35 B. Hospitals

36 4.1 The program must utilize at least one hospital where family physicians have admitting

37 privileges. At a minimum, hospital training resources shall include:

38 a. Adult inpatient.

39 b. Critical care.

- 1 c. Surgery.
- 2 d. Obstetrics.
- 3 e. Emergency medicine.
- 4 f. Newborn care.
- 5 g. Pediatrics.

6 C. Extended Care Facilities

- 7 4.1 The program must utilize at least one extended care facility where family medicine residents
8 can care for patients under supervision by residency faculty.

9 D. Ambulatory Continuity of Care Site

- 10 4.1 The institution must provide a minimum of one osteopathic family medicine training site.
- 11 4.2 Multiple sites may be utilized only if all sites fully meet the standards set forth in this
12 document.
- 13 4.3 Each must be organized to support resident continuity of care training with a designated
14 panel of patients. At a minimum each site must provide the following:
- 15 a. Defined space for waiting area, examination rooms, resident's office, laboratory, business
16 office.
 - 17 b. OMM capability.
 - 18 c. On site procedural capability including: blood sugar, throat culture or rapid strep screen,
19 urinalysis, office microscopy, EKG, spirometry, and screening audiometry.
 - 20 d. Minor surgery capability.
 - 21 e. Online access to reference sources.
- 22 4.4 A professional medical records system that provides for quality assurance and quality
23 improvement processes must be utilized. At a minimum this shall include:
- 24 a. A system for documentation of structural examinations and OMM treatments.
 - 25 b. A mechanism to identify each patient's primary care physician.
 - 26 c. Chronic medication lists.
 - 27 d. Problem lists.
 - 28 e. Health maintenance flow sheets.
 - 29 f. Chronic disease management flow sheets.
- 30 4.5 The economic aspect of the site must be self-contained and patterned after that of a private
31 practice. At a minimum this shall include:
- 32 a. Appointments.
 - 33 b. Statements.
 - 34 c. Billing functions.
 - 35 d. Resident specific economic data.
- 36 4.6 Faculty must be available in appropriate numbers to ensure that residents always have readily
37 available on site supervision.
- 38 4.7 Support staff must be available in appropriate numbers to ensure efficient patient care.
- 39 4.8 Patient care visits at the continuity of care site must be predominantly by appointment. An
40 urgent care center may not be utilized for this portion of the training.

- 1 4.9 The continuity of care training site may be located in proximity with a multi-specialty site
2 provided the operations are separate.
3
- 4 4.10 While interdisciplinary training in ambulatory sites is encouraged, the presence of other
5 learners in the program (fellows, nurse practitioners, physician assistants, etc.) must not
6 interfere with the appointed residents' unencumbered supervision and education as per CMS
7 resident teaching guidelines and these standards.
8

9 V. PROGRAM REQUIREMENTS AND CONTENT

10 A. Program Requirements

- 11 5.1 The residency training must be thirty-six months in duration.
- 12 5.2 The program shall have a written curriculum that defines rotation and longitudinal time
13 requirements. All areas of the curriculum shall have written educational objectives and
14 evaluation methodologies.
- 15 5.3 The program must provide residents with regularly scheduled lectures, conferences,
16 workshops or educational activities. Didactics shall be available for an average of at least
17 five hours per week.
- 18 5.4 Residents shall become competent to meet family medicine group call responsibilities
19 through supervised opportunities to function in on-call situations.
- 20 5.5 The program shall maintain a participation rate of 90% in the AOBFP certification
21 examination within a five year period after completion of training. The rate will be
22 calculated from the time of the previous inspection.
- 23 5.6 The program shall maintain a 90% pass rate (three year rolling average) on the AOBFP
24 certifying examination.
- 25 5.7 Pilot or demonstration programs and/or projects will be considered. All such projects must
26 be approved in advance by the ACOFP Committee on Education and Evaluation (CEE).
27 Proposals must demonstrate equivalent training to the basic program as outlined in this
28 document.
- 29 5.8 Residents must have ready access to specialty-specific and other appropriate reference
30 material in print and/or electronic format. Electronic medical literature databases with
31 search capabilities shall be available.

32 B. Curriculum Requirements

33 *Continuity of Care Training*

- 34 5.1 Continuity of care must be taught as a core value of osteopathic family medicine.
- 35 a. Each resident is expected to maintain continuity of care for his/her patients when such
36 patients require hospitalization or consultation with other health care providers. The
37 resident must maintain participation in the decisions involving the health of the patient.
- 38 b. For those patients unable to visit the continuity of care site, training opportunities must
39 be provided for the resident to gain experience in home care and care in long-term care
40 facilities.

- 1 c. No rotation, discipline or other duties are to interfere with the intent or implementation
2 of the continuity of care experience portion of the residency.
- 3 d. The delineation of, and opportunity for, progressive resident responsibility for patient
4 management over the continuum of the program shall be provided.
- 5 5.2 The major focus of the training program must be on providing comprehensive primary care
6 for patients in the ambulatory continuity of care setting including the following:
- 7 a. An AOBFP-certified physician who supervises the osteopathic portion in the clinic is
8 required, but on a day-to-day basis, the residents may also be periodically overseen by an
9 American Board of Family Medicine-certified physician.
- 10 b. For a given resident the continuity of care experience may be at no more than two sites.
11 Each site must meet all facility requirements and all continuity educational requirements
12 as outlined in these standards.
- 13 c. If the residency program elects to use two sites, the resident may be assigned to both
14 sites simultaneously or each site for at least twelve consecutive months during OGME-2
15 and OGME-3. During OGME-1, the continuity experience must be at a single site.
- 16 d. The patient population of the continuity of care site must include a variety of patients in
17 terms of age, gender, and ethnicity.
- 18 e. Each resident must be assigned a designated panel of patients.
- 19 i. The resident must be responsible, under supervision, for the health care needs of
20 their assigned panel of patients.
- 21 ii. The resident must be clearly identified as the health care provider for the panel.
- 22 iii. As the skill and proficiency of the resident improves, an increasing daily patient load
23 is expected.
- 24 f. The three year continuity of care site experience must include at least 1,650 in-person
25 patient visits throughout the continuum of the residency program, and must meet a
26 minimum of the following cumulative continuity clinic patient visits before a resident
27 can advance to the next year of training or graduate:
28
29 OGME-1: 150 continuity patient visits.
30 OGME-2: 650 continuity patients visits.
31 OGME-3: 1,650 continuity patient visits..
- 32 g. Residents must see patients in the continuity of care site for a minimum of forty weeks
33 per year.
- 34 5.3 The ambulatory care experience must train residents to be both productive and efficient in a
35 primary care setting. At a minimum this must include:
- 36 a. Appropriate utilization of osteopathic principles and manipulative treatment.
37 b. Diagnose and manage medical and surgical conditions.
38 c. Perform office procedures.
39 d. Incorporate preventive measures.
40 e. Provide patient education.
41 f. Provide counseling.
42 g. Coordinate care.
43 h. Manage consultations.
44 i. Exposure to telephone visits and/or e-visits.

- 1 j. Electronic health records, or maintenance of complete paper chart records while
2 awaiting implementation of an EHR system.

3 *Osteopathic Manipulative Medicine*

- 4 5.4 The program must train residents in the clinical application of osteopathic manipulative
5 medicine. At a minimum this must include:
6 a. A clearly defined mechanism to measure and document competency in OMM.
7 b. Training in outpatient and inpatient settings.
8 c. Didactic instruction and hands on training.
9 d. Exposure to multiple treatment technique approaches.
10 e. Documentation of OMM in the medical record.
11 f. Coding and reimbursement.

12 *Inpatient Medicine*

- 13 5.5 The program must train residents to competently manage hospitalized patients. At a
14 minimum this must include:
15 a. Management of acute and chronic illness.
16 b. Appropriate consultation.
17 c. Coordination of care.
18 d. Manage transfer of care to and from the primary care setting.
19 e. Produce comprehensive medical records.
20 f. Utilization management and discharge planning.

21 *Emergency Medicine*

- 22 5.6 The program must provide at least eight weeks or two (2) months of training in emergency
23 medicine, including at least four weeks or one (1) month of training during the OGME-1
24 year.
25 5.7 At a minimum emergency medicine training shall include:
26 a. Didactic and clinical training.
27 b. Triage emergency patients of all ages.
28 c. Certification in ACLS.
29 d. Stabilize and provide initial treatment for medical emergencies.
30 e. Stabilize and provide initial treatment for surgical emergencies.
31 f. Stabilize and provide initial treatment for psychiatric emergencies.
32 g. Stabilize and provide initial treatment for pediatric emergencies.

33 *Internal Medicine*

- 34 5.8 The program must provide at least thirty-two weeks or eight (8) months of clinical training
35 in internal medicine disciplines, including at least eight weeks or two (2) months of general
36 inpatient internal medicine experiences during the OGME-1 year. This requirement can be
37 met by either inpatient internal medicine or inpatient family medicine service.
38 5.9 At a minimum internal medicine training must include:
39 a. Twenty-four weeks or six (6) months of inpatient experience.
40 b. Four weeks of training or one (1) month in critical care medicine.
41 c. Didactic and clinical training.
42 5.10 Internal medicine training shall include exposure to the following disciplines, in either
43 inpatient or outpatient settings through either formal rotations or as part of other inpatient
44 or outpatient patient care experiences:
45 a. Allergy and immunology.
46 b. Cardiology.

- 1 c. Dermatology.
 - 2 d. Endocrinology.
 - 3 e. Gastroenterology.
 - 4 f. Hematology.
 - 5 g. Infectious diseases.
 - 6 h. Nephrology.
 - 7 i. Neurology.
 - 8 j. Oncology.
 - 9 k. Pulmonology.
 - 10 l. Rheumatology.
- 11 5.11 The training program must provide an opportunity for the resident to develop competency in:
- 12 a. The management of hospitalized adult patients.
 - 13 b. Cooperative management of patients with sub-specialists colleagues.
 - 14 c. Pre-operative medical evaluation.

15 *Women's Health*

- 16 5.12 The program must provide at least twelve weeks or three (3) months of training in women's
- 17 health, including at least four weeks or one (1) month of training during the OGME-1 year.
- 18 5.13 At a minimum training in women's health must include:
- 19 a. Didactic and clinical training experiences.
 - 20 b. Gender specific health care needs of women.
 - 21 c. Domestic violence identification and prevention.
 - 22 d. Gynecology.
 - 23 e. Obstetrics.
 - 24 f. Breast Disease.
- 25 5.14 The gynecological portion of this training experience shall include both ambulatory and in-
- 26 hospital patient care. At a minimum this shall include:
- 27 a. Family planning.
 - 28 b. Preventive medicine.
 - 29 c. Management of the abnormal PAP smear.
 - 30 d. Disorders of menstruation.
 - 31 e. Gynecological infections.
- 32 5.15 The dedicated obstetrical portion of this training experience shall include both ambulatory
- 33 and in-hospital patient care. At a minimum this shall include:
- 34 a. Prenatal care.
 - 35 b. Labor and delivery.
 - 36 c. Postnatal care.
 - 37 d. Medical complications of pregnancy.

38 *Pediatrics and Adolescent Medicine*

- 39 5.16 The program must provide at least sixteen weeks or four (4) months of training in pediatrics
- 40 and adolescent medicine, including at least four weeks or one (1) month of training during
- 41 the OGME-1 year.
- 42 5.17 At a minimum this shall include:
- 43 a. Care of the newborn.
 - 44 b. Ambulatory pediatrics.
 - 45 c. Well childcare.
 - 46 d. Inpatient pediatrics.

1 e. Emergency care of children.

2 *Surgery*

3 5.18 The program must provide at least sixteen weeks or four (4) months of training in surgical
4 disciplines, including at least four weeks or one (1) month of general in-patient surgery
5 training during the OGME-1 year.

6 5.19 At a minimum this shall include:

- 7 a. Preoperative and post-operative care.
- 8 b. Training in the following sub-specialties, which may be ambulatory or inpatient.
- 9 c. Ophthalmology.
- 10 e. Orthopedics.
- 11 d. Urology.
- 12 e. ENT.

13 *Geriatrics*

14 5.20 The program must provide at least 100 hours or one (1) month of training in the care of the
15 geriatric patient. This is in addition to training that occurs through the residents' continuity
16 of care patient panel, general internal medicine rotations or nursing home continuity of care
17 experience.

18 5.21 At a minimum this shall include:

- 19 a. Physiological changes of aging.
- 20 b. Pharmacokinetics in the elderly.
- 21 c. Functional assessment of the elderly.
- 22 d. Extended care facility management.
- 23 e. Hospice.
- 24 f. Home care.

25 *Behavioral Medicine*

26 5.22 The program must include training in behavioral science. At a minimum this shall include:

- 27 a. Psychiatric and psychological diagnoses common to family medicine.
- 28 b. The treatment of substance abuse.
- 29 c. Didactic instruction and clinical experiences.
- 30 d. Interviewing skills.
- 31 e. Counseling skills.
- 32 f. Psychopharmacology.
- 33 g. Physician well being.

34 *Practice Management*

35 5.23 The program must provide at least 100 hours or one (1) month of structured educational
36 experiences in practice management.

37 5.24 This training shall include:

- 38 a. Debt management.
- 39 b. Retirement planning.
- 40 c. Financial planning.
- 41 d. Disability insurance.
- 42 e. Medical liability insurance.
- 43 f. Risk management.
- 44 g. Coding.
- 45 h. HIPAA requirements in the ambulatory setting.
- 46 i. OSHA requirements for private practices.
- 47 j. Clinical Performance/outcomes data.

- 1 k. Payer mix and practice overhead management.
- 2 l. Personnel management.
- 3 m. Contract review and negotiation.
- 4 5.25 The program must utilize actual practice financial data to teach the principals of office
- 5 practice management. At a minimum this must include resident specific practice data from
- 6 the continuity of care training site.

7 *Sports Medicine*

- 8 5.26 The program must provide at least 50 hours or two (2) weeks of training in Sports Medicine.
- 9 This is in addition to time spent in the continuity of care ambulatory site and is separate
- 10 from an orthopedics rotation. At a minimum this must include:
- 11 a. Pre-participation assessment.
- 12 b. Didactic and clinical experiences.
- 13 c. Management of uncomplicated sports related injuries.
- 14 d. Rehabilitation of athletic related injuries.
- 15 e. Injury prevention/training.

16 *Diagnostic Imaging*

- 17 5.27 There must be a structured curriculum to train the resident in Diagnostic Imaging. At a
- 18 minimum this shall include:
- 19 a. Didactic and clinical experiences.
- 20 b. Utilization of appropriate radiographic studies.

21 *Procedural Medicine*

- 22 5.28 The program must have defined mechanisms to train residents to competency in the
- 23 following procedures:
- 24 a. Joint injections.
- 25 b. Biopsy of dermal lesions.
- 26 c. Excision of subcutaneous lesions.
- 27 d. Incision and drainage of abscess.
- 28 e. Cryosurgery of skin.
- 29 f. Curettage of skin lesion.
- 30 g. Laceration repair.
- 31 h. Endometrial biopsy.
- 32 i. Office microscopy.
- 33 j. Splinting.
- 34 k. EKG interpretation.
- 35 l. Office spirometry.
- 36 m. Toenail removal.
- 37 n. Defibrillation.
- 38 o. Removal of cerumen from ear canal.
- 39 p. Endotracheal intubation.

40 *Community Medicine*

- 41 5.29 The program must provide 50 hours or two (2) weeks of documented training in community
- 42 medicine. This shall include time spent in any of the following experiences:
- 43 a. Occupational health.
- 44 b. Mental health agencies.
- 45 c. Community based screening programs.
- 46 d. Public health agencies.
- 47 e. Community health centers.

- 1 f. Free clinics.
- 2 g. Drug and alcohol treatment centers.
- 3 h. School health programs.
- 4 i. Homeless shelters.

5 *Electives*

6 5.30 There shall be a minimum of sixteen weeks or four (4) months and a maximum of twenty-
7 eight weeks or seven (7) months of supervised electives available to all residents during the
8 course of the residency.

9 *Disease Prevention and Wellness*

- 10 5.31 The program must provide training in disease prevention and wellness promotion. Utilizing
11 didactic and clinical experiences residents shall become competent in:
- 12 a. Selection, critique, and implementation of evidence based practice guidelines.
 - 13 b. Provision of immunizations for adult, adolescent, and pediatric patients.
 - 14 c. Selection and interpretation of screening tests.
 - 15 d. Counseling patients to promote weight loss, exercise, and smoking cessation.

16 *Patient Safety and Quality Improvement*

- 17 5.32 The program must provide training in patient safety and quality improvement. At a
18 minimum this shall include:
- 19 a. Identification and analysis of inpatient and ambulatory measures of quality.
 - 20 b. Utilization of quality measurements to improve patient care.
 - 21 c. Participation in at least one national or regional quality improvement registry.
 - 22 d. Training in the principles of the Patient Centered Medical Home (PCMH).
 - 23 e. Training in Transitions of Care to ensure patient safety.

24 **VI. PROGRAM DIRECTOR/FACULTY**

25 **A. Program Director**

- 26 6.1 Each program must have a single Program Director who is compensated by the institution
27 to devote a minimum of 1,200 hours per year to residency training activities. This may
28 include time spent in teaching, supervising, program administration, and/or scholarly
29 activities.
- 30 6.2 Program directors and faculty must participate in faculty development defined as content that
31 is accredited by the AOA, AMA, or AAFP for continuing medical education (CME) and is
32 specifically dedicated to development of faculty. As a whole, faculty development should
33 contain elements that are specific to osteopathic training.

34 **B. Qualifications**

- 35 6.1 In addition to meeting all Program Director qualifications stipulated in the AOA Basic
36 Documents, the Program Director must meet the following qualifications:
- 37 a. At least three years of family medicine experience (not including time as a resident).
 - 38 b. Current board certification in Osteopathic Family Medicine and Manipulative Treatment
39 by the American Osteopathic Board of Family Physicians and be registered in an
40 Osteopathic Continuous Certification (OCC) track by 2020.
 - 41 c. Active staff membership in the department of family medicine or its equivalent.
 - 42 d. Engaged in patient care as a family physician.
- 43 6.2 A new Program Director of a residency with more than twelve approved slots shall fulfill
44 one of the following:

- 1 a. Have served as Program Director of another residency for no less than three years, or
- 2 b. Have served as Associate Program Director or a full-time faculty member of a residency
- 3 for no less than three years.
- 4 6.3 A new Program Director must be approved by the PTRC upon recommendation of the
- 5 ACOFP Committee on Education and Evaluation.
- 6 6.4 Program Directors may be approved by the Executive Committee of the CEE on an interim
- 7 basis for a maximum of 18 months, with re-evaluation after that period for a maximum of
- 8 three (3) years on an interim basis in geographic areas where a fully qualified Program
- 9 Director is not immediately available. .
- 10 C. Responsibilities
- 11 6.1 The Program Director must have sole responsibility and authority for the educational
- 12 content and conduct of the residency. The Program Director's authority in directing the
- 13 residency program must be defined in the program documents of the institution.
- 14 6.2 In addition to meeting all Program Director responsibilities stipulated in the AOA Basic
- 15 Documents, the Program Director's responsibilities shall include:
- 16 a. Leading the family medicine faculty in developing, scheduling, and evaluating all
- 17 educational experiences.
- 18 b. Selection and evaluation of program faculty.
- 19 c. Ensuring proper supervision during all educational experiences.
- 20 6.3 The Program Director or physician faculty designee must submit, one (1) Board quality
- 21 question, and have accepted, one In-Service Examination question each academic year in an
- 22 area assigned by the ACOFP CEE In-Service Examination Committee.
- 23 D. Family Medicine Residency Faculty
- 24 6.1 All programs regardless of the number of residents must have a minimum of two family
- 25 physician faculties including the Program Director.
- 26 6.2 The faculty, as a group, shall provide and teach a comprehensive spectrum of patient care,
- 27 including but not limited to: women's health, adult medicine and pediatrics.
- 28 6.3 There must be at least one (1) full-time equivalent (FTE) family physician faculty for each six
- 29 (6) residents in the program.
- 30 6.4 A faculty member is considered full-time based on time devoted to residency-related
- 31 activities (teaching as a clinical preceptor, administration, scholarship). Any of the following
- 32 methods may be utilized to determine FTE status:
- 33 a. 24 hours/week.
- 34 b. 1,200 hours/year.
- 35 c. 100 hours/month.
- 36 6.5 There shall not be greater than a 1:4 supervisor to resident ratio per CMS rules and ACOFP
- 37 basic standards.
- 38 6.6 There must be residency faculty with admitting privileges in the hospital(s) where the
- 39 residents' patients are hospitalized.
- 40 6.7 The family medicine program faculty shall, as a group, be qualified to teach all required
- 41 procedures as listed in this document.

1 E. Qualifications

2 6.1 In addition to meeting all faculty qualifications stipulated in the AOA Basic Documents,
3 family medicine faculty members shall:

- 4 a. Hold a current licensed to practice medicine in the state in which the training is located.
- 5 b. Be certified in family medicine and be registered in an Osteopathic Continuous
6 Certification (OCC) track by 2020.
- 7 c. Commit specific time to patient care, independent of supervision of residents.

8 6.2

- 9 a. Be board certified by the AOBFP or ABFM.
- 10 b. Have a reporting relationship to the Program Director.

11 F. Faculty Research and Scholarly Activity

12 6.1 The faculty as a whole must demonstrate involvement in scholarly activity. At a minimum
13 this must include the following:

- 14 a. Participation in clinical discussions and conferences.
- 15 b. Participation in national and regional professional societies, particularly through
16 presentations and publications.
- 17 c. Participation in research, especially projects that are funded following peer review.
- 18 d. Provision of guidance and support to residents involved in research.

19 G. Residency Support Staff

- 20 a. The program must have a designated residency program coordinator.

21 **VII. RESIDENT REQUIREMENTS**

22 A. Appointment of Residents

23 7.1 Have completed an AOA approved OGME-1 year prior to appointment to an OGME-2
24 position.

25 B. Resident Responsibilities

26 7.1 During the training program, the resident must:

- 27 a. Follow the schedule set forth by the Program Director.
- 28 b. Complete all assignments in the time frame specified by the program director or
29 preceptor.
- 30 c. Keep a log of each procedure performed.
- 31 d. Participate in the annual AOBFP In-Service Exam produced and administered by
32 ACOFP OR AOBFP In-Service Exam Plus produced and administered by ACOFP
- 33 e. Attend a minimum of one of the following: national ACOFP annual convention or an
34 AOA OMED, registered as an ACOFP Family Physician.
- 35

36 C. Research and Scholarly Activity Requirements

37 7.1 The participation of each resident in a scholarship activity is required. This requirement can
38 be met by participation in or completion of any of the following:

- 39 a. A resident scholarly project within the department of family medicine.
- 40 b. Institutional or regional research programs in which family physicians are actively
41 involved.
- 42 c. Author an original paper on a health-care related topic.

- d. Presentation at a state, regional, or national meeting.
- e. Authoring a grant.

VIII. EVALUATION

A. Evaluation of Residents

- 8.1 The program shall maintain a permanent record of formative and summative evaluations for each resident.

B. Formative

- 8.1 There must be semi-annual written evaluations of the knowledge and competencies of each resident. These evaluations shall be signed by the resident and by the Program Director.
- 8.2 Resident evaluations shall contain input from patients and from non-physician team members.
- 8.3 Performance on the AOBFP In-Service Exam produced and administered by ACOFP OR AOBFP In-Service Exam Plus produced and administered by ACOFP will be reviewed with each resident.

C. Promotion

- 8.1 Residents shall be advanced to positions of higher responsibility only on the basis of evidence of their satisfactory and progressive professional growth.
- 8.2 The privilege of progressive authority and responsibility, conditional independence and the supervisory role in patient care delegated to each resident must be assigned by the Program Director with annual approval by the institution's osteopathic graduate medical education committee (OGMEC).

D. Summative

- 8.1 The Program Director's final summative evaluation of each resident who completes the program shall include a review of the resident's competencies at the completion of training and must verify that the resident has demonstrated sufficient professional ability to practice competently and independently.
- 8.2 The ACOFP Competency-Based Evaluation, or an equivalent, shall be a component of the summative evaluation.
- 8.3 In cases of early termination of a resident's program, the Program Director shall provide the resident with written documentation regarding which rotations, if any, were completed satisfactorily. The AOA Postdoctoral Training Division and the ACOFP shall be notified of the early termination.

E. Evaluation of Faculty

- 8.1 All teaching faculty must be evaluated by residents.
- 8.2 At the completion of each rotation, the resident shall evaluate the rotation trainer(s).
- 8.3 These evaluations shall be reviewed by the Program Director.
- 8.4 All family medicine teaching faculty must be evaluated annually. This shall include evaluation of teaching ability, clinical knowledge, and communication skills. The evaluation shall include a mechanism for anonymous input by the residents.

- 1 F. Evaluation of Program
- 2 8.1 The educational effectiveness of the program must be evaluated in a regular and systemic
3 manner.
- 4 a. This shall include review of curriculum and success in meeting the educational goals and the
5 learning needs of the residents.
- 6 b. It will also include a review of the teaching responsibilities of the faculty, the availability of
7 administrative and financial support, and of the availability of teaching resources.
- 8 c. This evaluation shall examine the balance between education, scholarship, and service.
- 9 d. The faculty must hold regular meetings to accomplish these reviews.
- 10 e. At least one resident representative must participate in these reviews.
- 11 f. The evaluation shall include a mechanism for anonymous written input from residents
12 regarding the program's effectiveness.
- 13 8.2 At the completion of each rotation, the resident shall evaluate the educational quality of the
14 rotation.
- 15 a. These evaluations shall be reviewed by the Program Director.
- 16 8.3 The Program Director shall prepare an annual written program review.
- 17 a. This shall note the program's compliance or non-compliance with these standards and shall
18 be reviewed by the institution's graduate medical education committee.
- 19 b. This review may be waived during a year in which the institution completes a formal internal
20 review.
- 21 8.4 Each program shall survey its graduates at least every three years.
- 22 a. Feedback on demographic and practice profiles, licensure and board certification, the
23 graduates' perceptions of the relevancy of training to practice and suggestions for improved
24 training and new areas of interest shall be obtained.
- 25 G. Evaluation of Patient Care
- 26 8.1 There must be a mechanism to formally evaluate the care provided by the residents and
27 faculty in both inpatient and outpatient settings.
- 28 8.2 There must be evidence that this information is used to improve education and patient care.
29

1 **APPENDIX I**

2 **Guidelines for Advanced Placement**

- 3 A. Residents entering osteopathic family medicine residency programs who have taken previous
4 residency training in accredited osteopathic or allopathic residency programs may request
5 advanced placement. The Program Director of the accepting program is responsible for
6 reviewing previous training and comparing it to the training standards of this document. In
7 no instance is the Program Director compelled to recommend advanced standing.
- 8 B. The Program Director shall forward requests for advanced standing to the ACOFP
9 Committee on Education and Evaluation. The Committee on Education and Evaluation
10 shall report to the AOA Program and Trainee Review Council all approvals for advanced
11 placement.
- 12 C. The CEE will review all requests for advanced standing and will grant credit based on the
13 following criteria:
- 14 1. A maximum of twelve (12) months (52 weeks) of advanced standing shall be granted
15 for AOA approved OGME-1 training.
 - 16 2. For prior training in osteopathic family medicine, month-for-month credit for previous
17 training shall be awarded.
 - 18 3. For prior training in any discipline other than Osteopathic Family Medicine, the
19 program director will evaluate completed rotations to determine if any are applicable to
20 osteopathic family medicine. A maximum of six (6) months (24 weeks) of advanced
21 standing, beyond an AOA-approved OGME-1 year, shall be recommended for
22 approval.
 - 23 4. For prior training completed in allopathic family medicine, AOA approval of the
24 OGME-1 year is required. A maximum of twelve (12) months (52 weeks) shall be
25 granted beyond the OGME-1 year.
- 26 D. All transferring residents must complete the ambulatory continuity training requirements
27 described in the Basic Standards for Residency Training in Osteopathic Family Medicine and
28 Manipulative Treatment. The Committee on Education and Evaluation may modify this
29 requirement when a resident transfers due to a program closure.

30

1 **APPENDIX II**

2 **Documentation of Program Completion**

- 3 A. For residents completing an AOA-approved osteopathic family medicine program, the
4 Program Director must document, on forms provided by ACOFP, that the resident has
5 completed all requirements for training as stipulated in the Basic Standards for Residency
6 Training in Osteopathic Family Medicine and Manipulative Treatment. Any portion of
7 training that includes advanced standing must be clearly defined.
- 8 1. If basic standard training requirements change during an individual resident’s training
9 program, the program director will require the resident to complete either:
- 10 a. All basic standard requirements in place at the beginning of residency training, or
11 b. All revised basic standard requirements in place at the time of residency
12 graduation.
- 13 2. The Program Director must submit a Final Resident’s Report within thirty (30) days
14 of program completion.
- 15 3. If training includes an ACGME approved internship, the resident must apply to the
16 AOA Program and Trainee Review Council for OGME-1 approval. This approval
17 must be granted before program complete status may be granted.
- 18 4. The ACOFP Committee on Education and Evaluation will review documentation
19 and verify program complete status.

20

1 **APPENDIX III: RURAL TRAINING GUIDELINES**

2 SECTION I

3 The American College of Osteopathic Family Physicians encourages the training of physicians
4 competent to enter rural (i.e., non-metropolitan) practice with the following statement of
5 convictions:

- 6 A. The country has a continuing and increasingly pressing need for rural physicians.
- 7 B. The specialty best suited to serve the rural populace is Family Medicine.
- 8 C. A disproportionate number of family physicians currently in rural practice are DOs.
- 9 D. Rural practice demands a different level of ability than does that of the urban environ.
- 10 E. The physician and the rural community are served best by a training program tailored to rural
11 needs.
- 12 F. Family Medicine residents seeking training in anticipation of rural practice should have the
13 assurance of the ACOFP that those programs advertising rural tracks do indeed provide
14 adequate training.

15 SECTION II

16 **REQUIREMENTS FOR APPROVAL AS A RURAL TRAINING PROGRAM**

17 Upon recognition and approval of the curriculum in Articles II and III by the ACOFP Committee
18 on Education & Evaluation, the program would receive an official designation as a rural training
19 site. No additional certification would be provided to a resident completing the training.

20 RURAL EXPOSURE

21
22 The first year of training will remain as it is currently structured in the OGME-1 year of the Family
23 Medicine residency curriculum. During years two (OGME-2) and three (OGME-3) the resident
24 must spend time in the rural setting. The definition of rural shall remain that designated by the
25 federal government. If all curricular elements can be met, the entire two years could be
26 accomplished in the rural setting.

27 The primary emphasis of this exposure is to develop an appreciation for the delivery and
28 management (funding, training, staffing, reimbursement) of rural healthcare systems, including:

- 29 A. Behavioral skills related to lifestyle issues of the physician and physician's family.
- 30 B. Exposure to the social issues of rural practice: after hours call, relationships with colleagues
31 and distant consultants, emergency department coverage, resource utilization, community

- 1 leadership, confidentiality.
- 2 C. Experience in leading, managing, and team membership, in rural health resources: mental
3 health facilities, pastoral counseling, county health departments, public health responsibilities,
4 etc.
- 5 D. Delivery of medical care in a collaborative and interactive manner with nurse practitioners,
6 physician assistants, social workers, physical therapists, home health nurses and hospice
7 workers.
- 8 E. Funding, training, staffing and reimbursements appropriate to rural health systems

9 SECTION III

10 **Curricular Requirements Specific to Rural Training Emphasis**
11 **Osteopathic Family Medicine Residency Programs**

- 12 A. Rural training programs may have training sites that are geographically distant from the
13 sponsoring institution.
- 14 B. The continuity of care training site must be located at a rural site (non-urban, non-suburban).
- 15 C. The major focus must be on providing comprehensive primary care for patients in all
16 settings that exist in rural environments.
- 17 D. The program must provide training in the management of critical care patients including
18 stabilization and transport.
- 19 E. The program must have a defined curriculum to train residents that leads to procedural
20 competency in paracentesis, thoracentesis, chest tube placement, central line placement,
21 pericardiocentesis, and emergency tracheostomy.
- 22 F. Opportunities for certification in ATLS ALSO, PALS, and NRP must be provided.
- 23 G. Experience must be provided in diagnosis and management of common emergency
24 department cases to include major trauma.
- 25 H. Additional exposure to geriatrics as experienced in a rural setting is required (home service
26 coordination, home visits, etc.)
- 27 I. Training in the management of critical care patients, including ventilator management must
28 be provided.
- 29 J. The program must provide training to assure competency as a first assistant in the surgical
30 suite, conscious sedation, endoscopic procedures and office procedural skills.
- 31 K. Training must be provided to assure competency in neonatal resuscitation, intubation,

- 1 venipuncture, arterial puncture, lumbar puncture, umbilical catheter placement, newborn and
2 infant stabilization, as well as indications for transport.
- 3 L. The program must provide additional experience in obstetrics to include high-risk
4 emergency care, as well as obstetrical procedures of ultrasonography, outlet forceps, and
5 vacuum extraction.
- 6 M. Training in the gynecologic procedures dilation and curettage, cervical and endometrial
7 biopsy, and colposcopy must be provided and documented.
- 8 N. Experience in the basics of Occupational Medicine emphasizing the work types seen in rural
9 practice must be provided.
- 10 O. Documented training in the ability to interpret acute condition plain radiographs is required.
- 11 P. Experience must be provided for athletic training, the role of the team physician, fracture
12 management (closed reduction, splinting, casting), reduction of dislocations, and distant
13 consultation/coordination with orthopedic surgeons.
- 14 Q. Exposure to rural mental health systems and training in the diagnosis and management of
15 acute psychiatric emergencies must be provided and documented.
- 16
- 17 R. All existing curricular requirements.