AMERICAN OSTEOPATHIC ASSOCIATION

Basic Standards for Community Based Residency Training in Pediatrics

American Osteopathic Association
and the
American College of Osteopathic Pediatricians

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SECTION I - Introduction

These are the basic standards for community based residency training in pediatrics as approved by the American Osteopathic Association (AOA) and the American College of Osteopathic Pediatricians (ACOP). These standards are designed to provide the osteopathic resident with advanced and concentrated training in community based pediatrics.

SECTION II - Mission

The specialty of pediatrics consists of the study and management of care of newborns, infants, children and adolescents, as well as the diagnosis and treatment of their diseases. The purposes of an osteopathic community based pediatric training program are to:

A. Provide training and experience to enable the resident to care for the whole patient, incorporating osteopathic **PRINCIPLES AND PHILOSOPHY** in the practice of pediatrics.

B. Provide continuity of advanced educational experience and increased patient care responsibilities to prepare the resident for the complete medical care of the pediatric patient **IN THE COMMUNITY**.

C. Provide a structured educational program that will enable the resident, upon completion of training, to demonstrate expertise in clinical proficiency and in the technical skills required to perform at a level expected by a peer group of qualified community based pediatricians.

SECTION III- Educational Program Goals

The goals of the educational programs of the pediatric residencies are based on the core competencies as outlined by the American Osteopathic Association. Each Core competency is outlined below and is adapted to reflect the specific needs of the pediatric profession.

Competency 1: Osteopathic Philosophy Principles and Manipulative Treatment:

Pediatric residents shall demonstrate and apply knowledge of accepted standards in OPP/OMT appropriate to pediatrics. The educational goal is to train a skilled and competent osteopathic pediatrician who remains dedicated to life-long learning and to practice habits in osteopathic philosophy and manipulative medicine.

Competency 2: Pediatric Knowledge and Its Application Into Osteopathic Medical Practice:

Pediatric residents must demonstrate and apply integrative knowledge of accepted standards of clinical pediatrics and OPP, remain current with new developments in pediatrics, and participate in life-long learning activities, including research.

Compentency 3: Osteopathic Patient Care:

Osteopathic pediatric residents must demonstrate the ability to effectively treat patients, provide pediatric care that incorporates the osteopathic philosophy, patient empathy, awareness of behavioral issues, the incorporation of preventive medicine, and health promotion.

Competency 4: Interpersonal and Communication Skills in Osteopathic Pediatric Practice:

Residents must demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.

Competency 5: Professionalism in Osteopathic Medical Practice:

Residents mustuphold the Osteopathic Oath in the conduct of their professional activities that promote advocacy of patient welfare, adherence to ethical principles, collaboration with health professionals, life-long learning, and sensitivity to a diverse patient population. Residents shall be cognizant of their own physical and mental health in order to care effectively for patients.

Competency 6: Osteopathic Medical Practice-Based Learning and Improvement:

Residents must demonstrate the ability to critically evaluate their methods of clinical practice, integrate evidence-based traditional and osteopathic medical principles into patient care, show an understanding of research methods, and improve patient care practices.

Competency 7: System-Based Osteopathic Medical Practice:

Residents must demonstrate an understanding of health care delivery systems, provide effective and qualitative osteopathic patient care within the system, and practice cost-effective medicine.

SECTION IV - Community Based Institutional Requirements

1. The community based institution must provide patient care experience to train a minimum of three (3) residents in pediatrics. No program may accept a new resident unless at least two (2) other residents are also in the program. A new program will have three (3) years to enact this requirement.
2. The community based institution shall provide for the interaction between the pediatric service and other departments including, but not limited to, obstetrics, medicine, pathology, radiology, emergency medicine, and surgery.
3. The teaching staff shall be composed of physicians with diversified experience in clinical pediatrics, basic and behavioral sciences and allied health fields.
4. The community based institution must provide an opportunity for exposure in a supervised ambulatory site for continuity of care training. Institutional clinics or pediatricians' offices may be used. The residents must function as the patients' primary care providers. **UNDER A PRECEPTING PEDIATRICIAN'S SUPERVISION.**

SECTION V – Program Requirements and Content

5.1. The residency training program in pediatrics shall be three (3) years (thirty-six (36) months general pediatric medicine**. "IF THE OGME-1 YEAR IS A ROTATING INTERSHIP, IT SHALL BE FOLLOWED BY 3 YEARS (36 MONTHS) OF COMMUNITY BASED PEDIATRIC RESIDENCY."**

5.2. At least twenty-four (24) months of the required thirty-six (36) months must be served IN the same program unless an exemption is granted by the ACOP.

5.3. The general educational content of the residency training program must include:

5.3.1. The neuromuscular component of disease and the osteopathic concept of evaluating and treating the whole patient in inpatient care and ambulatory care settings.

5.3.2. Development of basic cognitive skills and knowledge pertaining to normal physiology and pathophysiology of the body systems and the correlating clinical applications of medical diagnosis and management.

5.3.3. Experience and training in the following procedures and development of respective interpretation skills. Verification by the program director of experience and competency in required procedures is necessary.

Required:

- developmental screening,
- intradermal subcutaneous and intramuscular injections,
- lumbar puncture,
- intravenous access,
- endotracheal intubation,
- umbilical artery lines,
- umbilical venous lines,
- arterial blood gas sampling,
- suturing of lacerations,
- bladder catheterization,
- phlebotomy,
- newborn resuscitation,
- intraosseous access,
- procedural sedation,
- pelvic examinations,
- Basic Life Support (BLS), Pediatric Advanced Life Support (PALS) and Neonatal Resuscitation Program (NRP).

5.3.4. Bio-psychosocial knowledge and skills shall be taught in both **DIDACTIC CLASSROOM** and **PATIENT CARE** settings throughout the residency. These shall include such factors as medical sociology doctor/patient/parent/guardian/family communication, crisis recognition and intervention, the effects of psychological components of health states, interviewing skills, recognition and management of uncomplicated behavioral disorders, substance abuse care, and death and dying.

5.3.5. All elective training must be approved by the program director.

5.3.6. Ambulatory Care: To include the traditional care of the well child and also the child with acute illness, trauma, poisoning and chronic disorders. Training must enable the resident to develop skills in counseling and guidance, developmental appraisal, referral, consultation, health maintenance assessment and the management of a practice as well as to prepare the resident to assist in the continuing care of the developmentally disabled child. Participation in the activities of the outpatient department and the emergency medicine department are important, as they pertain to the pediatric patient including child abuse evaluations, treatment and reporting.

5.3.7. Inpatient Care: To include the management and understanding of functional and organic diseases of newborns, infants, children and adolescents. Training shall enable the resident to appraise and react to the rapidly changing clinical status of the patient as well as to handle multiple or conflicting consultations and coordinate services for individual patients requiring multidisciplinary care.

5.3.8. Experience in the delivery room with newborn care and resuscitation, enabling the resident to become skilled in the process of infant stabilization when specialized facilities are not available prior to transfer. The resident must be capable of stabilizing the seriously ill newborn.

5.3.9. Experience in the newborn nursery to enable the resident to become proficient in the management of such conditions as asphyxia, hypoglycemia, jaundice, respiratory distress syndrome, sepsis and other conditions inherent in the management of a neonate. The resident shall demonstrate knowledge of the normal growth and development of the fetus and the effects of drugs, infection and malnutrition.

5.3.10. The training program shall make available pediatric board review opportunities to each resident, **IN ADDITON TO** weekly programs (such as Nelson's Club or Journal Club).

5.3.11. Residents must attend at least one ACOP meeting prior to completing their residency.

5.3.12. Provide training to make sound medical judgments with an understanding of ethical and legal considerations as well as cultural diversities and the care of the patient.

5.4. Advanced Placement

5.4.1. Advanced placement into osteopathic pediatric medicine from non-pediatric medicine fields or after OGME-1 Traditional.

a. One (1) month of credit may be awarded for each month of training in general pediatrics or its subspecialties taken under the direction of a pediatrician in an AOA- or ACGME-approved program.

b. Credit may be granted in non-pediatric medicine specialties to include radiology, pathology, emergency medicine and ambulatory surgical specialties (gynecology, orthopedics, ENT) up to a maximum of two (2) months credit towards a total program.

c. Total advance placement cannot exceed twelve (12) months towards the entire program.

5.4.2. Mechanism to request advanced placement. A request for advanced placement must be received from both the resident and the current pediatric program director and must include:

a. A letter requesting advanced placement standing from the resident

b. A letter requesting advanced placement standing from program director

c. ACOP resident annual report for previous training.

d. AOA program director report for previous training.

e. Determination of advanced placement within these guidelines shall be made by the ACOP GME Committee based on the concept of equivalency.

5.5. At least twenty-four (24) months of training must include actual clinical pediatric patient responsibility, and no more than six (6) months of the thirty-six (36) months of training can be assigned in non-pediatric services.

5.6. The program shall provide exposure to medical research/review skills and methods of presentation including

- How to read and understand the medical literature,
- Research types, methodology and statistics,
- Evidence based medicine,
- Quality, performance improvement and patient safety initiatives,
- Health services research, policies, administration (i.e., access of population groups to healthcare, compliance issues, public policies, managed care, etc.).

5.7. Each resident must participate in scholarly activity as determined by the program director.

5.8. Community Based Pediatric Training

5.8.1. Ambulatory

The curriculum must include at least eighteen (18) months in **VARIOUS** community based ambulatory settings, including general pediatric clinic, acute illness clinic, emergency department, private practice settings, adolescent clinics and behavioral-developmental clinics, in addition to the required time spent in the continuity clinic. **NO MORE THAN (FILL IN THE BLANK) MONTHS SHALL BE SPENT IN ANY SINGLE SETTING.**

The following requirements pertain to ambulatory general pediatric care:

5.8.1.1. Continuity Clinic The resident must have at least 36 sessions of continuity clinic scheduled in no less than 26 weeks per year. The volume per session must be enough to demonstrate skills in development, longitudinal care and chronic disease. The residents must be proctored by attendings with the experience in the above qualities and the medical home concept. OGME1and OGME2 must experience their sessions in an atmosphere that demonstrates the medical home concept. OGME3 may experience their sessions either in the same setting or in a longitudinal subspeciality clinic consistent with their future career goals. The medical home concept must be the center of the residents sessions including the above mentioned qualities of wellness, disease prevention, care coordination, longitudinal care, developmental awareness, chronic disease management and family centered care. The sessions must be organized to identify the resident as the primary care giver to the set of patients consistent with medical home model

5.8.1.2. Community-based assignments: Assignments may be solid blocks of time or may run concurrently with other assignments on a part-time basis. Verification of all patients seen must be kept by residents. Residents must be involved in decision-making processes and not function merely as observers. Assignments must show evidence of experience with business aspects of practice, medical home model, office based scholary work and electronic medical records. Evidence of a daily didactic activity must be present in each assignment in topics such as immunization, well child care, development, chronic disease management, behavioral, addiction, obesity, and mental health.

5.8.1.3. Emergency/urgent care and acute illness experiences

In addition to their experience in the continuity clinics, residents must have at least three (3) months of experience managing pediatric patients with acute problems, including respiratory infections, dehydration, coma, seizures, poisoning, trauma, lacerations, burns, shock and status asthmaticus. At least one of these months must be a block rotation in an emergency department that serves as the receiving point for EMS transport and ambulance traffic and which is the access point for seriously ill and acutely ill pediatric patients. The residents must have the opportunity to function as the physician of first contact for pediatric patients with the problems mentioned above.

5.8.1.4. Behavioral/ Developmental Pediatrics

Residents must participate in a structured experience in normal and abnormal behavior and development involving didactic and clinical components. Experience must include the care of patients from newborn through young adulthood.

Residents must learn how to serve as care managers for patients with chronic diseases and multiple problems. Subspecialty consultants and ancillary personnel must be available to the residents as they care for these patients.

5.8.2. General Inpatient Care

General inpatient pediatric rotations must be a minimum of three (3) months.

The list of diagnoses and patient data requested in the program information forms must show evidence of a sufficient number and variety of complex and diverse pathologic conditions to ensure that the residents have experience with patients who have acute and chronic illnesses as well as those with life-threatening conditions in the pediatric age groups. Residents at more than one level of training must interact in the care of inpatients.

5.8.3. Newborn Nursery Care

There must be the equivalent of at least two (2) months that include care of newborns in the routine nursery setting. This experience must include routine physical examination of the newborns (at least 50 normal newborn **EXAMINATIONS)**, attendance at routine, high risk deliveries and C-sections, and counseling of the parents on the care, and comprehensive issues of the neonatal period. This requirement may be combined or included with other rotations that have a normal newborn service.

5.8.4. Critical Care

5.8.4.1. There must be a rotation in neonatal critical care (Levels II and III) for a minimum of one (1) month, exclusive of experience with the normal newborn. Residents must have the opportunity to participate in the resuscitation of newborns in the delivery room.

5.8.4.2. There must be a rotation in the pediatric intensive care unit for a minimum of one (1) months.

5.8.4.3. The maximum number of required rotations in both critical care areas combined must not exceed two months.

5.9. Electives

5.9.1. Subspecialty Electives

The total amount of time committed to all subspecialty elective rotations must be no more than five (5) months. No more than three (3) months may be spent on any one subspecialty during the three (3)-year residency. The subspecialty rotations must occur primarily in the second and third years of training.

5.9.2. Subspecialty rotations shall include any of the following: allergy/immunology, cardiology, child psychiatry, critical care, dermatology, endocrinology/metabolism, gastroenterology, genetics, hematology/oncology, infectious disease, nephrology, neurology, pediatric radiology, pediatric rheumatology, pediatric surgery, pulmonology, school health and international health, anesthesia, ophthalmology, orthopedics, sports medicine, otolaryngology, physical medicine & rehab.

5.9.3. Subspecialty Supervision

Subspecialty experience must be supervised by pediatricians who have been certified in their pediatric subspecialty areas by the appropriate sub-boards of the American Osteopathic Board of Pediatrics (AOBP) or by another specialty board or who possess suitable equivalent qualifications. The acceptability of equivalent qualifications shall be determined by the program director. These individuals must be directly involved in the supervision of residents during their training in the subspecialties.

5.9.4. Content of Required and Elective Subspecialty Experiences

All subspecialty rotations must have a number and variety of patients to provide each resident with broad experience in the subspecialty. These experiences also must include attending subspecialty conferences, reading assignments, and acquainting the residents with techniques used by subspecialists.

Each resident must have patient care responsibilities as a supervised consultant on the inpatient and outpatient services in each of his or her subspecialty experiences. As a supervised consultant the resident must have the opportunity to evaluate and to formulate management plans for subspecialty patients. Instances in which a resident functions solely as an observer shall not fulfill this requirement.

SECTION VI – Program Director/Faculty

6.1. Qualifications: The program director of a residency program shall possess the following qualifications:

6.1.1. Be certified in pediatrics by the AOA through the AOBP;

6.1.2. Have practiced in pediatrics or a pediatric subspecialty for a minimum of three (3) years;

6.1.3. Be a practicing specialist in pediatrics or a pediatric subspecialty;

6.1.4. Be a member in good standing of the ACOP

6.1.5. Attend an ACOP chairman's/program director's meeting at least once every three years.

6.2. Responsibilities

6.2.1. The program director must provide the ACOP with yearly electronic evaluation reports of the residents in the training program within thirty (30) days of completion of the contract year at www.acopeds.org.

6.2.2. The program director shall require the resident to apply for Candidate-in-Training status with the ACOP during the training program.

SECTION VII - Resident Requirements

7.1. Applicants for residency training in pediatrics must:

7.1.1. Be and remain member of the ACOP during residency training

7.2. During the training program the resident must:

7.2.1. Electronically submit Residents Annual Report to the ACOP within thirty (30) days of completion of each contract year at (www.acopeds.org).

7.2.2. Complete one scientific scholarly writing project with the oversight and approval of the program director which will be developed into a manuscript and submitted to the ACOP eJournal for consideration of publication.

7.2.3. Attend all meetings as directed by the program director, including the educational portion of the department/division of pediatric medicine, and participate in major committee meetings.

7.2.4. The resident must complete the ACOP/AOBP/NOBME inservice every year of their training.

7.2.5. Complete a comprehensive reading program as assigned by the program director, including participation in a journal club;

7.2.6. Maintain a record of educational and postgraduate work completed outside the training institution, listing dates, locations, subjects and speakers.

7.2.6.1. During the training program the resident must attend at least one ACOP CME meeting during 36 months of pediatrics residency**.**

SECTION VIII – Evaluations

A. The program director shall complete an evaluation of each resident, each year. The evaluation form is located on the ACOP website (www.acopeds.org).

B. The resident shall be required to complete a resident **ANNUAL** report each year. The evaluation form is located on the ACOP website (www.acopeds.org). The resident shall also be required to complete a 360 degree evaluation, quarterly evaluation as supplied by the training institution.

IDENTIFY THE EVALUATIONS AND IF THEY ARE/ARE NOT INSTITUTIONAL.

SECTION IX-OMT Specialist Curriculum

9.1 Complete one (1) POMT module every quarter throughout pediatric residency

9.2 Attend one (1) OMT workshop during an ACOP meeting within a three year pediatric residency.

9.3 Successfully complete a three (3) year AOA approved Pediatric residency.

APPENDIX A – Three-Year Required Pediatric ROTATIONS

	OGME 1	OGME 2	OGME 3
SURGERY	1		
INTERNAL MEDICINE	1		
WOMEN'S HEALTH	1		
EMERGENCY MEDICINE	1	1	1
AMBULATORY PEDIATRICS	6	6	6
NEWBORN NURSERY	1	1	
GENERAL IN-PATIENT PEDIATRICS	1	1	1
PICU	0	0	1
NICU	0	1	0
PEDIATRIC SPECIALTY ELECTIVES	0	2	3
TOTAL	12	12	12

APPENDIX B – Outline For Continuity Ambulatory Training Sites For Residents In Osteopathic Pediatric Medicine

1. The ambulatory site must provide for comprehensive continuous general pediatric patient care where residents can function as the primary care giver for the patient. The site may be in a clinic (free-standing or in-hospital) or in a private practice setting.
2. The training site must have the presence of an attending pediatrician for supervision of residents. The supervisor should not supervise more than four (4) residents per clinic.
3. Residents must be scheduled a minimum of one half (1/2)-day per week throughout the training program.
4. An educational program must be scheduled in the clinic with active participation between the supervisor and the resident. Cases must be discussed and all charts should be reviewed and signed by the supervising pediatrician.
5. The resident should be exposed to the broad spectrum of medical diagnoses in pediatric and adolescent patients, as well as to demonstrate the ability to integrate the concepts of disease prevention and health maintenance.
6. An emphasis on the development of a resident panel of patients must occur during all of the training years.
7. Separate resident performance evaluations must be conducted by the ambulatory supervisor at least quarterly and reviewed between the resident, ambulatory supervisor and program director.
8. In addition to clinical exposure in the ambulatory training site, the resident must also be exposed to osteopathic concepts, behavioral and psycho-social aspects of medical care, medical ethics, medical-legal implications and practice management.
9. An opportunity must exist for the resident to be involved and participate in the ongoing care of his/her clinic patients when they are hospitalized at the base hospital facility and through all phases of their care (under supervision).
10. A resident in a teaching ambulatory setting must see a minimum of OGME-1 three (3) patients, OGME-2 four (4) patients and OGME-3 five (5) patients per half (1/2)-day session.