AMERICAN OSTEOPATHIC ASSOCIATION

BOARD OF TRUSTEES

POLICY COMPENDIUM 2000 - PRESENT

Res. 16-A/2000 - SUBMISSION OF CONTINUING MEDICAL EDUCATION (CME) CREDITS

AOA policy notes that CME credit must be submitted within 6 months from the end of the CME cycle or that credit is forfeited. 2000

Res. 17-A/2000 - CONTINUING MEDICAL EDUCATION (CME) AND THE INTERNET

The AOA supports the concept of earning CME credit on the Internet; urges the AOA website to provide a linkage for osteopathic CME; requests that the AOA Council on CME proceed with establishment of standards for the accreditation of CME on the Internet and establish appropriate limits on the various amounts of CME that can be earned on the Internet in any 3-year CME cycle. 2000

Res. 18-A/2000 - CONTINUING MEDICAL EDUCATION (CME) CREDIT FOR PARTICIPATION ON A STATE LICENSING PROFESSIONAL REVIEW BOARD

The American Osteopathic Association will award Category 1-B credit for participation on an osteopathic State Licensing Professional Review Board Probably Cause Panel; and will award Category 2-B credit for participation on a combined State Licensing Professional Review Board Probably Cause Panel; and that credit for participation on a State Licensing Professional Review Board Probably Cause Panel will be awarded on an hour for hour basis. 2000

Res. 52-A/2000 - DEFINITION OF WOMEN'S HEALTH

The American Osteopathic Association adopt the following definition of women's health - Women's health is defined as diseases or conditions that are unique to or more prevalent or serious in women, have distinct causes or manifest themselves differently in women, or have different outcomes or interventions. 2000

Res. 43-A/2000 - DEVELOPMENT OF SUFFICIENT QUALITY AOA-APPROVED INTERN AND RESIDENCY PROGRAMS THROUGH OPTI-AFFILIATES

The AOA reaffirms its commitment to the development of sufficient, quality internship and residency programs for the graduates of AOA-accredited colleges of osteopathic medicine; reaffirms its commitment to the Osteopathic Postdoctoral Training Institute (OPTI) as its vehicle for conducting osteopathic graduate medical education (OGME) within the standards and procedures for accreditation of OPTIs; that the AOA, AACOM and osteopathic specialty societies will initiate the development of additional programs through AOA OPTI affiliates to ensure sufficient numbers and geographic diversity of quality osteopathic internship and residency programs for the graduates of the Colleges of Osteopathic Medicine; and the AOA will move immediately to achieve the goal of providing sufficient quality AOA-approved intern and residency programs through OPTI affiliates for the anticipated osteopathic graduates by providing staff support for the development of these new AOA-approved internship and residency programs in the small states. 2000

Res. 53-A/2000 - POLICY ON EDUCATION IN WOMEN'S HEALTH

AOA policy states that objectives related to women's health and gender based biology be incorporated into the Standards of Accreditation for osteopathic medical schools, including longitudinal and interdisciplinary women's health issues integrated throughout the four-year undergraduate curriculum; and that the NBOME be encouraged to reflect a longitudinal, interdisciplinary context for women's health in its Board examinations; and that each specialty be encouraged to define and adopt residency program objectives appropriate to the area of specialty for graduate medical education training in women's health; and that physicians, state and local associations be encouraged to include continuing medical education in women's health and gender based biology as a part of continuing professional development. 2000

Res. 9-M/2001 - FAMILY PRACTICE RESIDENCY PROGRAM BE INCREASED FROM TWO TO THREE YEARS

AOA policy notes that the Osteopathic Family Practice Residency program be increased from two years to three years, with the first year consisting of the Special Emphasis in Family Practice internship or its equivalent; that the equivalent must include experiences in general internal medicine, general surgery, family practice, pediatrics and female reproductive medicine, each of which shall be no less than four (4) weeks or one (1) month duration, in accordance with the AOA Basic Documents for Postdoctoral Training; that, when available, the Family Practice equivalent be met by a continuity ambulatory experience throughout the first year that the AOA Basic Standards for Residency Training in Family Practice and Osteopathic Manipulative Treatment be revised to incorporate standards for the Special Emphasis in Family Practice internship; and that the AOA/ACOFP Inspection Workbook and inspection procedures incorporate the evaluation of the Special Emphasis in Family Practice internship. 2001

Res. 16-M/2001 - CONTINUING MEDICAL EDUCATION (CME) ON THE INTERNET

AOA policy notes (1) that real-time, interactive CME on the Internet that is sponsored by AOA-accredited CME sponsors and meeting the AOA quality guidelines be awarded Category 1-A credit; (2) that real-time interactive CME and audio/video CME on the Internet that is accredited by the Accreditation Council on Continuing Medical Education (ACCME) or the American Academy of Family Physicians (AAFP) be awarded Category 2-A credit; (3) that audio and video CME programs on the Internet sponsored by AOA-accredited CME sponsors be awarded Category 1-B credit; (4) that journal-type CME on the Internet be awarded Category 2-B credit; (5) that the CME provider of the Internet CME program must designate the number of credit hours that it determines most physicians should be able to obtain upon completion of the program with final determination of credit hours to be awarded by the AOA Council on CME; (6) that osteopathic physicians may obtain the designated CME credit hours from the CME Internet event if the CME provider certifies that the physician completed a CME quiz with a passing grade of 70% or better, and the sponsor provides this information to the AOA; osteopathic physicians may obtain up to 30% of their Category 1-A requirement from Internet CME (i.e., up to 9 hours of Category 1-A CME Internet credit may be applied to a 30 hour Category 1-A requirement); (7) that osteopathic physicians may complete all of their Category 1-B requirement from Category 1-A or 1-B CME Internet programs (Category 1-A CME Internet hours exceeding the 9-hour limit would be applied to the Category 1-B requirement); (8) that osteopathic physicians may complete all of their Category 2 CME requirement through Category 1-A, 1-B, 2-A or 2-B CME Internet programs;

and (9) that the Council on CME continues to reserve its authority to evaluate programs and activities on an individual basis, and to deny CME credits at its discretion. 2001

Res. 18-M/2001 - PHYSICIAN INFORMATION SERVICE
The AOA will evaluate the feasibility of implementing a program to provide relevant information from the physician profile to the public at no charge to improve quality of care. 2001

Res. 3-I/2001 - ESTABLISHING NEW FACILITIES TO PRODUCE VACCINES AGAINST BIOLOGIC WARFARE
The American Osteopathic Association, the official voice of osteopathic medicine, must speak to promote the safety and health of the general population; and strongly urges the rapid action of the Congress to create and fund a permanent system of vaccine development and manufacture; this system must have an appropriate level of redundancy to assure that our citizens have the maximum protection from present and future threats of bioterrorism. 2001

Res. 32-M/2002 - ELECTRONIC RESIDENCY APPLICATION SERVICE
The AOA will pursue discussions with AACOM regarding the possible development of an ERAS-type system or joining AAMC in its ERAS system; and will not pursue the concept of a single osteopathic/allopathic match at this time. 2002

Res. 37-M/2002 - ROTATING INTERNSHIP REQUIRES EMERGENCY MEDICINE AS A ROTATION
The requirements for an AOA-approved rotating internship be revised to include a sixth core rotation consisting of one month of emergency medicine. 2002 [See Res. 44-M/2002]

Res. 38-M/2002 - ROTATING INTERNSHIP, VISION OF THE
One of the purposes of the osteopathic internship program is to provide first year graduate osteopathic physicians (DO) with a year of postdoctoral clinical and academic experience that provides a base for entry into specialty training. 2002

Res. 39-M/2002 - ANNUAL POST-MATCH SURVEY OF COM GRADUATES - APPROVED RES. 55 (A/2001)
An annual survey of COM graduates, who do not match in the AOA Intern Registration Program (AOA Match), will be undertaken after the AOA Match is concluded. 2002

Res. 42-M/2002 - RECORD RETENTION OF THE CONTINUING MEDICAL EDUCATION (CME) AND ACCREDITATION PROGRAMS
The American Osteopathic Association's CME Division will maintain the CME files for 12 years (4 CME cycles); that AOA accredited CME Sponsors maintain its files for a minimum of 6 years and at least two full 3-year CME cycles. 2002

Res. 44-M/2002 - REPORT OF THE ROTATING INTERNSHIP TASK FORCE
The Task Force on the Rotating Internship recommends that the data be updated annually and reviewed and revised as necessary. 2002

Preface

This task force is completing its work during a period of intense activity of review of AOA policies and procedures in graduate medical education. In 1999, the Task Force on Graduate Medical Education (GME) Alternative Funding issued its report entitled *"Financing Osteopathic Graduate Medical Education: Options for the Future"*. The Educational Policies and Procedures Review Committee–II (EPPRC-II) submitted resolutions to the AOA Board of Trustees in February, 2000 and presented its full report to

the AOA Board of Trustees at its July 2000 meeting. A June 2000 conference was conducted under the auspices of the EPPRC-II to gather opinion makers in the profession and solicit their input. The Postdoctoral Task Force reviewed selected current policies for recognition of training, as an AOA-approved internship, when taken in programs approved by the Accreditation Council for Graduate Medical Education (ACGME), and presented its report at the July 2000 meeting of the AOA Board of Trustees. The report of the Osteopathic Graduate Medical Education State Development Task Force (OGMESD) was also presented at the July 2000 meeting. This report led to the establishment of an OGME Development Initiative to develop new training programs.

This monograph represents the work product of the AOA Rotating Internship Task Force. It is intended to advise the AOA Board of Trustees on a broad range of matters pertaining to the osteopathic rotating internship.

The osteopathic graduate of 2001 is a savvy, sophisticated decision-maker when it comes to selection of a graduate medical education experience. In order for OGME to maintain its current position and grow it will be necessary to understand the mindset of the osteopathic graduates of the first decade of the 2000's.

Executive Summary

This document is the final report of the Rotating Internship Taskforce and its activities from inception in November 2000 through December, 2001. The Rotating Internship Task Force was established by action of the AOA Board of Trustees in October 2000 to broadly review the osteopathic rotating internship as a key component of osteopathic medical education and our distinctiveness as a profession.

Chronicle of Committee Activity

The committee met in four face-to-face meetings held in Chicago, IL, and one meeting by teleconference. The committee began with a discussion of graduate medical education in the broadest sense. As a result of that discussion, it was agreed that the committee needed to survey key stakeholders in osteopathic graduate medical education (OGME):

- directors of medical education (DMEs)
- specialty colleges; and the
- Osteopathic Postdoctoral Training Institutions (OPTIs).

Later, the committee added a survey of COM graduates in 2001, who did not enter the AOA match. The committee also considered recently completed survey results on views and attitudes of osteopathic residents. At its final meeting the committee identified four (4) key areas of domain that could be the basis for implementation of a 3-5 year strategic plan for the internship.

Background and Statement of the Problem

The decade of the 1990s brought increases in numbers of osteopathic trainees because of development of 4 new colleges of osteopathic medicine (COMs) and expansion within the already existent 15 colleges of osteopathic medicine. As a result, the demand for OGME greatly increased, especially for residency training. Moreover, the latter portion of the decade saw the numbers of graduates exceed the numbers of funded internship positions. The AOA has a long record of approaching OGME needs through review of its existing policies and procedures to permit more flexibility for osteopathic graduates to obtain training, in ACGME-approved programs, which can be approved by the AOA.

Contemporaneous with this development was the first major revision of graduate medical education funding in the Balanced Budget Act of 1997 (BBA97), the *Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999* (BBRA), and the *Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)*. As of the time of this report, it is clear that market forces and the BBA, the BBRA and BIPA together have greatly influenced the GME educational endeavor. For reasons that are explained in this report, this has had a material effect on recent osteopathic graduates' perceptions of the rotating internship.

Approach to the Problem

The internship training of osteopathic physicians has been modified considerably since its inception in 1936. With external forces playing a larger role on attractiveness as a training choice, the Internship Task Force sought expert opinion of those "in the trenches" as to the viability of the currently constructed internship. The Task Force asked the following questions:

- Is the internship relevant?
- Does the internship provide quality OGME?
- Is the internship experience competitive with other options in today's postdoctoral training environment?

The task force recognized the importance of making its recommendations based upon research data. The staff of the Division of Postdoctoral Training, in conjunction with the advice of the Psychometrician in the Division of Certification, prepared and distributed surveys to the key stakeholders in the osteopathic graduate medical education arena: the directors of medical education (DMEs); the specialty colleges; the Osteopathic Postdoctoral Training Institutions (OPTIs). The task force also surveyed graduates from the COMs in the year 2001 who did not enter the AOA intern match.

Questions for Further Consideration

The Task Force believes the following question should be considered by an appropriate committee of the AOA: "Should students who complete clerkships in an OPTI during their third and fourth year of osteopathic medical college be allowed to sign a contract with an OPTI for an internship prior to the AOA Match?" If yes, should there be a limit on the number of positions eligible for this pre-matching, e.g. 50%?

The Task Force believes the issue of recognition of the same year of experience as meeting both AOA postdoctoral training and ACGME-approved postdoctoral requirements should be studied. (Dual Recognition)

Domains for Strategic Planning

The Task Force has identified four areas of domain that it believes should be incorporated into the AOA Strategic Plan:

Objective 2-A: Identify the areas where Educational Paradigm Shifts are taking place, or are needed in osteopathic graduate medical education.

Objective 2-B: Study accreditation standards, policies and processes, making revisions as needed.

Objective 2-C: Review the current status of Educational Support resources for osteopathic graduate medical education making revisions where necessary.

Objective 2-D: Increase awareness and utilization of osteopathic internship and residency programs by establishing a national Marketing and Communication Program.

Recommendations Presented in July 2001
The task force presented the following six (6) recommendations to the AOA Board of Trustees for their review and consideration at its July, 2001 (A/01) meeting:

50. "Retention of Osteopathic Rotating Internship"
51. "OGME Programs Should Be Expanded"
52. "Rotating Internship Requires Emergency Medicine as a Rotation"
53. "Intern Program Director"
54. "Vision of the AOA Rotating Internship"
55. "Annual Post-Match Survey of COM Graduates"

Two resolutions (Resolutions 50 and 51) were passed by the BOT. Four resolutions (Numbers 52-55) were referred back to the Executive Committee of the Council on Postdoctoral Training (ECCOPT) for study.

The following recommendations were made by the ECCOPT and will be referred to the Council on Postdoctoral Training (COPT) at its November 17, 2001 meeting:

Resolution 52 – "Inclusion of Emergency Medicine Rotation as Core Internship Requirement". ECCOPT recommended inclusion of Emergency Medicine as one of the core internship requirements.

Resolution 53 – "Intern Program Director". ECCOPT recommended approval of this position, including draft language.

Resolution 54 – "Vision of the AOA Rotating Internship". ECCOPT recommended adoption as amended.

Resolution 55 – "Annual Post-Match Survey of COM Graduates". ECCOPT recommended adoption.

The Task Force will study the following areas for consideration for new recommendations to be used as the basis for preparation of a strategic plan for the AOA internship for the next 3-5 years.

- 1: Marketing and Communication;
- 2: Strongly support the linkage of the internship and residency ;
- 3: Primary monitoring guideline should be based upon quality;
- 4: Survey topic: Quality;
- 5: Curriculum for traditional rotating internship;

- 6: Intern Program Director – develop a required position for an intern program director;
- 7: Establish a program to improve training/educational process including a Masters Teachers concept; and
- 8: Consider developing an integration of core internship rotational requirements into all residency programs in place of internship.

Section 1 – Chronicle of Committee Activity

Meeting of November 18, 2000

The initial meeting of the task force began with a conjoint meeting between the task force and the AOA Council on Postdoctoral Training (COPT) for purposes of gaining input from the COPT. The task force began its own meeting with a review of the charge to the Task Force: to review the osteopathic rotating internship as a key component of osteopathic medical education and its role in maintaining the distinctiveness of the osteopathic profession. The task force had a general discussion on trends in graduate medical education, both osteopathic and allopathic.

Meeting of January 20, 2001

The second meeting of the task force began with a report from Mitchell Kasovac, D.O., Director of OGME Development, on the progress of the OGME development initiative. Konrad C. Miskowicz-Retz, Ph.D., Director, AOA Department of Education gave a review of principles of GME reimbursement under the Federal Medicare program. The task force reviewed the initial findings of its AOA Internship Survey that had been sent to DMEs, OPTIs, and specialty colleges. Michael I. Opipari, D.O., Chair, AOA Council on Postdoctoral Training gave a review of the findings in the recent "Siegel Report" on internship and residency decisions made or being made by osteopathic students. The Siegel Report was prepared at the request of the AOA Department of Membership. Gary Moorman, D.O., gave a report on the results from a focus group of students, interns and residents at the St. Vincent's Hospital in Toledo, OH. Michael I. Opipari, D.O. presented a comparison of the AOA rotating internship and the ACGME Transitional year residency. The task force then reviewed a draft strength / weaknesses / opportunities / threats ("SWOT") analysis and a draft mission statement for the AOA Internship. The task force also reviewed preliminary data from the 2001 AOA Internship match.

Meeting of February10, 2001

The third meeting of the task force began with a review of the SWOT analysis drafted at the previous meeting. Following this the task force reviewed the internship mission statement. This was followed by further review of the updated 2001 internship match statistics and the updated internship survey results. The meeting concluded with a review of a draft of this report.

Meeting of September 9-10, 2001

The fourth and final meeting of the task force began with presentations from various members of the Task Force and Profession. These presentations outlined topics that should be addressed in the refocusing of the AOA internship for the next 3-5 years. Presenters included representation from American Association of Colleges of Osteopathic Medicine (AACOM); Academy of Osteopathic Directors and Medical Educators (AODME); Executive Committee of the Council on Postdoctoral Training (ECCOPT); OPTI Administrators; Director's of Medical Education, Intern/Resident Committee; and Student Appointment on the Board of Trustees. The Task Force identified four areas of

domain from which to develop a 3-5 year strategic plan for the focus of the AOA internship: accreditation process and substance; marketing and communication; educational support; and educational paradigm shift. The Task Force is developing recommendations in eight areas, which can be used for strategic plan development in the four areas of domain.

Meeting of December 10, 2001 Teleconference

The Task Force was divided into four groups and assigned a specific domain. The group's assignment was to develop activities and tactics for their respective area of domain relevant to AOA's strategic plan. The group met via teleconference to discuss and finalize the points to be included in the internship strategic plan.

Section 2 – Background and Statement of the Problem

College Enrollment Trends in the 1990s

The establishment of new colleges of osteopathic medicine in the period from 1965 onward has resulted in an expansion in the number of osteopathic physicians in the United States. Table 1 shows that the annual number of osteopathic graduates has increased from 1,612 in 1988 to 2,544 in 2001.

AOA-Approved Internship Trends in the 1990s

Table 1 shows the trends in osteopathic internship positions. "Approved" indicates the total number of internships approved by the AOA Council on Postdoctoral Training each year. The Council approves an internship program for a specific number of internship positions, depending on that program's available resources to provide a quality education to the interns in that program. "Budgeted" reflects the total number of positions that the osteopathic internship programs decided to fund that year. Internships may be approved for more positions than they budget in an academic year. "Filled" reflects the number of osteopathic interns who are training in one of the AOA-approved internship programs.

Table 1 shows that the number of approved internship positions went from 2,497 in 1995 to 2,319 in the year 2000, a decrease of 178 positions. This was accompanied by a decline in the number of funded positions from 1,951 to 1,814, a decrease of 137 positions. During this same period, the number of filled positions 1,421 shows a slight increase of 38 positions to 1,459.

Table 1 **Approved, Budgeted, and Filled Intern Positions and COM Graduates: 1988 through 2001**

Training Year	COM Graduates	Internship Positions			Percent In AOA Internship
		Approved	Budgeted	Filled	
1988-89	1,612	1,845	1,515	1,369	84%
1989-90	1,528	1,859	1,622	1,257	82
1990-91	1,537	1,859	1,701	1,194	78
1991-92	1,523	1,942	1,648	1,195	78
1992-93	1,531	2,157	1,799	1,145	75
1993-94	1,658	1,994	1,866	1,225	74
1994-95	1,771	2,311	1,676	1,385	78
1995-96	1,850	2,497	1,951	1,421	77
1996-97	1,983	2,421	1,877	1,410	71
1997-98	2,074	2,443	1,964	1,540	74
1998-99	2,146	2,379	1,878	1,571	73
1999-00	2,234	2,350	1,825	1,572	71
2000-01	2,440	2,319	1,814	1,459	65
2001-02	2,544	2,399	1,876	1,463	57

Note: The year of graduation precedes the year of training. Training year refers to internship academic year.

Source: American Osteopathic Association. Please note that each year an additional number of recently graduated osteopathic physicians will enter into military training positions. For more information on these, please see Appendix 1 of this report.

The growing imbalance of funded AOA-approved internship positions relative to COM graduates has also been accompanied by increased participation of osteopathic physicians in the match process for ACGME-approved PGY-1 positions. The data describing osteopathic physicians' participation in the National Resident Matching Program (NRMP) Match are shown in Table 2. Over the period from 1994 to 2001 the number of osteopathic students participating rose from 1,062 to 1,793 for an increase of 731 (68.8%) with a corresponding increase in active applications from 670 to 1,241 for an increase of 571 (85.2%). Of these active applicants the percentage matching for a PGY-1 position rose from 61% to 71% over that same period.

Table 2 COM Graduates Participating in the National Resident Matching Program (NRMP) from 1994 – 2001

Year	COM			Active	for PGY-1	
	Registrants	Withdrew	No Ranking	Applicants	Matched	Unmatched
1994	1,062	127 (12%)	265 (25%)	670	410 (61%)	260 (38%)
1995	1,132	138 (12%)	238 (21%)	756	480 (63%)	276 (37%)
1996	1,176	176 (15%)	201 (17%)	799	552 (69%)	247 (31%)
1997	1,185	182 (15%)	213 (18%)	790	509 (64%)	281 (36%)
1998	1,343	218 (16%)	235 (18%)	890	614 (69%)	276 (31%)
1999	1,451	185 (13%)	282 (19%)	984	671 (68%)	313 (32%)
2000	1,665	225 (14%)	290 (17%)	1,150	823 (72%)	327 (28%)
2001	1,793	--	--	1,241	876 (71%)	365 (29%)

Source: National Resident Matching Program

The requirement for completion of an AOA-approved rotating internship prior to entering an AOA-approved residency does not have an exact parallel in residency education approved by the Accreditation Council for Graduate Medical Education (ACGME). However, the ACGME does recognize a single year Transitional Year Residency (TYR) experience for the first postgraduate year (PGY-1). This residency program also requires rotation through several specialty areas. The data from the NRMP for matching into this residency are summarized in

Table 3 using data analyzed by the American Academy of Family Physicians and the NRMP. Because of the similarities between the AOA rotating internship and the ACGME TYR, there is potential to gain access to the unfilled TYR positions and recognize these as AOA-approved internships.

Table 3 Transitional Year Residency Positions in the National Resident Matching Program (NRMP) from 1989 – 2001

Grad Year	Positions Offered	Positions Filled	% Filled	Filled with U.S. Seniors	% filled U.S. Seniors	Filled with D.O.s	% filled D.Os
1989	1,288	1,021	79.3 %	910	70.7 %	N/A	N/A
1990	1,328	984	74.1 %	864	65.1 %	N/A	N/A
1991	1,316	985	74.8 %	864	65.7 %	28	1.9%
1992	1,324	971	73.3 %	847	64.0 %	50	1.5
1993	1,328	1,026	77.3 %	869	65.4 %	45	2.9
1994	1,337	954	71.4 %	773	57.8 %	59	4.0
1995	1,217	916	75.3 %	700	57.5 %	68	4.8
1996	1,072	811	75.7 %	549	51.2 %	51	3.8
1997	987	864	87.5 %	627	63.5 %	43	3.4
1998	965	881	91.3 %	699	72.4 %	47	4.0
1999	978	922	94.3 %	742	75.9 %	73	6.0
2000	1,005	944	93.9 %	819	81.5 %	57	4.7
2001	1,031	966	93.7 %	866	84.0 %	--	--

Source: American Academy of Family Physicians, Division of Medical Education and NRMP

The distribution of AOA-approved, funded, and filled internships by specialty emphasis or specialty track is indicated in Table 4. Almost 42% of the graduates in 2000 were training in traditional internship programs. The rest of the interns were training in special emphasis or specialty tracked internships, or non-AOA programs. Some commentary on recent trends in the relationships between graduates, approved internships and funded internships is in order. These are examined more closely in the analysis "The AOA Internship Registration Program Statistics: 1996 – 2001 (see Appendix 1). Analyses of data for the years 1996 – 2001 show declines in the % {(approved-graduates) / approved} from 13% to -6%, indicating a decline in the number of "excess" approved positions, to a net deficit of approved positions, relative to numbers of graduates. Again during the years 1996 – 2001 the %{(funded-approved) / approved} went from –18% to –22% , where it has remained for the years 1999 – 2001. These data indicate a persistent, increasing deficit of funded positions relative to approved positions. When the % {(funded – current grads) / funded} was calculated, this declined from –6% to –36% over that same four-year period.

Table 4 Osteopathic Intern Training by Special Emphasis/Specialty Track Programs as of, 2000-01 Training Year

Out of the 2,319 AOA-approved positions, 1,814 were funded and 1,459 Filled for the 2000-01 training year.

	Programs	Offered	Funded	Filled
Total for the year 2000-01	170	2,319	1,814	
Traditional Rotating Internship				981
Special Emphasis				
Family Practice (1990)				164
Emergency Medicine (1991)				55
Psychiatry (1991)				1
Total				
Specialty Track				
Internal Medicine (1990)				155
Obstetrics & Gynecology (1990)				22
Otolaryngology /				
Facial Plastic Surgery (1995)				11
Pathology (1996)				-0-
Pediatrics (1997)				43
Internal Medicine / Pediatrics (1999)				-0-
Urological Surgery (1999)				-0-
Total				231
Total Filled Positions				1,459

Note: A single internship program may use its approved number of internship positions to conduct any or all three types of internships: traditional rotating; specialty track; or special emphasis if the appropriate AOA residency is also available at each institution. The number of trainees in the specialty track and emphasis may vary depending upon the individual institution allocation from year to year. The training conducted must meet the standards for each type of internship. There were 2,319 approved positions in 170 approved internship programs. The year of inception is noted in parenthesis after each specialty.

Source: American Osteopathic Association, Division of Postdoctoral Education.

AOA-approved Residency Trends in the 1990s

Table 5 reveals the distribution of osteopathic graduates by AOA-approved and ACGME-approved residency programs. When comparing the availability of AOA-approved residency training with numbers of graduates, there is a different picture from that seen when comparing internship availability. The number of osteopathic GME residency positions has increased, however approximately 60% of recent graduates take their training in ACGME-approved allopathic programs. In order to address this gap, there has been active development of AOA-approved internships and residencies in the years 1995,1996, and 1997. It should be noted that this growth is being achieved through new and through expanded programs. Table 7 shows the distribution of osteopathic physicians in osteopathic residency training programs by specialty for the 2001-02 academic year.

Table 5 COM Graduates and Residency Experiences during the years 1988-2000

Training Year	COM Graduates	D.O.s in Residencies			Percent in AOA
		AOA	ACGME	Total	
1988 – 1989	1,612	1,450	2,050	3,500	41.4%
1989 – 1990	1,528	1,440	2,170	3,610	40.0
1990 – 1991	1,537	1,550	2,440	3,990	38.8
1991 – 1992	1,523	1,750	2,900	4,650	37.6
1992 – 1993	1,531	1,825	3,025	4,853	37.6
1993 – 1994	1,658	1,875	3,100	4,975	37.7
1994 – 1995	1,771	1,802	3,296	5,098	35.3
1995 – 1996	1,850	2,606	3,333	5,939	43.9
1996 – 1997	1,983	2,141	3,288	5,429	39.4
1997 – 1998	2,074	2,632	3,367	5,999	43.8
1998 – 1999	2,146	2,998	3,639	6,637	45.1
1999 – 2000	2,405	2,928	3,869	6,797	43.1
2000—2001	2,440	2,781	4,175	6,956	39.9
2001—2002	2,544	--	--	--	--

Source: American Osteopathic Association

Educational Responses to the Demand for AOA-approved Internships and Residencies

The AOA has a long record of reviewing and assessing its postdoctoral education needs versus policy and procedure during the latter portion of the 20th century:

- early 1980s: report of task force to study alternatives for OGME
- 1984: introduction of college based internships. Pilot status was removed in 1986
- 1988-89: Task Force to Explore Alternate Approval Mechanisms for Postdoctoral Training
- 1990: introduction of specialty-track internships
- 1990: introduction of special emphasis internships

- early 1990s: introduction of exceptions program for recognition of ACGME training as an internship, subsequently revised in 1996, 1997 , and 1998
- 1992: report of the Educational Policies and Procedure Review Committee (EPPRC) and its enabling resolutions which included: restructuring of Department of Educational Affairs; limitations on terms of appointment to committees in the Department of Educational Affairs; criteria for appointment and service on one committee; revision of the structure of Bureau of Professional Education and its appeal committee; and revision of the structure of the structure of COPT, ECCOPT, and COPT Appeal Committee
- 1995: approval of the Osteopathic Postdoctoral Training Institution (OPTI) as the model for all osteopathic graduate medical education after July, 1999
- 1997: orthopedics residency match program approved
- 1998: beginning of discussions with the ACGME on equivalence of the TYR with the AOA rotating internship
- 1999: rotating internship requirements modified by reducing the number of required months of rotation from 9 down to 5
- 1999: diagnostic radiology residency match in 4th year of COM predoctoral education is approved
- 1999: re-entry pathway for certification approved for those individuals not having an AOA-approved internship
- 1999: National Resident Matching Program (NRMP) PGY-1 lockout approved for those individuals who match for an AOA-approved internship in the Intern Registration Program, effective in 2000
- 1999: matching for internship and residency in the 4th year of COM predoctoral education is approved, effective in 2001
- 1999: IRP match date is approved to be moved to a later date to permit students to have more rotational exposure prior to matching
- 1999, the Task Force on Graduate Medical Education (GME) Alternative Funding issued its report entitled *"Financing Osteopathic Graduate Medical Education: Options for the Future"*.
- 2000: TYR approved as pilot program for AOA internship
- 2000: TYR pilot includes participation in NRMP after registering with AOA
- 2000: Total program intern and resident minimum numbers reduced from 10 to 6 where AOA-approved program is integrated and functioning in coordination with an ACGME-approved program to meet OPTI number requirements
- 2000: The Osteopathic Profession : Educational Challenges and Opportunities – The Road Ahead. Educational Policies and Procedures Review Committee II (EPPRCII) Report
- 2001: "The Residency Decision and Its Impact on Affiliation with the Osteopathic Profession." The Gary Siegel Organization, Inc. January 2001, 151pp.
- 2001: Interim Report of the Internship Task Force including surveys/Combined Match/OGME State Development

It is clear that development of numbers of positions necessary to reduce the deficit between current needs and capacities will require more direct support of new programs in addition to continued review of AOA policies and procedures for OGME.

The AOA has developed the Osteopathic Postdoctoral Training Institution (OPTI), a concept to provide both high quality and cost-effective internship and residency training in a wide variety of settings (see Table 6). The development of OPTIs should better enable the profession to address the need for additional AOA-approved GME training programs.

Table 6 AOA –accredited Osteopathic Postdoctoral Training Institutions (OPTIs)

Name of OPTI, Abbreviation (City, State)
Appalachian Osteopathic Postgraduate Training Institute Consortium, Inc., A-OPTIC, Inc. (Pikeville, KY)
Centers for Osteopathic Research and Education, CORE (Athens, OH)
Consortium for Excellence in Medical Education, CEME (Ft. Lauderdale, FL)
Lake Erie Consortium for Osteopathic Medical Education Training, LECOMT (Erie, PA)
MEDCON – A Medical Education Consortium (Kansas City, MO)
Midwestern University OPTI, MWU/OPTI (Downers Grove, IL and Glendale, AZ)
Mountain State OPTI, MSOPTI (Lewisburg, WV)
New York College of Osteopathic Medicine Educational Consortium, NYCOMEC (Old Westbury, NY)
Northeast Osteopathic Medical Education Network, NEOMEN (Biddeford, ME)
OPTI-West Educational Consortium (Pomona, CA)
Osteopathic Medical Education Consortium of Oklahoma, OMECO (Tulsa, OK)
Osteopathic Postdoctoral Training Institution of Kirksville, OPTIK (Kirksville, MO)
PCOMMEDnet (Philadelphia, NJ)
Statewide Campus System of Michigan State University College of Osteopathic Medicine, SCS of MSU-COM OPTI (East Lansing, MI)
Still Consortium for Osteopathic Postgraduate Education, SCOPE (Des Moines, IA)
Texas OPTI (Fort Worth, TX)
Touro University Medical Education Consortium, TUMEC (Vallejo, CA)
UMDNJ-SOM OPTI (Stratford, NJ)

Source: Division of Predoctoral Education, Department of Education, American Osteopathic Association

It is noted that development of OGME positions described in Table 7 has yielded a net gain of approved and funded internship and residency positions. However, the increase for any given year, included in the total number of approved positions for that year, is still less than the increase in the number of graduates in a given year. This is clearly illustrated in the 1995-1999 changes in approved and funded internship positions compared to numbers of graduates (see Table 1), and in the number of residency positions over the June 1998 – June 2001 period (Table 5).

Table 7 - Trends in AOA-Approved Postdoctoral Training Since 1995

		Internships		Residencies	
		Programs	Positions	Programs	Positions
1995					
	New	7	166	32	67
	Expanded	13	38	46	144
	Subtotal	20	204	78	211
	Closures	2	21	16	54
1996					
	New	9	130	27	178
	Expanded	8	34	34	140
	Subtotal	17	164	61	318
	Closures	6	51	20	85
1997					
	New	4	47	12	68
	Expanded	3	8	18	57
	Subtotal	7	55	30	125
	Closures	6	65	21	93
1998					
	New	4	30	23	184
	Expanded	6	22	30	85
	Subtotal	10	52	53	269
	Closures	5	61	19	96
1999					
	New	7	40	14	130
	Expanded	6	20	25	76
	Subtotal	13	60	39	206

Closures	4	32	29	148
2000				
New	20	166	23	181
Expanded	10	40	19	51
Subtotal	30	206	42	232
Closures	8	63	19	121
2001 (as of 11/01)				
New	7	68	11	74
Expanded	9	32	17	30
Subtotal	16	100	28	104
Closures	4	30	8	47
Total 1995-2001				
New	58	647	142	882
Expanded	55	194	189	583
Total	113	841	331	1465
Closures	35	358	132	644
Net Gain(loss)	78	483	199	821

Source: American Osteopathic Association. Notes: The data in this table only reflect the addition of new and expanded programs and positions. These data include net changes due to additions and loss of positions and programs due to closures and mergers

Table 8 represents the number of trainees in osteopathic residency programs by a particular specialty as of October, 2001. Included in this report is a separate total of the number of trainees currently participating in a specialty track internships.

Table 8 Resident training by Specialty as of 10/01/01 – (2001-02 Training Year)

Positions			Programs		
Approved	Funded	Filled	Count	Abbreviation	Description
39	27	14	10	AN	Anesthesiology
46	35	22	9	C	Cardiology
6	5	1	3	CCM	Critical Care-Medicine
2	0	0	1	CCS	Critical Care-Surgery

2	1	1	1	CHP	Child Psychiatry
57	36	35	13	D	Dermatology
85	66	66	11	DR	Diagnostic Radiology
534	409	268	31	EM	Emergency Medicine
2	2	1	1	EMS	Emergency Medical Services
0	0	0	0	END	Endocrinology
22	17	13	4	FEM	Family Practice/Emergency Med
23	10	7	6	FOM	FP/Osteo Manipulative Medicine
1432	1104	736	117	FP	Family Practice
6	3	0	2	SMF	Sports Medicine-Family Practic
16	11	8	5	GE	Gastroenterology
19	7	3	6	GFP	Geriatric Medicine-FP
4	3	1	2	GIM	Geriatrics-Internal Medicine
19	15	2	8	GVS	General Vascular Surgery
2	0	1	1	HEO	Hematology & Oncology
8	3	2	2	ID	Infectious Diseases
100	69	51	11	IEM	Internal Med-Emergency Med
618	447	238	53	IM	Internal Medicine *155
10	2	1	2	IPD	Internal Med-Pediatrics
3	3	0	1	MFM	Maternal Fetal Medicine
29	22	8	5	N	Neurology
4	3	2	2	NEP	Nephrology
34	26	18	7	NMS	Neuromusculoskeletal Med/OMM
10	7	0	3	NMS1	Neuromusculoskeletal Med +1
39	29	22	10	NS	Neurological Surgery
299	249	169	35	OBG	Obstetrics & Gynecology *22

3	3	0	1	OE	Preventive-Occupat'l-Envir Med
84	78	59	19	OOP	Otolaryn & Facial Plastic Surg *11
40	38	31	10	OPH	Ophthalmology
261	240	208	29	ORS	Orthopedic Surgery
11	9	0	3	OM1	Osteopathic Manipulative Med+1
3	0	0	1	OTL	Otolaryngology
3	0	0	1	OTA	Otolaryngic Allergy
2	1	2	1	OTR	Otolaryngology
33	27	15	3	P	Psychiatry
144	97	43	13	PD	Pediatrics *43
4	2	4	1	PEM	Pediatric Emergency Medicine
9	8	1	1	PHM	Physical Medicine & Rehab
3	0	0	1	PHP	Preventive Med/Public Health
12	5	5	3	PLR	Plastic & Reconstructive Surg
2	2	0	1	PR	Proctology

Table 8 Resident training by Specialty as of 10/01/01 – (2001-02 Training Year) – continued

Positions			Programs		
Approved	Funded	Filled	Count	Abbreviation	Description
4	1	0	2	PUC	Pulmonary-Critical Care
281	252	202	34	S	Surgery-General
13	8	3	6	SM	Sports Medicine
11	9	1	2	TCV	Thoracic Cardiovascular Surg
36	20	20	5	URS	Urological Surgery
4434	3409	2,536	501	GRAND TOTAL	

Source: American Osteopathic Association, Division of Postdoctoral Training Report by Specialty as of October 2, 2001.

*Represents the number of tracked internship positions counted as the 1st residency year.

Estimating Osteopathic GME Training Needs

The osteopathic profession has undergone a period of significant growth since the enactment of Medicare and Medicaid legislation in 1965. The growth of numbers of COM graduates indicates that there will be the need to provide internships for the 2,848 students who enrolled at the 19 colleges of osteopathic medicine in the fall of 2000. Assuming an average of three years additional residency in order to become board-eligible, there will be the need for a total of 8,544 residency positions in the year 2003.

Basic Principles of Medicare Support of GME

The legislation responsible for enactment of the Medicare program in 1965 provided financial support for graduate medical education (GME) in order to ensure a supply of physicians would be available for providing healthcare to the program's beneficiaries. Medicare support for Graduate Medical Education (GME) involves reimbursement for direct expenses related to a GME program – Direct Medical Education (DME). Medicare also provides reimbursement to teaching hospitals for other costs incurred as an indirect result of graduate medical education – Indirect Medical Education (IME). It must be understood that both DME and IME reimbursements are just that, reflective of expenses incurred and reported on a hospital's Medicare cost report (known as the "IRIS" report). Medicare funds are administered by the U.S. Department of Health and Human Services (DHHS), Center for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA), recently. Since 1984, this payment mechanism has been based on HCFA's hospital inpatient prospective payment system. In this system the DME component is fixed upon the "Per Resident Amount" in 1984, annually adjusted for inflation.

The DME component is based upon the trainees' wages, teaching expenses, and administrative expenses for the program; and indirect medical education (IME) payments designed to compensate the hospital for additional costs of patient care associated with having GME programs present. The DME payment is based upon multiplying costs times the Medicare bed utilization at that institution. The number resulting from this calculation is compared with the hospitals' 1984 base year payment updated for inflation (for hospitals with existing programs), or if this is a new program then the comparison is against the CMS "Per Resident Amount" for that geographic region. In either case, the reimbursement is the lesser of the two amounts.

It is important to point out that the IME payment was not intended to be a subsidy for the costs of providing medical education. Rather, it was understood that teaching hospitals tended to provide care to more seriously ill patients than did non-teaching hospitals, and thus were justified in receiving a higher rate of reimbursement. In theory, this reimbursement could be given as a modification to the usual Diagnosis Related Group (DRG) payments. Because of difficulty in estimating the severity component of DRG payments, the approach that was taken in the IME reimbursement was to focus on teaching intensity. The measure of teaching intensity selected was the ratio of (residents / beds).

The IME payment is calculated in two steps:

- the "education adjustment factor" is calculated as the product of a constant "c" (specified by federal statute, multiplied by an exponentiation of a term containing the resident to bed ratio, then
- the hospital's Medicare DRG payments are multiplied by the education adjustment factor.

The amount of reimbursement is greater if a hospital meets any of the following: has more residents, hospitals have more (residents / beds), has higher Medicare DRG payments. The IME payment is also increased by an increase in the value of the constant "c".

Over the first 20 years of Medicare's existence, few modifications were to its financial support for GME. There was concern over the rise in costs of this part of the program. Medicine had changed greatly over this period with the increase in length of training in the primary specialty, accompanied by subspecialty training. Some physicians were electing to train in two different primary specialties. In 1985, legislation revised the program to ensure that Medicare would not pay for training in more than one specialty. As a result, the Medicare program limited its DME payments in the following manner, up to a maximum of 5 years or the number of years of training to become board certified, whichever is less, the hospital would receive full payment, i.e. "1.0 FTE". For training beyond this time, the hospital's DME payment would be reduced to half, i.e. "0.5 FTE", without limit on the number of years of payment. The number of years to become board certified would be based upon the first specialty in which the resident trained. In the period from 1985 to 2000 there were some exceptions enacted so as to not impair training in areas of key importance for the beneficiaries, such as geriatrics, preventive medicine, and combined primary care programs (e.g. pediatrics / emergency medicine, pediatrics / internal medicine, and internal medicine / emergency medicine).

The CMS recognized the requirement of an internship as a prerequisite for entrance into an osteopathic residency, and allows payment of the 1.0 FTE DME rate for completion of the internship and the osteopathic residency up to 5 total years of training. Training thereafter would be eligible for 0.5 FTE DME payments. The key factor here is that this recognition of the osteopathic internship for eligibility of 1.0 FTE DME payment is applicable only to training, which occurs completely in osteopathic programs. If an osteopathic graduate were to complete an osteopathic internship and then enter a 3-year internal medicine residency approved by the Accreditation Council on Graduate Medical Education (ACGME), the ACGME-approved residency does not require the osteopathic internship, and thus the trainee's first residency is now a 3-year program. One year of funding was given during the internship, making the trainee eligible for 2 years at 1.0 FTE followed by 1 year of 0.5 DME. The significance of this will be explored later.

Regulations for Medicare Support of GME

The regulations for Medicare payments are published in the ***Code of Federal Regulations (CFR)***, which may be accessed through the National Archives and Records Administration's web site for the ***CFR***. The regulations are found in Title 42 The Public Health Service, Volume 2, section 412 for IME and section 413 for DME. This publication is updated annually in October. Changes to these regulations are initially announced in the ***Federal Register (FR)*** in May as "Medicare inpatient hospital prospective payment system proposed changed and fiscal year 2XXX rates, proposed rules". The final rules are issued in late July or early August for the federal fiscal year to begin On October 1 of that calendar year. Thus, depending on the time of the year, it is necessary to have the current ***CFR*** sources

for the entire regulation, as well as the current fiscal year's final rule in order to have a complete set of regulations in force. Materials from the ***FR*** may also be accessed through the National Archives and Records Administration's web site for the ***FR***.

The GME Enterprise in the 1990s

Experiences in GME Programs Under Allopathic Medical Sponsorship

The American Medical Association conducts an annual study of graduate medical education. The results of this study are published annually in September in medical education issue of ***JAMA***, (September 5, 2001). Among the statistical compilations, are data on graduate medical education for programs approved by the Accreditation Council for Graduate Medical Education (ACGME). These data have also been complied in a recent publication from the U.S. DHHS, Health Resources and Services Administration (HRSA), Bureau of Health Professions (BHPr). The number of residents has remained stable for the period between 1995-2000, varying between 97,383 in 1998-1999 and 98,143 1997-1998. However, this five-year period was immediately preceded by a five-year period of rapid growth in residents in the early 1990s. The number of residents in 1990-1991 was 82,902, rising to 97,370 in 1993-1994. Much of this increase is due to the increase in international medical graduates from 12,259 in 1989-1990 to 25,880 in 1999-2000.

Experiences in Osteopathic GME Programs

The American Osteopathic Association conducts an annual study of OGME for the osteopathic profession. The results of this study are published annually in the osteopathic medical education issue of the ***JAOA***, usually issued in November. The most recent publication is found in the November 2001 issue of the ***JAOA***. In the 1990's the osteopathic profession saw an increase in the number of colleges of osteopathic medicine (COM) from 15-19 accompanied by an increase in class size among the 15 existent colleges. The number of COM graduates rose from 1,523 in 1991 to 2,544 in 2001. Over the same time period, the increases in numbers of approved internship positions from 1,942 to 2,319, and in funded internship positions from 1648 to 1,814 were of a lesser magnitude. The numbers of osteopathic graduates in AOA-approved residencies increased from 1,875 in 1993-1994 to 2,781 in 2000-01. Over the same period the numbers of osteopathic graduates in ACGME-approved residencies increased from 3,100 to 4,175, representing approximately 3.9% of the residents in ACGME-accredited programs.

Experiences with Medicare IME and DME Reimbursements

Recently the Council on Graduate Medical Education (COGME) reported the changes in Medicare GME payments in the 1990s (see Table 9). Not unsurprisingly, the rise in number of residents in ACGME-approved residencies in the 1990 –1995 period was accompanied by a rise in the Medicare reimbursements for IME and DME.

Table 9 Medicare Payments for GME: 1990 – 1998

Federal Fiscal Year	IME Payments ($billion)	DME Payments ($billion)	Total Payments ($billion)	Change vs. previous year (%)
1990	2.91	1.76	4.67	N/A

1991	3.21	1.89	5.10	9
1992	3.67	2.36	6.03	18
1993	4.09	2.55	6.64	10
1994	4.50	2.61	7.11	7
1995	5.10	2.74	7.84	10
1996	5.55	2.86	8.41	7
1997	5.16	2.43	7.59	-10
1998	4.99	2.10	7.09	- 7

Source: COGME 15th Report: "Financing Graduate Medical Education in a Changing Health Care Environment" (December 2000)

Reform in the late 1990s

The Balanced Budget Act of 1997 (BBA97)
Since the last major revisions to Medicare in the mid-1980s, there was a growth of numbers of GME positions such that the number of first year positions in exceeded 140% of the number of graduates by 1995. Coupled with the growth in the overall Medicare budget, there was concern that the U.S. was training too many physicians relative to its needs. In particular, it was acknowledged that the current formula for calculation of IME encouraged the growth of programs, and the writers of the original Medicare legislation purposely set the IME rate to be higher than the then best estimates of IME costs.

The DME and IME payments were only part of the concerns about Medicare financing, given that these payments are approximately 7-8% of total Medicare activity on a dollar basis. First, the pool of Medicare beneficiaries was known to be rapidly increasing, leading to estimations that the Medicare Hospital Instance Trust fund could be depleted as early as 2001. The rise in the Medicare inpatient hospital margin was projected to reach 12.7% in 1997, implying that hospitals were being reimbursed in excess of expenses. Against this backdrop, the Congress enacted the Balanced Budget Act of 1997 (BBA97).

The BBA97 made many changes outside of those affecting the GME reimbursements within the hospital inpatient prospective payment system. For the first time outpatient services would be reimbursed on a prospective payment system starting in 2000. A case adjusted per diem prospective payment system was established for skilled nursing facilities (SNFs). Home health services would be reimbursed on a prospective payment system starting in 2000. The Medicare + Choice program was established as Part C of Medicare; IME and DME payments were carved out of HMO payment rates for a five year period.

Because the IME and DME reimbursements are part of the inpatient prospective payment system, it is important to note changes in related areas. Disproportional Share Hospital (DSH) payments intended to reflect hospitals providing care to Medicaid populations was reduced. Medicare bad debts reimbursement was reduced. Capital payments were reduced. Annual hospital payments were reduced. Regarding GME reimbursement, on the DME side, Congress capped the numbers of reimbursable

trainees based upon a program's last cost reporting year prior to December 31, 1996. On the IME side, the Congress adjusted the constant "c" in the calculation of the education adjustment factor in a manner that would reduce the IME payments by approximately 30% over a five-year period.

The initial shock value of the BBA was probably magnified by the fact that President Clinton rapidly signed the bill into law in early August 2000, normally a quieter time for legislative activities. The hospital inpatient prospective payment system regulations were issued in final form on August 29, 1997, without opportunity for prior commentary. In order to understand fully the implementation and development of the regulations pertaining to DME and IME funding, it is necessary to study the rationale developed in the preamble of these regulations. The resulting regulations in the federal FY1998, FY1999, FY2000, and FY 2001 have further refined the current payment process. The proposed regulations for FY2002 were issued on May 4, 2001.

The Balanced Budget Refinement Act of 1999 (BBRA)

The effects of the BBA have just begun to be observed, largely because of the lag time in the reporting and reimbursement from CMS. In addition to overall IME and DME reimbursements, there are two other financial parameters, which are closely watched by GME policymakers: hospital Medicare inpatient margin and hospital total margin. Because of the effects of the BBA and other factors in the healthcare industry as a result of managed care, hospital total margins have been reduced more dramatically than the rate of decline suggested from looking at Medicare funding for GME. In the minds of some policy makers and Congress, the BBA97 had worked too well, too fast to accomplish its intended effect. Because of other structural changes taking place in the healthcare market to force economic competition among institutional providers, the BBA97 was believed to have facilitated, if not caused, hospital bankruptcies, mergers and closures.

Because of concerns about the effects of the BBA97, further revision to this act occurred with the *Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999* (BBRA). Preliminary regulations and final regulations have been issued for FY 2001. The BBRA is intended to slow the full transition to the BBA endpoints, not to reverse them. The BBRA offers some slowing of the reduction of the IME payments and some slowing of the reduction of DSH payments. The BBRA also addresses other issues of GME reimbursement by: establishing a national per resident amount with a floor of 70% of national average, and a ceiling of 140% of national average; allowing for an increase in the DME cap for rural programs; allowing limited increases in DME caps for those programs who had residents on medical leave during the December 31, 1996 time when the cap was established by the BBA; and allowing GME reimbursements to urban hospitals for portions of a residency program that occur in a rural setting.

Other authors have summarized the effects of both the BBA97 and BBRA on funding for graduate medical education. In general, the growth of Medicare funding for GME has been capped at FY 1997 levels, with planned incremental reduction in the IME payments. Also, the number of GME positions that will be supported by Medicare DME payments have been capped. There is the flexibility to start new programs, including the ability for expansion of rural programs. However, new programs will have a cap applied to their Medicare payments based upon the numbers of trainees in the third year of the new program. Therefore development of a new OGME program will require that internships and residencies be established and optimally developed within three years in order to maximize Medicare financial

support. Those who development of new GME programs must also consider the typical 12-18 month period between closure of a Medicare reporting year and receipt of Medicare reimbursements.

The Medicare, Medicaid and SCHIP Benefits and Improvement and Protection Act of 2000 (BIPA) Further revision occurred with the passage of the *Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA)*. The BIPA delays the IME and DSH adjustments further from what was modified by the BBRA. The regionally adjusted floor per resident amount was increased from 70% to 85% of national average for FY 2002.

Effects of Medicare Reform on OGME

To date, the hospitals that have been traditionally considered osteopathic, either by history or by virtue of holding accreditation from the AOA Healthcare Facilities Accreditation Program (HFAP), have experienced more mergers and closures of what were once major training institutions in the profession. Because osteopathic hospitals are typically smaller in size of operations than hospitals used for education in the allopathic medical profession, their vulnerability for further consolidations is still great.

Section 3 – Approach to the Problem

History of the AOA Internship Development – An Evolutionary Process

Osteopathic Internship Model

The institution of the osteopathic internship has provided a necessary part of the osteopathic education for every DO intern who has experienced this one-year of training since its inception in the 1920s. Many have utilized this as their final year of formal osteopathic education and others as a bridge to a specialty-training program. At the present virtually every osteopathic medical student graduate who completes an osteopathic internship will also complete residency education in one of the many areas of specialty practice. At present there are 23 osteopathic specialty practice affiliates (see Table 10) and 18 osteopathic certifying boards recognized by and incorporated within the AOA (see Table 11).

General Reasons for Taking the AOA Internship

The osteopathic medical profession has prided itself on providing a physician who has been well trained as a generalist, able to enter family practice should he or she so desire. The osteopathic rotating internship has been the capstone of that educational process. The residency also provides further distinctiveness for the osteopathic student, physician and the profession in general. Interns and residents provide role models and teachers for undergraduate osteopathic medical students in their 3rd and 4th years. From a service prospective they also provided hospitals with inpatient day, night and emergency room coverage. Another benefit was as a new source of future staff members to the respective teaching hospitals.

Table 10 AOA Specialty Practice Affiliates

Name of affiliate
American Academy of Osteopathy
American Osteopathic Academy of Addiction Medicine
American Osteopathic College of Allergy and Immunology

American Osteopathic College of Anesthesiologists
American Osteopathic College of Anesthesiologists
American Osteopathic College of Dermatology
American College of Osteopathic Emergency Physicians
American College of Osteopathic Family Physicians
American College of Osteopathic Internists
American College of Osteopathic Neurologists and Psychiatrists
American College of Osteopathic Obstetricians and Gynecologists
American Osteopathic College of Occupational and Preventive Medicine
American Osteopathic Colleges of Ophthalmology and Otolaryngology, Head and Neck Surgery
American Osteopathic Academy of Orthopedics
American College of Osteopathic Pain Management and Sclerotherapy
American Osteopathic College of Pathologists, Inc.
American College of Osteopathic Pediatricians
American Osteopathic College of Proctology, Inc.
American Osteopathic College of Radiology
American Osteopathic College of Rehabilitation Medicine
American Osteopathic College of Rheumatology, Inc.
American Osteopathic Academy of Sports Medicine
American College of Osteopathic Surgeons

Source: **Yearbook and Directory of Osteopathic Physicians**. American Osteopathic Association (January 2001).

Florida, Michigan, Pennsylvania, Oklahoma, and West Virginia require the AOA rotating internship for licensure. A rationale frequently expressed by licensing boards for retaining the internship requirement is that it is a generalist standard believed to reflect generalist competency. In the state licensing board's experience, those physicians in a non-primary care specialty who elect to move to practice in a primary care specialty frequently do so with out appropriate clinical experience in primary care medicine. The traditional internship provides the basis for sound practice as a generalist physician, comfortable with the primary care disciplines.

History of the AOA Internship

The internship has undergone considerable evolution over the past 75 years, from the initial hospital-sponsored internship in the 1920s, i.e., Detroit Osteopathic Hospital, 1927, to the first AOA approved internship in 1936. The first approval of osteopathic hospital/residencies followed in 1947. There were many residency programs that were ongoing, but the approval mechanism had not yet been put in place. To a certain extent, the pace of this activity reflected relative stability in the then colleges of osteopathic medicine. By 1947, there were six colleges of osteopathic medicine in the following locations (with starting dates listed): Kirksville, MO (1892); Los Angeles, CA (1896, 1914); Philadelphia, PA (1898); Chicago, IL (1902); Des Moines , IA (1905); and Kansas City, MO (1916).

Table 11 AOA –recognized Osteopathic Certifying Boards and date of its inception

Name of Certifying Board
American Osteopathic Board of Anesthesiology, 1956
American Osteopathic Board of Dermatology, 1945
American Osteopathic Board of Emergency Medicine, 1980
American Osteopathic Board of Family Practice, 1972
American Osteopathic Board of Internal Medicine, 1942
American Osteopathic Board of Neurology and Psychiatry, 1941
American Osteopathic Board of Neuromusculoskeletal Medicine,1999*
American Osteopathic Board of Nuclear Medicine, 1974
American Osteopathic Board of Obstetrics and Gynecology, 1942
American Osteopathic Boards of Ophthalmology and Otolaryngology – Head and Neck Surgery, 1940
American Osteopathic Board of Orthopedic Surgery, 1978
American Osteopathic Board of Pathology, 1943
American Osteopathic Board of Pediatrics, 1940
American Osteopathic Board of Preventive Medicine, 1982
American Osteopathic Board of Proctology, 1941
American Osteopathic Board of Radiology, 1939
American Osteopathic Board of Rehabilitation Medicine, 1954
American Osteopathic Board of Surgery, 1940
Select Committee on certificate of competence of the American Osteopathic Academy of Sports Medicine, 1989

Source: **Yearbook and Directory of Osteopathic Physicians**. American Osteopathic Association (January 2001).

Note: Year in which the board was formed is listed following the board's name.

*Formerly the American Osteopathic Board of special Proficiency in Osteopathic Manipulative Medicine (AOBSPOMM).

Little changed over the ensuing 15 years until 1962, when the College of Osteopathic Medicine of Physicians and Surgeons, Los Angeles, (1896 and 1914) converted to an allopathic college leaving only 5 osteopathic schools. Subsequently, new colleges of osteopathic schools were added increasing to the present day 19 approved colleges (see Table 12). The last two approved schools, Touro University College of Osteopathic Medicine and Pikeville College School of Osteopathic Medicine graduated their first class of students in 2001. Since the 1970s the growth rate of graduate Dos has increased to 2,544 in the year 2001, which has greatly impacted the demands on the osteopathic internship (see Appendix 1).

Many alterations to the internship have evolved over the years. The AOA approved a pilot program for the college-sponsored internship either in osteopathic or allopathic hospitals in 1983. The AOA Board of Trustees approved this for pilot status in March, 1984. This contributed greatly to the number of AOA college-sponsored internships available. In 1990, the AOA approved the first specialty track internship (Internal Medicine and Obstetrics/Gynecology) and the first specialty emphasis internship Family Practice the same year (see Tables 13, 14). Other specialty colleges in the past 10 years have added both special emphasis and track internship categories.

Table 12 AOA –accredited Colleges of Osteopathic Medicine

Name of College, Abbreviation (City, State)
Arizona College of Osteopathic Medicine / Midwestern University, AZCOM (Glendale, AZ)
Chicago College of Osteopathic Medicine / Midwestern University, CCOM (Chicago, IL)
Des Moines University – Osteopathic Medical Center, DMU-OMC (Des Moines, IA)
Kirksville College of Osteopathic Medicine, KCOM (Kirksville, MO)
Lake Erie College of Osteopathic Medicine, LECOM (Erie, PA)
Michigan State University – College of Osteopathic Medicine, MSU-COM (East Lansing, MI)
New York College of Osteopathic Medicine / New York Institute of Technology, NYCOM (Old Westbury, NY)
Nova Southeastern University – College of Osteopathic Medicine, NSU-COM (Fort Lauderdale, FL)
Ohio University College of Osteopathic Medicine, OUCOM (Athens, OH)
Oklahoma State University – College of Osteopathic Medicine, OSU-COM (Tulsa, OK)
Philadelphia College of Osteopathic Medicine, PCOM (Philadelphia, PA)
Pikeville College School of Osteopathic Medicine, PCSOM (Pikeville, KY)
The University of Health Sciences – College of Osteopathic Medicine, UHS-COM (Kansas City, MO)
Touro University College of Osteopathic Medicine, TUCOM (Vallejo, CA)
University of Medicine and Dentistry of New Jersey – School of Osteopathic Medicine, UMDNJ-SOM (Stratford, NJ)
University of New England – College of Osteopathic Medicine, UNE-COM (Biddeford, ME)
University of North Texas Health Science Center at Fort Worth – Texas College of Osteopathic Medicine (UNTHSC-TCOM)
Western University of Health Sciences – College of Osteopathic Medicine of the Pacific, Western U – COMP (Pomona, CA)
West Virginia School of Osteopathic Medicine, WVSOM (Lewisburg, WV)

Source: Division of Predoctoral Education, Department of Education, American Osteopathic Association

DOs in the Military

The majority of individuals who choose to enter postdoctoral training in the military do so while still at the predoctoral level. Many apply for acceptance into the federal Health Professions Scholarship Program (HPSP). Recipients are given tuition assistance in return for serving their country for a minimum of four years. The conundrum, which has been resolved, is that federal law mandates that a DO student on a military scholarship apply to the military for training. If accepted by the military, the DO must train at the institution of the military's choosing. DOs who have applied to complete training in one specialty can and do end up in another residency. Given that the military DO must comply with federal law, the AOA has taken a more forgiving approach to the approval of training as comparable to

an AOA internship. The tougher issue is the one of the military DO who does not match with a military training program. When this occurs, AOA's military representative to the AOA Council on Postdoctoral Training (COPT) of the AOA Bureau of Professional Education, in concert with AMOPS, follows the AOA rules for AOA internships. If the DO does not choose an AOA internship, then the DO follows the rules for non-military ACGME programs. The AOA's military representative to the COPT counsels military DOs to consider the choice of AOA-approved training programs as back up to the military ACGME program. It is important to note that mechanisms exist for expedited review of ACGME-approved programs in the military to determine if they qualify for AOA approval as an osteopathic internship or residency.

Evolution of the AOA Internship – College-sponsored, Specialty track, Specialty emphasis, OPTI
In the last twenty years the internship has evolved considerably. The AOA approved a pilot program for the sponsored COM internship in 1983 and removed the pilot status in 1986. Under this new policy training could be provided in either osteopathic or allopathic hospitals under specified conditions. The number of AOA internships available increased considerably because of the new policy. In 1990, the AOA approved the first specialty track internships (Internal Medicine and Obstetrics/Gynecology) and the first special emphasis internship, Family Practice. In the past 10 years several additional specialty colleges have added either special emphasis and/or specialty track internships (see Table 4).

The concept of the OPTI was approved by the AOA in 1995. The AOA moved from a process of solely approving individual postdoctoral training programs (internships and residencies) to accrediting systems of postdoctoral training or OPTIs. An OPTI consists of at least one hospital accredited through the AOA Bureau of Healthcare Facilities Accreditation and one college of osteopathic medicine accredited by the Bureau of Professional Education. Accreditation provides assurance that OPTIs have met or exceeded basic established levels of quality for postdoctoral training in osteopathic medicine. Benefits realized from this process include assessment of training institution's financial and philosophical ability to provide quality training programs and the assurance to interns and residents of entering educationally and financially stable programs. All AOA approved internships and residencies became part of an OPTI system no later than July 1, 1999 (see listing of OPTIs in Table 6).

A more recent addition is the linked internship residency selection process commencing with the July, 2001 internship training year. This process links an internship with the subsequent year residency commitment. This eliminates application and selection of a residency during the internship year and assists in filling AOA residencies during the student's 4th COM year. Other initiatives that have played roles in postdoctoral training are the military training programs that have been described earlier.(Table 13)

Table 13 Combined Programs Offering Positions beginning with Year 2001 Match

(2001-02 Academic Year)

	Offered	Filled	Unfilled
Combined Anesthesiology	5	4	1
Combined Diagnostic Radiology	16	16	0

Combined Emergency Medicine	34	31	3
Combined Family Practice	126	91	35
Combined Family Prac/Emer. Med	3	2	1
Combined Family Prac-Osteo Manip Med.	2	2	0
Combined General Surgery	24	17	7
Combined Internal Medicine	55	34	21
Combined Internal Med/Emer. Med.	5	2	3
Combined Neurological Surgery	1	1	0
Combined Neurology	3	3	0
Combined Obstetrics-Gynecology	14	12	2
Combined Ophthalmology	0	0	0
Combined Orthopedic Surgery	13	13	0
Combined Osteo Manipulative Med.	1	1	0
Combined Otolaryn-Facial Plastic Surg.	7	7	3
Combined Pediatrics	15	11	4
Combined Psychiatry	4	3	1
Combined Urological Surgery	1	1	0
Total Positions Being Offered	**329**	**251**	**78**

Source: 2001 AOA Match Statistics.

The current osteopathic rotating internship provides both in-hospital and ambulatory care experience. The curriculum includes, as a minimum, at least five one-month core rotations, including (1) family medicine, (2) internal medicine, (3) general surgery, (4) obstetrics and gynecology, and (5) pediatrics. The internship provides opportunities to enter further levels of residency training, and assists an individual osteopathic physicians' transition from academic osteopathic medical education to the everyday practice of medicine.

Allopathic Internship Model

Kenneth Ludmerer, MD has recently described graduate medical education in the allopathic profession in detail. The reader is referred to this excellent reference.

In 1919 the Council of Medical Education of the American Medical Association published "essentials for approved internship". In 1920 the name was change to Council on Medical Education and Hospitals. In 1920 the Massachusetts General Hospital used the term "intern" to replace "housepupil". In 1927 the first list of approved internships was published. For the first time in 1923, there were enough internships available for all the allopathic graduates of allopathic medical schools. After WWII, 1/3 of the 4,000 hospitals of the US had internship positions, far exceeding the number of graduates of allopathic medical schools.

Internships were divided into three categories: rotating, straight (medical or surgical) or mixed (a combination of rotating or straight internships). These varied from one to three years in length and the quality of these programs also varied greatly. The internship programs that were judged to be of higher quality were generally found in hospitals affiliated with medical schools and those judged to be of lower quality were often small teaching community hospitals. However, this generalization was not absolute, and exceptions were found in both categories.

The modern residency program was introduced at Johns Hopkins Hospital in 1889. Other hospitals added residency programs with the first list published by the AMA's Council on Medical Education and Hospitals on 1925.

The first allopathic specialty board was the American Board of Ophthalmology organized in 1917. As other boards were developed, the current certification authority for the allopathic profession, the Advisory Board of Medical Specialties was formed in 1933.

The growth of allopathic graduate medical education continued to the point in the late 1958. 6861 graduates were available for 12,325 approved intern positions, forcing many hospitals to seek FMG to fill their unfilled positions.

Going into the 1960s, there was concern that allopathic graduate medical education was conducted under multiple systems of oversight, with limited linkage to the colleges of medicine. Both the American Medical Association through the Millis Report, and the Association of American Medical Colleges through the Coggeshall Report recommended that medical colleges and universities take a greater role in graduate medical education.

The pressure on the allopathic internship from the improved medical school clerkships and residencies led to the 1970 decision to eliminate the free-standing internship affective July 1, 1975. This is well described by Max Michael in 1971. The much smaller residual of this internship year experience was called the transitional year, which exists today with 1200 positions in 1999.

Comparison of the AOA Rotating Internship with the ACGME Transitional Year Residency
This year (2001) is the first year that there will be ACGME, PGY-I (transitional year) approved training as comparable to an AOA internship on a pilot program basis. The requirements of the AOA-approved rotating internship are very similar to the ACGME-approved transition year residency with the exceptions as noted in the chart (see Table 14).

Types of institutions in which internship education is occurring

The osteopathic internship as offered in 2001 needs to also be viewed in light of where the education is being offered. Until 1984 when the college-sponsored internships were begun on a pilot basis, OGME occurred only in institutions accredited by the AOA's then Committee on Hospital Accreditation, now HFAP. Today the environment in which this training occurs is considerably different, with much participation from facilities accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

One definition of an "osteopathic" hospital would be that it is accredited by the AOA's Health Care Facilities Program (HFAP). If this definition is accepted, then when the 110 acute care facilities accredited by the HFAP are considered, 46 (42%) of these are accredited by the HFAP only, and of these only 30 (65% of HFAP accredited only) participate in OGME (see Figure 1 and Table 15). These 30 hospitals represent just over one-quarter (27.3%) of the 110 hospitals accredited by the HFAP. This quick analysis shows that the numbers of hospitals accredited by HFAP only is a small number, of which roughly one-third (35%) do not participate in OGME.

Another way of looking at the role of "osteopathic" hospitals in the present AOA internship programs is to examine where internships are located based upon the type of accreditation held by the hospital. There are presently AOA-approved internship programs in 203 institutions (see Figure 2). Of those 203 institutions, 64 (32%) have HFAP and JCAHO accreditation, 30 (15%) have HFAP accreditation only. The data in Figures 2 show that only a minority of hospitals offering AOA-approved internships has HFAP accreditation, either alone, or with JCAHO accreditation. How this will shape the maintenance and development of AOA-approved internship programs is not clear. But clearly, these programs exist in a different environment than they were in prior to the college-based internships and development of OPTIs.

Table 14. Comparison of AOA-approved Rotating Internship with ACGME-approved Transition Year Residency

ACGME Transitional Year	AOA Internship Year
- major objective that ACGME states is that it must be a balanced exposure - three categories of trainees; • graduates who have a requirement of a preliminary year • graduates who have not decided on an specialty • graduates who plan to serve in the Public Health services/military prior to completing GME. - TY Programs must be in an institution with two or more ACGME programs. Two specialties must be designated as sponsors. One Sponsor must be a specialty that provides fundamental clinical skills (these are included in EM, FP, IM, OB/GYN, Peds	- Core rotations were decreased from 9 months of core requirements to 5 core requirements (FP, IM, GS, OB/GYN, Peds). - All rotations must be at least 4 weeks or 1 month in duration. - DME oversees the AOA internship year; with inclusion of Program Director for specialty track internships. - New internship programs must be in an institution with two residency programs, of which one must be in primary care. - Programs must be an OPTI participant. - Minimum number of four interns must be within each intern program.

and Surg). Sponsors must provide 25% of each resident's clinical exposure. - Program director is required for transitional residency. - Institutional coordinating committee that oversees the TY program (sub group of GME hospital committee or freestanding committee). - Ability to obtain clinical history, perform clinical exam, define a patients problem, development of rational plan for diagnosis and implement therapy.. - Emergency medicine must be present with a minimum of 140 hours (4-week rotation). - Transitional Year must have 140 hours of (non-ER) ambulatory care in some form of continuity of care clinic. This can be 140 hours in one rotation or a combination. (35 hours equals one week based upon work hour policies.) - 6 months must be on services where TY residents must work with a senior resident, the other 6 months could be on services where no higher resident supervision is scheduled. - if a hospital losses one of the two main sponsored residencies they lose its transitional year.	

Source: Michael I. Opipari, D.O., Chair, AOA Council on Postdoctoral Training

Impact of the International Medical Graduate (IMG)

Recent data demonstrate that the numbers of IMGs matching into PGY-1 residency programs through the NRMP is declining. Part of this represents a continuing trend over the last two years since the Educational Commission for Foreign Medical Graduates changed its examination requirements and processes. With fewer IMGs competing for existing positions, there is the potential for osteopathic graduates to become more competitive for ACGME-approved programs. There is also the opportunity to develop AOA-approved internship programs in institutions which had traditionally have ACGME-approved programs with large numbers of IMGs.

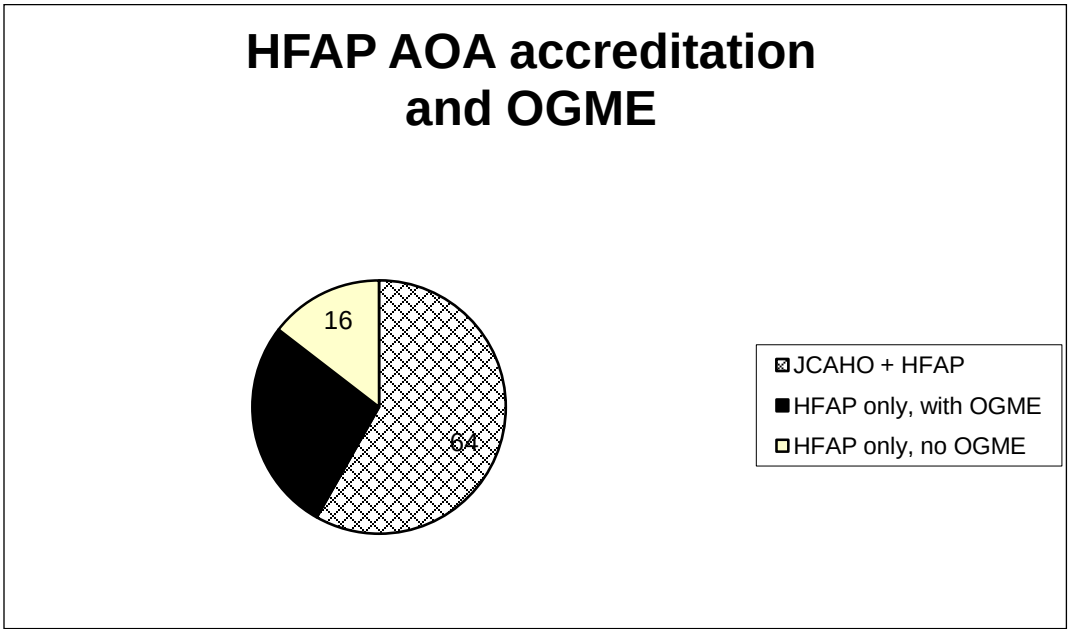

Figure 1. Hospitals Which Are Accredited by the HFAP in June 2001. This figure depicts the 110 acute care facilities accredited by the AOA's Health Care Facilities Program (HFAP). JCAHO = hospitals which are accredited by the Joint Commission for Accreditation of Healthcare Organizations. As of May 31, 2001, there were 545 approved, 484 funded, and 360 filled internship positions in the 30 hospitals having only HFAP accreditation and offering OGME programs.

Figure 2 breaks out the number of internships within the type of accredited hospital. Out of the 203 acute care hospitals in which AOA –approved internship programs are located the following funded and filled positions currently exist:

Table 15 LOCATION OF INTERNSHIPS BY HOSPITAL ACCREDITATION

		Positions		
	Hospitals	Approved	Funded	Filled
HFAP only	30	545	484	360
HFAP + JACHO	64	874	694	560
JACHO	109	1,074	758	534
Total	203	2,493	1,936	1,454

Source: Division of Postdoctoral Training, Internship Training Programs by State Report as of 9/01.

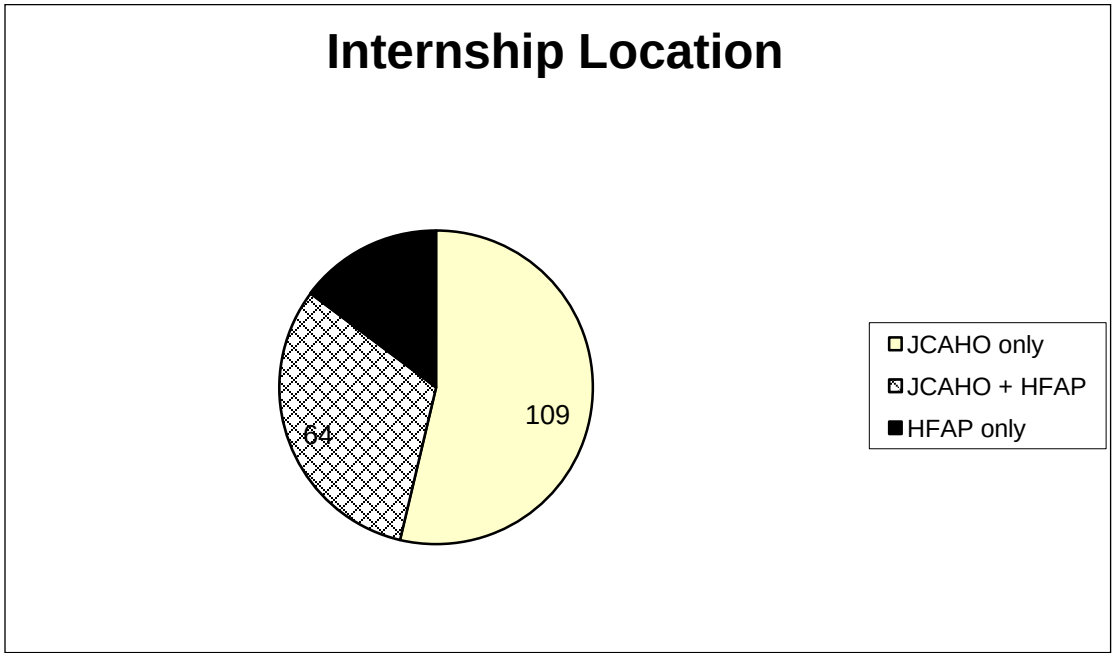

Figure 2. Location **of AOA-approved Internships Based Upon the Source of Accreditation of the Hospital in Which the Program is Located.** This figure depicts the 203 acute care hospitals in which AOA-approved internship programs are located. See legend for figure 1. As of May 2, 2001 there were 874 approved, 694 funded, and 560 filled internship positions in the 64 hospitals having both JCAHO and HFAP accreditation.

Understanding the Vision of the Current Internship

In its deliberations, the Task Force noted that there is no formal statement of mission for the AOA-approved internship. In order to consider the findings of its research, the Task Force developed a statement about the mission of the internship:

> The mission of the osteopathic internship program is to provide first year graduate osteopathic physician's (D.O.) with an in-depth, high-quality and comprehensive year of postdoctoral clinical and academic experience that provides a base for entry into further residency training. Basic to the internship program is the premise that specialist physicians should first be educated as generalist physicians.

Some of the quality measures of a program are:

- patient material of superior depth and breath
- carefully constructed educational plans for each service, including outcomes objectives
- a system of evaluation which would include both performance-based assessment, the prototype of which is the "Objective Structured Clinical Examination" (OSCE) and Clinical Practice Examination
- developed excellent teachers (medical educators) at least in one of the classic primary care disciplines of Family Medicine, General Internal Medicine, and General Pediatrics.
- the following also should apply: "Anyone with responsibility for educating students, residents and physicians should be skilled and well-informed about medical education –as preparing these learners to provide safe, humane and effective care for the members of our society is a heavy responsibility." (Distlehorst, Dunnington and Folse, 2000).

Suggested methods to enhance the quality of training programs include:

1) Identify the individuals who aspire to become excellent teachers and medical educators;
2) Develop an educational program (could take 1 year or longer) to be offered in person and via distance learning technology to include cognitive science and feedback and effective evaluation; and
3) Develop incentives to encourage and promote the continued desire and effort of excellent medical educators.

The internship is founded on the principles of osteopathic medicine, and is under the guidance of qualified osteopathic, and in defined instances, allopathic faculty. Osteopathic medical students, as they approach graduation, may select programs from one of four alternative categories: (1) the traditional rotating internship, (2) the special emphasis internship (3) the specialty track internship, or (4) the combined internship and first year residency.

The internship provides a mix of clinical instruction with "hands-on" service. The program is patient care centered, intensive, varied, and rigorous. It provides for increasing levels of responsibility in clinical decision-making, is academically and medically relevant and challenging. The internship may serve as a first year of residency training as determined by the sponsoring institution in concert with the pertinent specialty college regulations, and approved by the AOA. Also, the internship may be conducted as a freestanding year of training, although few institutions use this model.

Section 4 – Research Findings

Research Question

The internship training of osteopathic physicians has been modified considerably since its inception. With external forces playing a larger role on it attractiveness as a training choice, the Internship Task Force sought expert opinion of those "in the trenches" as to the viability of the currently constructed internship. Is the internship relevant, quality training able to prepare physicians sufficiently and compete with other options in today's postdoctoral training environment?

Research Process

Introduction

The task force recognized the importance of making its recommendations based upon research data. The staff of the Division of Postdoctoral Training, in conjunction with the advice of the Psychometrician in the Division of Certification, prepared and distributed surveys to the key stakeholders in the osteopathic graduate medical education arena: the directors of medical education (DMEs); the specialty colleges; the Osteopathic Postdoctoral Training Institutes (OPTIs). The task also surveyed graduates from the COMs in the year 2001 who did not enter the AOA intern match.

DME's, specialty colleges and OPTI's survey results—because of different roles and different questions asked–reflect differing perspectives on the current state of the traditional rotating internship and its variants.

Results from the DMEs

Two hundred surveys were sent to DME's. As of mid-January 2001, 48% of the surveys had been returned. (See Appendix 2 for the survey instrument and Appendix 6 for the results of the analysis.)

Those DME's who responded in general support the status quo for the traditional rotating internship: they want it retained and maintained with its current structure and curriculum, but they can support combin

DME's also strongly agree that the internship needs to be marketed to COM students very early in their careers (Items 12 & 15).

DME's are a bit less sure but still largely in agreement that the special emphasis and specialty track internships help recruit and retain DO's in osteopathic postdoctoral training. (Items 8 and 9.) They do not think that time spent in either the emphasis or track can be better utilized in the residency (Item 19).

What do DME's think most discourages student choice of the internship? Perceived quality problems (Item 6). They are less convinced of the role of funding differentials, which affect movement between AOA and ACGME training, although they do recognize these issues as important (Items 5 and 7). They see geographic location as a lesser factor, yet relevant, to students' rejection of the internship (Item 10). High student debt load is seen by DME's as least affecting choice of the internship option (Item 11).

In considering their function, DME's would like to be the administrative leader of all osteopathic training at their institutions, would like to see the role "Intern Program Director" developed and would appreciate more time within which to fulfill their responsibilities. (Items 13, 12, and 18.)

In general DME's support closer working relationships with ACGME regarding dual track programs (Item 17).

Finally, the DMEs strongly recommended the inclusion of an emergency medicine rotation as one of the core requirements of the internship.

Results from the Specialty Practice Affiliates

The survey was sent to seventeen specialty colleges, three copies—one for the executive director, the president and the chair of the education evaluating committee. (See Appendix 4 for the survey instrument and Appendix 8 for the results of the analysis.) Eleven colleges responded; of those two returned three surveys each.

There was overwhelming support for the traditional rotating internship as currently configured (Items 9, 1, 4, 3, 12, and 2) and for the existing specialty track and special emphasis options (Items 5, 11, and 6). Specialty colleges also believed, however, that the traditional rotating internship could be modified to enhance its value to the physician in preparation for specialty program requirements (Item 7).

If the specialty college did not have a special emphasis internship, it might or might not (50% for, 50% against) see the need to develop one (Item 14). If it did not have a specialty track internship, it likely did not see the need to develop such a track (Item 13).

Some trainees perceive that the osteopathic internship lacks sufficient value for them to seek to include this component in their GME plans. There was total agreement that this perception of the internship needs to be changed (Item 17).

Specialty colleges were not inclined to support the concept of role, "Internship Program Director," (Item 8) and even less likely to accept the ACGME Transitional Year as the first year of residency training (Item 16).

Results from the OPTIs

Sixteen OPTI's were surveyed; ten returned completed questionnaires. (See Appendix 3 for the survey instrument and Appendix 7 for the results of the analysis.) OPTI's agree that the specialty track is the superior tool for recruitment (Item 8); 100% agreement compared to 89% for the special emphasis internship (Item 9) and 80% for the traditional rotating internship (Item 7). There is almost equal agreement to use "telemedicine," i.e., televideo conferencing within all of the internships regardless of type (Items 15, 13, and 14).

The traditional internship is considered to have been of positive value by those trainees who have completed one (Items 20 and 21). Moreover sixty percent of OPTI's report that the rotating internship is not more difficult to administer than other types of first year training experiences (Item 19).

OPTI's believe that they should be playing a larger role (sometimes in the hospital) regarding all types of current internship experiences (Items 8, 1, 2, 9, 3 and 1).

More like the specialty colleges than DME's, OPTIs appear to be receptive to (or unaffected by) changes in the traditional rotating internship (Item 18), and they perceive no negative financial impact upon the OPTI if the structure of the traditional rotating internship were changed (Item 18).

In general, the OPTIs do not see DME's as resistant to integration of the internship into the OPTI (Item 16).

Results from COM Graduates in 2001 Who Did Not Enter the Match

In May 2001, the Division of Postdoctoral Education of the AOA Department of Education conducted a survey of COM graduates in the present 2001 year who did not enter the AOA Match. As of August, 2001, 389 responses out of 982 surveys have been received. Of the 389 respondents, 16 indicated military training, 339 indicated their plans to enter an ACGME training program, 29 did not plan to enter an ACGME-approved program, and 5 respondents failed to complete the survey. The results from the respondents, are ordered in descending frequency below:

1. 144 = Perceived quality problems in osteopathic internship programs.
2. 141 = No AOA-approved internships were available within my chosen geographic location.
3. 125 = Too much hassle to seek an internship and then a residency.
4. 115 = Limited osteopathic opportunities in chosen specialty.
5. 112 = The AOA internship is not accepted by my ACGME residency program, which would have made it necessary to repeat the PGY-I training year.
6. 95 = Cost considerations of moving from an internship to a residency.
7. 72 = Limited numbers of tracked internships are available.
8. 52 = Perceived lack of recognition of AOA training in obtaining hospital privileges in allopathic hospitals.

9. 52 = The institution for my residency program will not accept Dos into a PGY-II position after completion of an AOA internship due to funding reimbursement issues.
10. 15 = An inability to match with a residency program in the 4th year of osteopathic medical school.

Summary

DME's, who have the strongest stake in the traditional rotating internship, are the most inclined to support it as currently configured. What was not asked of them, however, is what internship are they speaking about? In other words, what is the way or what are the ways in which they implement the traditional rotating internship at their institutions? What are the specifics of the training (the rotations, the curriculum, the experiences) which make this internship of value to the physician in training at their institution?

Specialty Colleges, which are more attuned to the residency experience than the internship, are quite receptive to the possibility of modification of the traditional rotating internship to enhance the residency experience. Specialty colleges should be charged by the AOA to propose models for changing the traditional rotating internship configuration to better serve their residencies.

OPTI's seem to be saying they should be getting more active with the internship—promoting it? If this is the meaning to be derived from the survey results, systematic, effective marketing of the internship, especially the traditional rotating internship, is strongly supported by both of the above constituencies.

The sampling of COM 2001 graduates who did not enter the AOA match indicated perception of quality, geographic availability, "hassle" of seeking an internship and residency, limited opportunities in specialty as the top four reasons.

Study conducted for AOA Department of Membership

During the deliberations of this task force, the AOA Department of Membership was completing a study of trends affecting osteopathic physician's decisions to become members of the AOA. The focus of that study was to better understand how osteopathic students make decisions about selection of residency programs and what impact that selection process has on later decisions to affiliate with the osteopathic profession. When residents were asked why they did not enter into the AOA match, the major reasons cited were: location of the programs; the ACGME match includes the entire residency period; residents' career choices included areas of limited or no osteopathic residency programs; and ACGME-approved programs offered more selection possibilities. The four most important factors in selecting a residency were: quality of training; reputation of program; location of program; and career prospects.

Study Conducted by the St. Vincent's Hospital (Toledo, OH)

During the deliberations of this task force, a series of discussions on the osteopathic internship were also taking place at the St. Vincent's Hospital in Toledo, OH. The discussions were structured around focus groups with the residents at that institution. Some of their conclusions were reported to the task force at its January 20, 2001 meeting. The findings of those discussions are now listed:

- The PGY-1 year should be connected with the residency program when possible.
- Special emphasis and specialty track internship programs should be expanded.

- Some members of the interviewed group felt the internship should be structured more like the ACGME-approved Transitional Year Residency.
- The internship year becomes a disadvantage because of the added financial burden.
- The internship year becomes a disadvantage when an ACGME residency is pursued.
- The requirement that an AOA internship be completed for licensure in five states should be changed in those states.
- Internships should be created in additional geographic locations.
- The perception of the quality of training in an osteopathic internship should be addressed.
- Students make decisions regarding their preferences for postdoctoral training in the second and third years of osteopathic medical school.
- The AOA "Opportunities" data need to be kept more current.
- Students questioned the internship and membership requirement for participation in future AOA training programs.
- The group suggested having the match on the same day as the NRMP match.

SWOT Analysis

As part of its work product, the task force prepared a Strengths / Weaknesses / Opportunities / Threats "SWOT" analysis. The results of that analysis are listed below.

Strengths "S"

Perception

- The rotating internship provides a setting for development of skills in OPP/OMT.
- The rotating internship is an osteopathic tradition
- The rotating internship is one of the defining elements of the profession. It is distinctive; what makes a D.O. a D.O.
- The rotating internship produces physicians who have demonstrated attainment of core competencies.
- The rotating internship is accepted and recognized in the osteopathic community.
- The rotating internship fulfills societal responsibilities by producing well-rounded physicians.

Service

- **The rotating internship provides a setting for development of skills in OPP/OMT.**
- **The rotating internship produces a scope of experience.**
- **The intern learns basic manual skills and procedures.**
- **Primary** care is an emphasis of the rotating internship.
- Interns become more patient-friendly in their orientation.

Education

- The rotating internship provides a setting for development of skills in OPP/OMT.
- The rotating internship provides flexibility to the trainee.
- The rotating internship offers education focused on primary care.
- The rotating internship prepares the graduate for a residency.
- The rotating internship develops communication skill and personal maturity.
- The rotating internship promotes maturation of clinical skills.
- The rotating internship promotes patient advocacy.
- The rotating internship provides opportunities to develop core competencies.

- Allopathic attending physician's report that osteopathic trainees have a better attitude about learning.

Weaknesses "W"
Perception

- There is a perceived lack of quality in some internship training programs.
- The rotating internship is perceived by some as only a tradition.
- The rotating internship is perceived by some as more oriented to a hospital's service needs rather than toward education.
- The rotating internship is one less productive year.
- Without linkage to a residency, the rotating internship becomes a year where the trainee is in limbo.
- Does the rotating internship still have value in contemporary medical education?
- There is a perceived lack of definition of function and purpose in the rotating internship.

Reality

- There are not enough AOA-approved internship positions for our present COM graduates.
- The geographic location of AOA-approved internship positions is concentrated in the Eastern and Midwest regions of the U.S.. The 19 COMs are spread throughout the U.S.
- The osteopathic intern incurs a financial burden because of debt from educational loans and because of lost income due to marketability of the graduate to ACGME-approved residencies.
- Completing an osteopathic internship reduces the flexibility of entry into ACBME-approved residencies.
- The osteopathic rotating internship has less recognition and acceptability outside of the osteopathic profession that within the osteopathic profession.
- The osteopathic intern feels s/he loses salary and benefits by participating in the program, thereby making family financial hardship more likely.
- The BBA97 reduced ability to expand current programs, reduced reimbursement, and placed a cap on the number of positions.

Education

- The rotating internship program as a whole has a lack of consistency and quality
- The rotating internship program as a whole has variability in individual program leadership and orientation for the trainee.

Opportunities "O"
Perception

- The opportunities to address concerns about the rotating internship are greater than one imagines.
- Communication is improved at all levels.
- Presence of an internship program assists recruiting of medical staff and marketing of services.
- The internship strengthens and balances the role of education versus service.
- The internship can be redefined.

- The perception of value of the rotating internship versus the track and emphasis internships can be better balanced.
- The internship reinforces distinctiveness of the osteopathic profession.

Reality

- Collaboration with ACGME on acceptance of the AOA rotating internship will enhance the value of these programs.
- Development of internships leads to residency development also.
- The geographic imbalance in location of internship positions and their demand can be addressed.
- OGME in ambulatory sites is expanding.
- The rotating internship can be modified to meet the needs of contemporary medical education.
- The rotating internship serves as a point of collaboration in the osteopathic profession through the OPTIs, COMs and hospitals.

Education

- The rotating internship can be modified to meet contemporary medical education needs.
- OPP/OMT can be incorporated to a greater degree in the rotating internship.
- The rotating internship is a springboard for developing residency training.
- Outcomes evaluation (with pre- and post- testing) can be incorporated into the rotating internship curriculum.
- Education in rotating internships is supportive of COMs' missions.
- The rotating internship provides opportunity to strengthen and balance the role of education versus service.

Threats "T"

Perception

- The growing acceptance of midlevel providers will provide competition for the services traditionally provided by osteopathic physicians.
- Any statement of lack of support for the rotating internship is perceived as a lack of commitment to the osteopathic profession.
- The educational relevance of the rotating internship is undergoing severe scrutiny.
- Osteopathic students perceive a lack of value in the rotating internship.

Reality

- There is a loss of internship training capacity that is being caused by mergers and closures of traditionally osteopathic hospitals.
- The movement from fee for services medicine to managed care.
- The development of hospitalist physicians could limit need and opportunities for hospital-based services provided by trainees in rotating internships.
- Financing of OGME is less than optimal.
- The BBA97 has begun to reduce the funding available for GME in general, and OGME especially.

Education

- DO educator leadership role models are lacking in programs, which have both AOA and ACGME approval.
- Osteopathic internships do not provide linkage with DO residencies.
- OGME faculty numbers are limited, and clinicians face mounting pressures to refrain from service as teaching faculty.
- OGME programs are dependent on voluntary faculty.
- There are insufficient primary care rotations, especially in family practice.
- There are insufficient pediatrics, obstetrics & gynecology, and psychiatry rotations.
- There are insufficient numbers of patients for clinical teaching opportunity.
- There are insufficient continuity of care rotations.
- There is competition for patients who are available for clinical teaching.
- The educational relevance of the rotating internship must be continually be demonstrated to the potential osteopathic trainee.

Workforce

- Because of the marketability of COM graduates to ACGME programs, will the need for an osteopathic internship for each COM graduate continue to exist?
- Growth in the number of students at COMs exceeds the rate of development of new OGME positions, creating a growing imbalance.
- OGME programs are facing greater competition within the profession for recruiting of trainees.
- There is competition for patients who are available for clinical teaching.

Section 5 – Questions for Further Consideration

Qualified Pre-matching Within an OPTI

In the course of its deliberation, the task force identified a question for further consideration. The research data collected and reviewed by this task force illustrated the importance of early decision and articulation of the internship and residency experience as factors of importance to the student in making a choice for graduate medical education. The Task Force believes the following question should be considered by an appropriate committee of the AOA: "Should students who complete clerkships in an OPTI during their third and fourth year of osteopathic medical college be allowed to sign a contract with an OPTI for an internship prior to the AOA Match?" If yes, should there be a limit on the number of positions eligible for this pre-matching, e.g. 50%? The ECCOPT discussed this topic at its July, 2001 meeting. The Executive Committee reviewed a proposal to allow OPTIs to withhold half their internship positions for their own students. The Executive Committee concluded that this proposal would only help students in large OPTIs. It would not level the playing field for students. The Executive Committee decided not to support the proposal.

Dual Recognition of the first GME Training Year

The Task Force believes the issue of recognition of the same year of experience as meeting both AOA postdoctoral training and ACGME-approved postdoctoral requirements should be studied. This Year (2001) is the first year that there will be ACGME, PGY-I (transitional year) approved training as comparable to an AOA internship on a pilot program basis.

Section 6 – Four areas of domain for strategic planning

The Task Force identified the following points for development of the strategic plan for the AOA internship. These points have been identified into the following objectives to fit into the format of the AOA Strategic plan.

Objective 2-A: Identify the areas where Educational Paradigm Shifts are taking place, or are needed in osteopathic graduate medical education.

Goal a: Improve quality OGME through the continuum of medical education.
Activity: Develop a program to establish identifiable linkages between osteopathic internship and residency training.

Responsibilities: DME's, OPTI education committees, and specialty college educational committees, with a report to ECCOPT.

Time-Line: Conduct a one-year study, throughout academic year 2003.

Goal b: Improve quality by focusing on the educational aspects of OGME, keeping a balance between service and education.
Activity: Establish a system within the AOA on-site evaluation process to assess the relationship between the Educational and the service aspects of each program. Incorporate this in the OPTI self study procedures.

Responsibility: ECCOPT.

Time-Line: Prepare a report to COPT for presentation in the fall of 2002.

Goal c: Improve the competitiveness of OGME programs by equalizing the number of years of OGME training with counter-part allopathic training.
Activity: Prepare a study that identifies the training requirements between ACGME and AOA programs to equate years of training between osteopathic and allopathic programs.

Responsibility: Identified specialty colleges, oversight by ECCOPT.

Time-Line: Identified specialty colleges report their findings to the September 2002 ECCOPT.

Goal d: Address quality in the traditional internship program by offering specialty didactic opportunities to trainees.
Activity: Request OPTIs and DMEs to prepare and implement a program that

encourages programs to integrate specialty didactics, lectures, and related experiences, into the traditional intern curriculum at their institutions.

Responsibility: OPTI leadership, with oversight by ECCOPT.

Time-Line: Incorporate this as a session at the September OME Conference, and Integrate into the OPTI self study process by the spring of 2003.

Goal e: Create internships that are relevant to individual intern educational/service experience needs.

Activity: Establish an Internship Curriculum Committee to assess the traditional intern training program and identify the means for personalizing the training of each intern.

Responsibility: ECCOPT in coordination with AODME.

Time-Line: Prepare a report for ECCOPT review, Spring 2003.

Goal f: DMEs role in OGME programs.

Activity: Change title and responsibilities of the DME to Chief Academic Officer.

Tactic: Develop specific criteria pertaining to what constitutes a true Chief Academic Officer, i.e., educational training, experience, financial awareness and assessment and development of skills appropriate to this position. Establish intern program director. All programs within an institution need the assistance of an intern program director to promote all of the specialty programs and to communicate to trainees.

Responsibility: AOA Staff/ECCOPT in conjunction with AODME.

Time Line: Prepare for inclusion in AODME workshop for March, 2002.

Goal g: Expand AOA training opportunities by promoting the utilization of ACGME programs through OPTIs.

Activity: The AOA, through its OPTIs should continue to encourage postgraduate training within the osteopathic profession whenever possible for all of its trainees through dual accreditation process.

Tactics: Programs should parallel ACGME requirements when possible to allow ease of transferring training between AOA and ACGME programs.

Responsibility: to be determined.

Time-Line: Explore during Year 2002 with full implementation by the 1st quarter of Year 2003.

Goal h: Improve the geographic distribution of AOA approved graduate medical education.

Activity: Address issues of geographic mal-distribution.

- Complex issues should be addressed at the various levels of national, state and various specialty groups.

Suggestions: This should be address under Objective 2-A, and is not a marketing or communication issue per se.

Responsibility: OGME Initiatives/ACGME/OPTIs/AOHA

Time-Line: Ongoing

Objective 2-B: Study accreditation standards, policies and processes, making revisions as needed.

Goal a: Incorporate outcome measures into the accreditation process.

Statement of Purpose: The osteopathic profession has historically avoided inclusion of outcome measures in its assessment instruments and determination of educational quality.

Objective: Agree upon outcome measures, e.g., certifying board results, performance on in-service examination, etc. that are indicators of educational quality and incorporate them into the inspection process.

Tactic: Appoint a subcommittee of specialty colleges, DMEs, and educational specialists to formulate and agree upon universal outcome measures.

Responsibility: Bureau of Professional Education.

Timeline: to be determined

Goal b: Create a core of paid-trained inspectors to evaluate AOA postdoctoral programs. The osteopathic profession has relied exclusively on volunteer inspectors to assess postdoctoral programs. The effectiveness of the inspection process has wide variability in terms of quality.

Activity: Create a cadre of professional inspectors to standardize the inspection process.

Tactic: Provide a system that supports a set of professional evaluators both on a full

and part-time basis.

Responsibility: ECCOPT/AOA Staff in collaboration with ACGME leadership.

Time-Line: Currently in progress. Pilot program of select specialty colleges being conducted for implementation by Spring, 2002. Results from pilot will determine time line for full initiation, ideally within 18 months after conclusion of pilot.

Goal c: Access the efficacy of training standards by means of self-assessment and outcomes data on a scheduled basis.
Statement of Purpose: Changes are made in accreditation standards with the intent of generating a desired end or an enhancement in educational quality. Currently, no mechanism is in place to assess the effectiveness of accreditation changes and whether the desired end has occurred.

Objective: Policy changes, when adopted, should include a rationale and an articulation of how the policy will improve current policy and identify desired ends.

Tactic: The responsible accrediting group should evaluate policy/accreditation policies after stated periods of time to assess qualitative improvement and achievement of desired ends.

Objective 2-C: Review the current status of Educational Support resources for osteopathic graduate medical education making revisions where necessary.

Goal a: Develop OGME program in settings already approved for ACGME programs (dual accreditation).
Activity: Continue discussions with ACGME leadership. Develop a planned program for identifying and initiating discussions with receptive ACGME Institutions.

Responsibility: OPTI leadership and the Kasovac Initiative, with ECCOPT oversight.

Time-Line: This is already initiated, and should be further developed administratively. Plan to be in place by the 1st Quarter of Year 2003.

Goal b: Encourage development of specialty track internships.
Activity: Prepare a workshop for OPTI and program leadership.

Responsibility: ECCOPT and OPTI leaders, AODME

Time-Line: Conduct the workshop at the Spring, 2002 meeting of COPT.

Goal c: Assist new OGME training sites with faculty and support development.
Activity: Plan a program for identifying locum tenens/consultants, mentors and change agents for new training sites.

Tactic: Develop a team of specialists to address faculty development and support. Solicit input from specialty colleges.

Responsibility: OPTI leadership, AODME

Time-Line: For discussion at the AODME workshop at is Spring, 2002 meeting, and the OPTI workshop in May, 2002. Finalize the program for review by Spring, 2003.

Goal d: Develop teacher/leaders throughout the OGME system.
Activity: Create a "Master Teachers" program.

Responsibility: AACOM in concert with specialty colleges and OPTIs.

Time-Line: Develop during 2002.

Goal e: Establish faculty status within the OGME system for residents who teach.
Activity: Plan a program to elevate residents that teach to faculty status. Incorporate this information in the OPTI annual report.

Responsibility: OPTI leadership/AACOM with AOA staff .

Time-Line: Prepare recommendations from Group to COPT at the Fall, 2002 Meeting.

Goal f: Assist OPTIs with their search for external grants.
Activity: Develop a network of grant writers within the educational field.

Responsibility: AOA staff, Research and OPTI offices.

Time-Line: Prepare a report for the fall meeting of COPT, 2002.

Goal g: Improve OPTI and OGME program evaluation of their own programs.
Activity: Institute a program to integrate self-study mechanisms into each OPTI sponsored internship and residency, as well as self study of the OPTI itself.

Tactic: Integration of self-study program with OPTIs.

Responsibility: ECCOPT

Time-Line: To be determined once process has been defined between OPTI and

ECCOPT.

Objective 2-D: Increase awareness and utilization of osteopathic internship and residency programs by establishing a national Marketing and Communication Program.

Goal a: Develop and maintain a strategic marketing plan for osteopathic graduate medical education institutions both locally and at a national level.

2000 Develop a strategic marketing plan for training institutions:

a. Training institutions must recognize that decreasing number of D.O. graduates are going into AOA approved programs and take proactive measures to promote osteopathic training.
b. Training institutions should consider budgeting funds to contact schools and market their programs where and when appropriate.
c. Training institutions should develop a core of strongest links, i.e., interns, residents, staff to communicate positively with the schools and student physicians to convey the advantages of an AOA approved postgraduate program.
d. Foster a strong link with new students following acceptance into a college of osteopathic medicine. Links to include various entities of the osteopathic profession including specialty organizations/colleges along with training institutions, hospitals and national and state organizations as well as local county organizations, OPTIs, etc.
    i. Target Fall, 2002 class;
    ii. Target current 2nd and 3rd year students; and
    iii. Create a new AOA recruitment pamphlet.

Responsibility: AACOM, with assistance of AOA Staff, Division of Postdoctoral Education and AODME with oversight by the ECCOPT.

Time-line: Interim Plan implementation in June, 2002.

Goal b. Enhance Internet and technological sources, including the development of an electronic application system similar to ERAS.

Activity: Enhance internet and technological resources including the development of an electronic application system similar to ERAS:

Tactic: Simplify paperwork to enter multiple training programs. Develop a database of students' interests in various specialties and continue communications with them.

Responsibility: AOA Staff, Division of Postdoctoral Education and Department of Communication.

Time-Line: Complete the initial phase no later than March 2002, project to be completed By March 2003.

Goal c: Involve DMEs in marketing their OGME programs.

Activity: Initiate an AOA/AODME program on marketing within Goal a above.

Responsibility: Convene an ECCOPT and AODME work group to develop a marketing plan within Goal a above.

Time-Line: Prepare a workshop program for the March, 2002, AODME meeting.

Goal d: Involve AOA leadership in the OGME marketing/communication program.

Activity: AOA leaders serve as presenters and in supporting roles within the National Marketing and Communication Program as designed within Goal a above. All leaders of the AOA are encouraged to promote AOA postgraduate training programs with conviction and enthusiasm at every opportunity.

Responsibility: Coordinate through the offices of the President and the Executive Director.

Time-Line: Initiate in early 2002.

Goal e: Increase awareness of internships programs.

Activity: Identify various vehicles for increasing the advertising of internship programs, and create the tools for use of those vehicles. Advertise, through personal contacts by one-on-one communication via e-mail, fax, and telephone calls.

Responsibility: Brochure to be developed by AOA Division of Postdoctoral Training Opportunity
Website enhancement to be developed by IT Department in collaboration with the Division of Postdoctoral Training.

Time-Line: January, 2002, field-testing. Full implementation/active on-line, March/April, 2002.

Goal h: Develop an aggressive marketing campaign to COMs, hospitals and OPTIs.

Activity: Develop aggressive marketing campaign to colleges of osteopathic medicine, hospitals and OPTIs.

Tactics: Develop protocol for handling students coming to educational institutions, i.e. hospitals for inspections and interview.

a. Student inquirers should have knowledgeable persons receiving calls, answering warmly and setting up appointments to visit and tour the institution.
b. Arrange to meet people in programs, i.e. intern directors, DME (Chief Academic Officer), program directors, chief residents, strong link residents, staff physicians.
c. Time must be spent with all potential intern, residents if the hospital desires a particular student or physician, they must aggressively pursue this, given the climate in which postgraduate education is currently dealing with.
d. Determine costs associated with campaign.

Responsibility: OPTI Leadership in collaboration with AOA Staff.

Time-Line: May, 2002

Goal i: Enhance AOAs Web site and provide methods to access AOA's training opportunities.

Activity: Enhance AOAs website to facilitate member's ability to access AOA's training opportunities.

Responsibility: Institutions have access to AOA's website to update its respective information. Oversight by AOA Division of Postdoctoral Training in collaboration with IT Staff.

Time-Line: Work-in-progress to be field-tested ready by January, 2002, with full implementation by March or April, 2002.

Goal j: Develop AOA leaders to define and promote osteopathic distinctiveness within the internship.

Activity: Develop a skeletal framework as a starting point. Identify good communicators within the AOA to present this message at-large, preferably physicians in the various areas of specialty: Family Practice, IM, Surgery, Anesthesia, OB/GYN, Pediatrics, PMR, etc. Provide an in-depth understanding of osteopathic principles and practice.

Tactic: The distinctiveness of the AOA internship and/or postgraduate training should be emphasized, in additional our residents who are graduates of AOA programs must be made aware of the fact that they have an excellent opportunity to be accepted in ACGME Fellowship programs after completing an AOA-approved residency. This has not been marketed well and the misconception regarding opportunities for our graduates does not exist.

Note: This matter has been extensively addressed by the curriculum committees of COMs, and the education committees of specialty colleges. If there is confusion, then the Bureau of Professional Education should convene a special group to draft a clarification statement.

Responsibility: ECCOPT/Bureau of Professional Education

Time-Line: To be discussed by ECCOPT at its January, 2002 meeting and for discussion by BOT in February, 2002. Complete the work prior to the July 2003 House of Delegates.

Section 7 – Recommendations presented in July 2001

Recommendations to the AOA Board of Trustees

The task force presented six recommendations to the AOA Board of Trustees for consideration at its July, 2001 meeting. The text of the RESOLVED clauses is now listed. (Complete copies of the resolutions will be found in the agenda books for the meeting).

Resolution 50 (A/01): Retention of Osteopathic Rotating Internship

RESOLVED, that the AOA-approved rotating internship should be retained. BOT Action: Approved.

ECCOPT Action: The ECCOPT supports this resolution. The ECCOPT noted that the AOA Board of Trustees adopted this resolution so no further action by ECCOPT is required. The ECCOPT recommends that the Rotating Task Force consider amending the resolution to provide a rationale for the retention of the rotating internship, why the internship should be retained, and what the internship is intended to accomplish.

Resolution 51 (A/01): Osteopathic Graduate Medical Education (OGME) Programs Should be Expanded
RESOLVED, that more osteopathic graduate medical education (OGME) programs need to be developed; and, be it further

RESOLVED, that osteopathic specialty practice affiliates which do not currently have specialty track or emphasis internships be encouraged to consider the development of such programs.

BOT Action: Approved.
ECCOPT Action: The ECCOPT supports this resolution with one modification. The ECCOPT noted that the AOA Board of Trustees adopted this resolution, so no further action by ECCOPT is required. However, the ECCOPT believes the second resolve should be modified to "strongly" encourage the development of specialty track or emphasis internship programs. The ECCOPT recommends that the Rotating Internship Task Force communicate the concept of this resolution to the relevant specialty colleges.

Resolution 52 (A/01): Rotating Internship Requires Emergency Medicine as a Rotation
RESOLVED, that the requirements for an AOA-approved rotating internship be revised to include a sixth core rotation consisting of one month of emergency medicine.

BOT Action: Referred back to Executive Committee of the Council on Postdoctoral Training (ECCOPT).

ECCOPT Action: The ECCOPT supports this resolution. The ECCOPT is recommending to the full AOA Council on Postdoctoral Training the addition of one month of emergency medicine as a core rotation. Revisions to the Basic documents for Postdoctoral Training has been approved by the ECCOPT and will be reviewed by the COPT at is November, 2001 meeting.

Resolution 53 (A/01): Intern Program Director
WHEREAS, the time needed to conduct the administration of an internship program represents a distinctive professional activity; now, therefore be it

RESOLVED, that each AOA-approved internship must have an Intern Program Director, who shall have responsibility for the conduct of that internship.

Explanatory Statement. The same person who serves as the Director of Medical Education may fill this position.

BOT Action: Referred back to Executive Committee of the Council on Postdoctoral Training (ECCOPT).

ECCOPT Action: The ECCOPT supports this resolution. The ECCOPT is recommending to the full AOA Council on Postdoctoral Training the addition of an internship program Director in the Basic Documents of Postdoctoral Training. Revisions to the Basic Documents has been approved by the ECCOPT and forwarded to the COPT for its November, 2001 meeting with the inclusion of draft language.

Resolution 54 (A/01): Vision of the AOA Rotating Internship
WHEREAS, basic to the internship program is the premise that specialist physicians should first be educated as generalist physicians. ; now, therefore be it

RESOLVED, that the mission of the osteopathic internship program is to provide first year graduate osteopathic physicians (D.O.) with an in-depth and comprehensive year of postdoctoral clinical and academic experience that provides a base for entry into further residency training.

BOT Action: Referred back to Executive Committee of the Council on Postdoctoral Training (ECCOPT).

ECCOPT Action: The ECCOPT supports this resolution and recommends the following modification:
RESOLVED, that the mission of the osteopathic internship program is to provide first year graduate osteopathic physicians (D.O.) with an in-depth and comprehensive year of postdoctoral clinical and academic experience that provides a base for entry into ~~further residency~~ SPECIALTY training.

Resolution 55 (A/01): Annual Post-Match Survey of COM Graduates
WHEREAS, it is important to have a current understanding of reasons why COM graduates do not pursue an AOA-approved osteopathic internship; now, therefore be it

RESOLVED, that an annual survey of COM graduates, who do not match in the AOA Intern Registration Program (AOA Match), be undertaken after the AOA Match is concluded.

BOT Action: Referred back to Executive Committee of the Council on Postdoctoral Training (ECCOPT).

ECCOPT Action: The ECCOPT supports this resolution and recommends that it be adopted.

Listing of Appended Materials

Appendix 1: Statistics for AOA Intern Match, January 2001
The AOA Department of Education, Division of Postdoctoral Education, maintains a statistical report of the Intern Registration Program "the Match" with revision for post-match activity and projection of future activity and needs, based upon current experience. A copy of that report is appended, current as of the issuance of the task force's report.

Appendix 2: Survey of DMEs
The AOA Department of Education, Division of Postdoctoral Education constructed a survey instrument to query directors of medical education about internships.

Appendix 3: Survey of Osteopathic Postdoctoral Training Institutes (OPTIs)
The AOA Department of Education, Division of Postdoctoral Education constructed a survey instrument to query OPTIs about internships.

Appendix 4: Survey of Specialty Practice Affiliates
The AOA Department of Education, Division of Postdoctoral Education constructed a survey instrument to query specialty practice affiliates about internships.

Appendix 5: Survey of COM graduates in 2001
The AOA Department of Education, Division of Postdoctoral Education constructed a survey instrument to query COM graduates in 2001 about internships.

Appendix 6: Data From Survey of DMEs
Staff of the Division of Postdoctoral Education, and the AOA Psychometircian analyzed data from surveys returned by the DMEs.

Appendix 7: Data From Survey of OPTIs
Staff of the Division of Postdoctoral Education, and the AOA Psychometircian analyzed data from surveys returned by the OPTIs.

Appendix 8: Data from Survey of Specialty Practice Affiliates
Staff of the Division of Postdoctoral Education, and the AOA Psychometrician analyzed data from surveys returned by the Specialty Practice Affiliates.

AOA Internship Survey to Director's of Medical Education

Appendix 2

	Internship Questions	Strongly Agree	Agree	Disagree	Strongly Disagree
	Value of Internship:				
1	All of the required rotations of the traditional internship are valuable.				
2	Aspects other than the required rotations make the traditional rotating internship valuable.				
3	You favor the continuing traditional rotating internship model.				
4	The AOA internship should be combined with AOA residency training.				
	Recruiting Issues:				
5	You think federal funding differences between the AOA internship and ACGME transitional year puts DO students at a disadvantage for DO Intern/Residency slots.				
6	You feel DO students are avoiding DO internships because of perceived quality problems.				
7	You feel D.O. students are avoiding DO internships because of financial concerns about losing a year of federal reimbursement if they enter ACGME programs.				
8	You think tracking and special emphasis internships help **recruit** DO students for Osteopathic residency programs.				
9	You think tracking and special emphasis internships help **retain** DO students in Osteopathic training programs.				
10	You feel that DO students avoid an internship because of lack of geographically appealing sites.				
11	You feel that DO students avoid an internship because of high student debt load.				
12	It is important to have an organized marketing plan for the				

	internship.				
	AOA Policy Issues:				
12	There should be a more defined role for an Intern Program Director.				
13	Do you think the DME role should be more clearly defined as the administrative leader for all DO training programs at an institution.				
14	The DO internship should be structured more like the ACGME transitional year.				
15	The OPTI process should provide more support for Osteopathic internships.				
16	The current five required rotations of the traditional rotating internship could be modified. The additional rotations that should be added to the five core requirements are: _____ _____ _____ _____ _____ _____ _____ _____				

AOA Internship Survey to Director's of Medical Education

	External Policy Issues:	Strongly Agree	Agree	Disagree	Strongly Disagree
17	The AOA should explore a closer working relationship with ACGME regarding dual track programs.				
18	The DME has enough time to appropriately manage the internship program.				
19	Some of the time spent in the specialty track/emphasis could be better utilized in the residency. Some suggestions of this would be: _____ _____ _____ _____ _____ _____ _____ _____	---------- -	------- -	---------- -	---------- --

20. When do you think DO students decide about future post-graduate training positions?

Circle One:

A. 1st year COM
B. 2nd year COM
C. 3rd year COM
D. 4th year COM

	What kind of role DOES the DO internship play in the following tasks?	Major Role	Minor Role	No Role
21	The AOA Internship prepares a well-rounded physician.			
22	The AOA Internship prepares a student for a DO residency program.			
23	The AOA Internship meets state licensing requirements.			
24	The AOA Internship provides an additional year of training for the student to decide on a career.			
25	The AOA Internship integrates the clinical aspects of OMM.			
26	The AOA Internship provides patient care service.			
27	The AOA Internship prepares the student for an ACGME program.			

Appendix 3

AOA INTERNSHIP SURVEY TO OPTI's

Code: OPTI

	Question	Strongly Agree	Agree	Disagree	Strongly Disagree
1 2 3	**The OPTI should play a larger role in the following:** - Traditional Rotating Internship - Specialty Track Internship - Special Emphasis Internship				
4 5 6	Your present OPTI structure is conducive to interaction in the following: - Traditional Rotating Internship - Specialty Track Internship - Special Emphasis Internship				
	Your OPTI plans to expand your activities at the local hospital level or at the OPTI site within the following: - Traditional Rotating Internship - Specialty Track Internship - Special Emphasis Internship				

7 8 9					
10 11 12	**The following internship(s) is a strong attraction for the recruitment of interns:** - Traditional Rotating Internship - Specialty Track Internship - Special Emphasis Internship				

AOA INTERNSHIP SURVEY TO OPTI's

	Question	Strongly Agree	Agree	Disagree	Strongly Disagree
16	You perceive a resistance by the DME's to integrate the internship into the OPTI.				
17	Your OPTI would be significantly affected if changes were made in the structure of the traditional internship.				
18	Changes in the structure of the traditional internship would have a negative financial impact your OPTI.				
19	It is more difficult to provide educational programming for traditional interns than for track/emphasis interns.				
20	Upon graduation, traditional interns express a positive educational value of their program.				
21	When compared to track/emphasis interns, graduating traditional interns perceive their experience as a marginally valuable to their professional development.				

Appendix 4

Code: SC

	Question	Strongly Agree	Agree	Disagree	Strongly Disagree
1	The specialty college believes that the five core rotations of an AOA rotating internship (Family Practice, Internal Medicine, General Surgery, Female Reproductive Medicine, and Pediatrics) are necessary to the overall training program for your specialty college program requirements.				
2	The specialty college believes that the remaining seven elective rotations of an AOA internship can be used to shorten/decrease the length of a residency program.				
3	All of the required rotations of the traditional internship are valuable.				
4	Aspects other than the required rotations make the traditional rotating internship valuable.				
5	The specialty track/or emphasis developed by any specialty college helps to prepare a qualified specialist.				
6	The required elements of the traditional rotating internship are an effective part of the specialty track/emphasis.				
7	The traditional rotating internship can be modified to enhance the value for the physician in preparation for the specialty program requirements.				
8	As DME's have considerable responsibilities to an entire educational department, the creation of a position of an "internship program director" to oversee the intern training year would be beneficial.				
9	The following AOA internship(s) has been adopted by your Specialty College as part of its program requirements: - Traditional Rotating Internship - Specialty Track Internship - Special Emphasis Internship				

10 11					
12	Some of the time spent in the specialty track/emphasis could be better utilized in the residency. Suggestions would include: _____ _____ _____ _____				
13	The specialty college does not have a specialty track internship, but perceives a need to develop one.				
14	The specialty college does not have a special emphasis internship, but perceives a need to develop one.				
15	The specialty track internship or special emphasis internship has helped increase the membership in your specialty college.				
16	The specialty college accepts the ACGME Transitional year as the 1st year of a residency training program.				
17	It is important to improve the perception that some may have that the AOA internship is not of value to the physician in training. Suggestions for improvement might be: _____ _____ _____				

Appendix 5

Dear Osteopathic Graduate:

The AOA Internship Task Force is charged with suggesting ways to improve the osteopathic internship. Our records indicate that you plan to enter an ACGME postdoctoral training program and not an AOA internship program. We would appreciate it if you could respond to this short questionnaire. Please return it to the AOA in the enclosed business reply envelopes by June 1, 2001.

Are you planning to enter an ACGME training program?

[ ] Yes [ ] No

If YES, check the reason(s) for your decision:

[ ] No AOA-approved internships were available within my chosen geographic location.

[ ] The AOA internship is not accepted by my ACGME residency program, which would have made it necessary to repeat the PGY-I training year.

[ ] Limited numbers of tracked internships are available.

[ ] An inability to match with a residency program in the 4th year of osteopathic medical school.

[ ] Perceived quality problems in osteopathic internship programs.

[ ] Limited osteopathic opportunities in chosen specialty.

[ ] Too much hassle to seek an internship and then a residency.

[ ] Cost considerations of moving from an internship to a residency.

[ ] The institution for my residency program will not accept Dos into a PGY-II position after completion of an AOA internship due to funding reimbursement issues.

[ ] Perceived lack of recognition of AOA training in obtaining hospital privileges in allopathic hospitals.

Res. 45-M/2002 - BOS MISSION STATEMENT

The AOA Bureau of Osteopathic Specialists (BOS) is the certifying body for the approved specialty boards of the American Osteopathic Association and is dedicated to establishing and maintaining high standards for certification of osteopathic physicians. The Bureau of Osteopathic Specialists seeks to ensure that the osteopathic physicians it certifies demonstrate expertise and competence in their respective areas of specialization. The AOA BOS is deeply committed to delivery of quality health care to all patients by working with all its approved specialty boards in the enhancement and continuous improvement of its certification process. 2002

Res. 48-M/2002 - PROPOSED POLICY REGARDING COMPLEMENTARY AND ALTERNATIVE MEDICINE

Policy of the American Osteopathic Association notes that (1) the physician shall undertake an assessment of the patient which shall include but not be limited to conventional methods of diagnosis, and may include non-conventional methods of diagnosis and shall be documented in the patient's chart; (2) the physician shall exercise his or her professional judgement in undertaking the assessment, and the assessment may include but not be limited to: documentation as to whether conventional medical treatment options have been discussed with the patient; documentation of consideration of referral information; documentation as to whether conventional medical options have been tried and, if so, to what effect, or a statement as to whether conventional or complementary and alternative therapies have been refused by the patient; if a treatment offered which is not considered to be conventional, documentation of at least a verbal informed consent for each treatment plan (including documentation that the risks and benefits of the use of the treatment were discussed with the patient or guardian); documentation as to whether the complementary and alternative health care therapy could interfere with any other ongoing conventional treatment; documentation of physician inquiry regarding the use of complementary and alternative therapies whether through referral, self-care or self-referral; (3) that the physician may offer the patient complementary and alternative treatment pursuant to a documented treatment plan tailored for the individual needs of the patient by which treatment progress or success can be evaluated with stated objectives such as pain relief, improved physical and/or psycho-social function, and maintenance of health and wellness; such a documented treatment plan shall consider pertinent medical history, previous medical records and physician examination, as well as the need for further testing, consultations, referrals, or the use of other treatment modalities, including complementary and alternative therapies used as part of self-care or through physician or self-referral to a variety of CAM practitioners, (4)that the physician may use the treatment subject to documented periodic review of the patient's care by the physician at reasonable intervals in view of the individual circumstances of the patient in regard to progress toward reaching treatment objectives which take into consideration the treatment prescribed, offered or administered, as well as any new information about the etiology of the complaint, (5) that complete and accurate records are kept of the care provided; (6) that osteopathic education include CAM at the undergraduate,

graduate, and CME levels, and (7) that complementary and alternative medicine remains an ongoing focus of activity within the designated committee(s) of the American Osteopathic Association. 2002

Res. 59-M/2002 - END-OF-LIFE CARE ADVISORY COMMITTEE – B/C/C HISTORICAL INFORMATION

The End-of-Life Care Advisory Committee become a standing committee and be placed under the Department of Educational Affairs. 2002 [EDITOR'S NOTE: Now known as the Council on Palliative Care Issues]

Res. 60-M/2002 - COMMITTEE ON HEALTH RELATED POLICIES – CHARGE – B/C/C HISTORICAL INFORMATION

The charge to the Committee on Health Related Policies be expanded to include a policy review of existing policies, related to national, legislative and/or regulatory developments, prior to the current 5-year sunset requirement. 2002 [EDITOR'S NOTE: Now known as the Council on AOA Policy]

Res. 61-M/2002 - DO-ONLINE: REGISTRATION FOR AOA COMMITTEE MEMBERS AND HOUSE OF DELEGATES

It is incumbent on all members of the American Osteopathic Association House of Delegates and all AOA Committee members to set up a DO-Online site. 2002

Res. 62-M/2002 - OSTEOPATHIC GRADUATE MEDICAL EDUCATION (OGME) DEVELOPMENT INITIATIVE

The American Osteopathic Association's Board of Trustees approves the expansion of the OGME Development Initiative to include contacting ACGME-approved programs in states where there are no osteopathic postdoctoral programs; that the OGME Development Initiative may be extended to all states with fewer than six AOA-approved programs; and that the OGME Development Initiative may offer assistance to all OPTIs in their efforts to develop new osteopathic internships and residencies. 2002

Res. 27-A/2002 - POLICY TO MAINTAIN BASIC STANDARDS CURRENT

Frequent review and updating is essential to maintain quality in residency training requirements. Review of AOA Standards reveals some being unchanged in excess of 20 years. Therefore, American Osteopathic Association policy notes: (1) All AOA approved Basic Standards must be reviewed, updated and amended where and when necessary, not less frequently than every four (4) years and any specialty Basic Standards not dated within four (4) years of the last review will be considered invalid and could result in closures of all programs under those basic standards. Review and ratification by the specialty college evaluating committee is required even when amendment is deemed not necessary. Inspection Workbooks must be amended simultaneously with the Standards; (2) All specialty basic standards be made available to training programs and electronically on the AOA website. (3) New residency training programs will be ineligible for AOA-approval if standards have not been reviewed within the time period specified. (4) Training standards

which have not been updated may ultimately result in program closure or denial of continuing program approval. 2002

Res. 29-A/2002 - ADVERTISING FOR AOA CATEGORY 1-A CME CREDIT – CME SPONSORS

AOA Category 1 CME Sponsors shall use the following language, when there has been no prior AOA approval, for advertising AOA Category 1-A CME programs: "This program anticipates being approved for X number of AOA Category 1-A CME credit pending approval by the AOA CCME. 2002

Res. 30-A/2002 - RESTRICTIONS ON INTERNET CME PROGRAMS

The American Osteopathic has approved the following policies for CME presentations on the Internet. This places Internet Presentations on the same standard as all other CME accredited activities:

1. No advertising of any type of ads within accredited educational materials.
2. No mention of specific products in the acknowledgement of commercial support, even if they are not related to the topic of the CME program.
3. The use of hidden technical mechanisms for transferring learning data (cookies) be prohibited.
4. AOA accredited provider does not host CME programs on a pharmaceutical or device manufacturer's website. 2002

Res. 40-A/2002 - CODE OF LEADERSHIP FOR THE BOARD OF TRUSTEES

The American Osteopathic Association has adopted the following Board of Trustees "Code of Leadership."

AOA Board of TRUSTEES
CODE OF LEADERSHIP

The mission of the AOA, as established by the Board of Trustees and the House of Delegates, is to serve the membership by advancing the philosophy and practice of osteopathic medicine and by promoting excellence in education, research, and the delivery of quality cost-effective healthcare in a distinct, unified profession.

As a Board Member of the American Osteopathic Association, I am fully committed to the American Osteopathic Association and its mission. I recognize that wearing the mantle of leadership is a higher calling and carries additional responsibilities and obligations to support the activities of the American Osteopathic Association. As a leader, my decisions and actions must be guided by what is best for the Association. To this end, I pledge to honor and promote the American Osteopathic Association and its mission by following three guiding principles:

I. I will maintain and strengthen the **Vision** of the AOA by the Board of Trustees and House of Delegates, as demonstrated by…
   - Defining with my Trustee colleagues the mission of the Association and participating in strategic planning to review the purposes, programs, priorities, funding needs, and targets of achievement.

- Annually contributing to osteopathic philanthropy, encouraging DO colleagues to do the same, and encouraging my spouse to participate in the Auxiliary.
- Publicly supporting and promoting the Association's policy within the osteopathic family and to the public.

II. I will conduct myself with the highest level of **Integrity** to honor the AOA and to support the highest ideals of the osteopathic profession for which it stands, as demonstrated by…
- Accepting the by-laws of the Association, understanding that I am morally and ethically responsible for the health and vitality of the Association, and adhering to the AOA Conflict of Interest policy by recusing myself from discussions or votes in which I may not be impartial.
- Leading the way by being an enthusiastic booster and a positive advocate for the Association, and extend that enthusiasm to the Association' s affiliates and auxiliary groups.
- Accepting that every Board member is making a statement of faith about every other Board member, we trust each other to carry out this Code to the best of our ability.

III. I will be **Competent** in my actions and decisions for the AOA, as demonstrated by…
- Fulfilling my financial responsibilities by reviewing and approving the annual budget, overseeing adherence to it, ensuring an independent audit takes place, and overseeing the investment policies and procedures of the association.
- Making myself available to attend Board meetings, taking phone calls, and serving on committees, and being prepared for these meetings by reading agenda and other materials.

Understanding that the job of the Board is to govern, not manage, and that the only staff member I have responsibility for and authority over is the Executive Director. 2002

Res. 10-M/2003 - INTERN TRAINING PROGRAM S- SPECIAL CIRCUMSTANCES DEVIATION FROM THE MINIMUM NUMBERS REQUIREMENT

Intern training programs with special circumstances, including institutional restructuring, a new Director of Medical Education (DME), program redevelopment with new affiliation(s), curriculum, etc., may, upon request of the DME by the third consecutive year of being below the minimum of four interns, be reconsidered for one additional year to meet the minimum. 2003

Res. 11-M/2003 - SPECIAL CIRCUMSTANCES DEVIATION FROM THE MINIMUM OGME NUMBERS REQUIREMENTS

Institutions with Medicare reimbursement cap limitations that prevent funding of four intern positions in a continuous Internship/Residency in the same specialty, may request the American Osteopathic Association to approve a minimum of three intern positions, as long as the associated total Internship/Residency maintains at least seven (7) trainees. 2003

Res. 15-M/2003 - OSTEOPATHIC POSTDOCTORAL TRAINING INSTITUTIONS (OPTI) AFFILIATIONS

All new applications for American Osteopathic Association postdoctoral training programs from institutions not already affiliated within an OPTI include:

1. The relationship between the training program and its OPTI.
2. The OPTI's method(s) of oversight of the program.
3. The OPTI's contribution to curriculum, faculty development, research and quality improvement at the training program.

This description must be signed by both the OPTI administrator and program institution official; be provided with the application for approval to the Council on Postdoctoral Training. New programs are encouraged to affiliate with a geographically proximate OPTI to better enable constructive interaction. 2003

Res. 17-M/2003 - COMPLIANCE WITH AOA PROGRAM AND DATA SUBMISSION REQUIREMENTS

Due to increasing federal, public and profession-wide need for information and data, timely transmission of information and communication needs to be expedited. In addition, manual processing of paper and forms must be minimized to conserve manpower and costs. Participation in data and information sharing is also essential to retain COM graduates in osteopathic programs. Therefore, it is required that timely compliance with required electronic intern/resident AOA postdoctoral registration, electronic Opportunities data submission (updated yearly by June 30), utilization of AOA electronic Intern/Resident application form, utilization of AOA electronic Intern/Resident contracts, participation with AOA program self study, on-site reviews, program audits and payment of fees be required as a condition of continued AOA program approval. 2003

Res. 19-M/2003 - GRADUATE MEDICAL TRAINEES WHO MAY BE DRAFTED INTO THE ARMED FORCES OF THE UNITED STATES

The American Osteopathic Association and its affiliated graduate medical training programs support their post- graduate medical trainees who are called to service from their training programs in accordance with Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and the Soldier and Sailors Act; the AOA will circulate USERRA guidelines to all training programs, OPTIs, specialty colleges, etc. and urge them to become compliant with these federal policies. 2003

Res. 22-M/2003 - RESTRUCTURING OF PROGRAM ON-SITE REVIEWS

The issue of graduate medical education for interns and residents provided with public funds has increasingly come under public and federal scrutiny. Subjective, internally performed and long overdue program reviews can no longer be accepted and only risk the loss of AOA self-accreditation. Therefore, it is the policy of the AOA that program approval and re-approval of the on-site review process be conducted based on reformatted self-study (prepared workbooks submitted in advance with documentation); and that program reviews may, at the discretion of the AOA and with proper notification to the specialty college, utilize independent professional educational experts, including physicians and non-physicians, to conduct program surveys in a validation review of the submitted self-study. physicians and non-physicians, to conduct program surveys in a validation review of the submitted self-study. 2003

Res. 23-M/2003 - GRADUATE MEDICAL TRAINEES WHO SERVE IN THE RESERVE / NATIONAL GUARD FORCES OF THE UNITED STATES

The American Osteopathic Association and its affiliated graduate medical training programs support their post- graduate medical trainees who serve in the Reserves/National Guard by adhering to Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA); and will circulate USERRA guidelines to all training programs, OPTIs, specialty colleges, etc. and urge them to become compliant with these federal policies. 2003

Res. 45-M/2003 - DEFINITION OF AN OSTEOPATHIC HOSPITAL AS IT RELATES TO OSTEOPATHIC RURAL REFERRAL CENTERS

The American Osteopathic Association has approved the following criteria for use in defining an osteopathic hospital for purposes of determining a hospital is an osteopathic rural referral center:

> For purposes of defining an osteopathic rural referral center, an institution providing osteopathic healthcare is one which is accredited by the Healthcare Facilities Accreditation Program (HFAP) of the American Osteopathic Association (AOA), and/or is a site for AOA approved graduate osteopathic medical education programs (Internships and Residencies). 2003

Res. 52-M/2003 - RESERVISTS AND NATIONAL GUARD CALLED TO ACTIVE DUTY, DUES WAIVERS FOR

AOA policy will waive the dues for one year for physicians in the Reserve and the National Guard who are called to active duty. 2003

Res. 55-M/2003 - SMALLPOX VACCINATION

The American Osteopathic Association expresses its strong support for the smallpox vaccination program for healthcare workers beyond first responders including laboratory workers and those involved in care; and in conjunction with local, state, and federal public health partners, will develop guidelines for voluntary smallpox immunization for the general public; and will continue to disseminate information and education to physicians and the general public on the benefits and risks of the smallpox vaccine. 2003

Res. 60-M/2003 - THE OSTEOPATHIC PLEDGE OF COMMITMENT

The American Osteopathic Association has approved the following Osteopathic Pledge of Commitment; and will begin seeking methods by which to implement use of the Osteopathic Pledge of Commitment in coordination with colleges of osteopathic medicine, state divisional societies, specialty organizations, and non-practice affiliates.

As members of the osteopathic medical profession, in an effort to instill loyalty and strengthen the profession, we recall the tenets on which this profession is founded – the dynamic interaction of mind, body and spirit; the body's ability to heal itself; the primary role of the musculoskeletal system; and preventive medicine as the key to maintain health. We recognize the work our predecessors have accomplished in building the profession, and we commit ourselves to continuing that work.

I pledge to:

- Provide compassionate, quality care to my patients;
- Partner with them to promote health;
- Display integrity and professionalism throughout my career;
- Advance the philosophy, practice and science of osteopathic medicine;
- Continue life-long learning;
- Support my profession with loyalty in action, word and deed; and
- Live each day as an example of what an osteopathic physician should be. 2003

Res. 64-M/2003 - CMS CHANGES TO THE MEDICARE CONDITIONS OF PARTICIPATION

The American Osteopathic Association approves the incorporation of the new CMS changes to the Medicare Conditions of Participation that will be affective in 90 days of their publication in the Federal Register, into the AOA HFAP Accreditation Requirements for hospital accreditation. 2003

Res. 23-A/2003 - DEVELOPMENT OF OSTEOPATHIC GRADUATE MEDICAL EDUCATION PROGRAMS

Policy of the American Osteopathic Association notes that (1) all institutions requesting AOA internship program approval must agree to submit the completed application, to initiate at least one associated AOA residency within two years of approval of the internship; (2) failure to initiate the AOA residency will result in the termination of the internship approval; (3) all previously approved AOA internship programs comply with this requirement and be required to submit a completed application for at least one AOA residency within one year of approval of this policy and initiate the residency by the following July; (4) if a specific rationale exists as to why an intern training institution cannot comply with this requirement within the two-year time period, as stated, that a request for individual consideration must be submitted by the sponsoring OPTI and that the request include justification for delay together with a detailed plan for development of one or more AOA residencies within a three-year period; and (5) all internship only training institutions, and their OPTI, be notified of this requirement. 2003

Res. 31-A/2003 - "FELLOW / FELLOWSHIP" – USE OF THE TERM FOR SUBSPECIALTY TRAINING

Policy of the American Osteopathic Association notes that any subspecialty residency training occurring after completion of a base residency (preliminary specialty) may be designated by the term "fellow/fellowship;" and that the term "fellow/fellowship" only be used where AOA-approved training standards currently exist; and that AOA specialty colleges may amend their documents to reflect this terminology upon adoption by the AOA Board of Trustees. 2003

Res. 34-A/2003 - ON-SITE MONITORING FOR CONTINUING MEDICAL EDUCATION PROGRAMS

Policy of the American Osteopathic Association notes that as a condition of continuing accreditation the accredited AOA CME sponsor provide a signed attendance sheet from each attendee indicating the number of hours actually attended for each sponsored CME activity. 2003

Res. 35-A/2003 - MILITARY CME WAIVER – OSTEOPATHIC PHYSICIANS CALLED TO ACTIVE DUTY

It is the policy of the American Osteopathic Association that an osteopathic physician in the military who is in active status during the last year of the 2001-2003 CME cycle (December 31, 2003) be granted a waiver of his or her AOA CME requirement for membership if that physician is CME deficient at the end of the current CME cycle. 2003

Res. 40-A/2003 - CORE COMPETENCY TASK FORCE – FINAL REPORT

Policy of the American Osteopathic Association notes that (1) all AOA specialty certification and re-certification board examinations incorporate core competency testing beginning July 2007; (2) that the AOA Council on Continuing Medical Education incorporate core competency requirements in life-long learning and the continuing medical education process, offering 1-A credit is essential; (3) that the intern and resident institution training programs and all specialty college Program Director and Resident Annual Reports incorporate the core competencies into the evaluation process as appropriate for each specialty; (4) that all OPTIs are required to participate with their partner training institutions and programs in training and monitoring intern and resident progress toward core competency initiatives; and (5) that the AOA and specialty affiliates are required to incorporate core competency education, training, methodology and evaluation into conferences, conventions, and program director's seminars. 2003

Res. 45-A/2003 - BONE AND JOINT DECADE, AFFILIATE SUPPORT FOR

The American Osteopathic Association encourages each osteopathic affiliate to formally endorse the Bone and Joint Decade (BJD); and encourages each osteopathic affiliate to evaluate the options for supporting the Bone and Joint Decade, as indicated on the BJD Web site <http://www.boneandjointdecade.org/usa/>, and pursue those options, which seem most relevant to it. 2003

Res. 48-A/2003 - POSTPARTUM DEPRESSION

The American Osteopathic Association encourage its members to participate in continuing medical education programs on postpartum depression (PPD); urges the state and specialty associations to offer CME on PPD as part of their educational offerings; the AOA will develop a speakers bureau on this subject which can be added to the AOA Speakers Bureau publication; endorses the use of screening tools and encourage the measurement of outcomes in their use; and will link to organizations whose mission is to educate patients and physicians on PPD. 2003

Res. 59-A/2003 - COMLEX-PE EXAMINATION

The American Osteopathic Association does not believe it is appropriate to endorse COMLEX-PE at this time. However, the AOA recommends that the American Association of Colleges of Osteopathic Medicine (AACOM) and the National Board of Osteopathic Medical Examiners (NBOME) collaborate on the clinical skills assessment process to assure patient and public concerns are met. 2003

Res. 4-I/2003 - DEVELOPMENT OF OSTEOPATHIC GRADUATE MEDICAL EDUCATION PROGRAMS

This policy is to clarify the timeline afforded to institutions regarding the establishment of AOA-approved residency programs:

- An institution with a newly approved internship program must apply for a osteopathic residency program within two years of the beginning of its first class of osteopathic interns;
- All previously approved AOA internship programs comply with this requirement and be required to submit a completed application for at least one AOA residency within two years of approval of this policy and initiate the residency by the following July;
- If an institution cannot comply with the two-year time limit, a request for individual consideration must be submitted to the ECCOPT by the sponsoring OPTI and that the request include justification for delay and a detailed plan for development of one or more AOA residencies;
- Institutions must have one or more approved and functioning osteopathic residencies within 5 years of the beginning of its first class of osteopathic interns; and
- Failure to initiate the residency within the prescribed time frame will result in internship termination. 2003

Res. 5-I/2003 - IMPLEMENTATION OF HIGHER QUALITY STANDARDS IN POSTDOCTORAL TRAINING

The intent of this policy is to give new programs a chance to get started under the rules in which they were recruited.

- The Internship Program Director requirements of AOA-approved residency training and AOA certification be waived until July 1, 2004 for individuals applying to be directors of medical education;
- All individuals waived by this policy have three years from the date they were approved as a director of medical education (DME) Internship Program Director in which to fully comply with all requirements to be an osteopathic Internship Program Director.

[Note: The DMEs will have three years from their date of approval as DMEs in which to fully comply with all requirements to be a DME. It is the intention that the requirements for DMEs be applied to new DMEs or DMEs who are accepting a DME position at another institution. The new requirements are not to be applied retrospectively to DMEs who have been in their position prior to February, 2003]. 2003

Res. 30-M/2004 - POST MATCH INTERNSHIPS AND RESIDENCY POSITION AVAILABILITY

The American Osteopathic Association will provide space, at no cost**,** on its website for programs to list available AOA-approved intern positions, and their respective residency linkages no later than February 20, 2004, and annually after each Match; and, will annually make a reasonable attempt to notify osteopathic students who are involved in the AOA match process concerning the web site postings. 2004

Res. 32-M/2004 - SUPPORT OF THE OSTEOPATHIC POSTDOCTORAL TRAINING INSTITUTIONS (OPTI)

Policy of the American Osteopathic Association notes that (1) OPTIs are to assure high quality osteopathic graduate medical education programs through stringent educational and administrative standards; (2) failing to meet these standards will be subject to withdrawal of accreditation; (3) continuing cooperation occur between colleges of osteopathic medicine (COMs) as a member of the OPTI to provide osteopathic principles and practice, oversight, faculty development and research; (4) the Bureau of Osteopathic Education, Council on Osteopathic Postdoctoral Training Institutions (COPTI) and the Commission on Osteopathic College Accreditation (COCA) work with OPTIs and the college member, to provide sufficient numbers, quality and specialty mix of AOA approved osteopathic graduate medical education programs for its graduates; and (5) that OPTIs develop a business model and process for funding. 2004

Res. 38-M/2004 - EXTENSION OF CERTIFICATION / RECERTIFICATION TIME LIMITS FOR OVERSEAS AND / OR REACTIVATED MILITARY PERSONNEL

This policy is to assist those osteopathic physicians who have been called to serve in the military.

- In times of military conflict or war, military personnel outside the United States are unable to return for a certification or recertification examination will be given an extension of one year from the date of discharge to sit for the certification or recertification examination;
- Prior to the expiration of the extension, board-eligible candidates shall remain board-eligible and certified osteopathic physicians shall remain certified;
- It is the responsibility of the individual certifying boards to administer this extension policy for their candidates;
- The certifying boards must provide:
    1. a list of candidates who have been granted the extension and the expected expiration date of each extension,
    2. a list of candidates whose extension has expired, and
    3. a list of those candidates who completed certification or recertification after having been granted the extension.

[Note: The certifying boards must provide the AOA with information on candidates who have been granted the extension so that the AOA maintains accurate information on the certification status of all osteopathic physicians.] 2004

Res. 46-M/2004 - LITIGATION FUND

The American Osteopathic Association approves the establishment of a Litigation Fund; and that the following criteria be used to evaluate requests for funds from the Litigation Fund:

1. The lawsuit must be an active, pending lawsuit of national significance to the osteopathic medical profession and must be supportive of the programs, policies and mission of the AOA.
2. The chances of succeeding on the merits of the case
3. The precedential value of the case (i.e., level of court, jurisdiction, and nature of legal proceeding).
4. The scope of applicability of the case (i.e., state, regional, national or specialty-specific matter).
5. The level of assistance requested of the Litigation Fund.
6. The level of assistance made by others, including the parties and the person who has requested support.
7. The comparative value of selecting a particular case as against other pending, likely, or funded litigation requests.
8. The individual osteopathic physician requesting litigation support must be an active member of the AOA.
9. The request must be made sufficiently in advance so that the Litigation Fund Committee can make a reasoned recommendation to the AOA Executive Committee regarding support and/or request additional information with which to make a reasoned recommendation.
10. The advice of the relevant osteopathic state society and specialty college is sought and considered before making a recommendation to the AOA Executive Committee who will make a final decision within 90 days of the date the request was submitted. 2004

Res. 66-M/2004 - METHODS TO MAINTAIN TIME-DATED CERTIFICATES

The American Osteopathic Association believes that instead of converting time-dated certificates to lifetime certificates for infrequently given examinations, the Standards Review Committee of the BOS will work with the certifying boards to reduce the psychometric costs associated with those infrequently given examinations. 2004

Res. 68-M/2004 - SUPPORT FOR TIME-DATED CERTIFICATES

The American Osteopathic Association endorses the following concept to address the issues of certification of added qualifications (CAQ) and certificates of special qualification (CSQ) recertification exams with small candidate pools and financial constraints:

1. A specialty board would consult with the Standards Review Committee for a modified examination process of a recertification CAQ or recertification CSQ exam.
2. Boards would have the capability of selecting the cycle of administration of recertification CAQ or recertification CSQ exams in order to be more cost effective. If a Board elects this option, they must be cognizant of the time-dated certificates and offer the exam in a cycle that would prevent any lapse of certification.

[NOTE: The Standards Review Committee (SRC) is aware of both the financial constraints and the expense of administering statistically and psychometrically sound exams. However, the Committee believes that giving lifetime certificates to a minimal number of candidates would be a regression of the process that the BOS has worked diligently to develop and

implement. By giving all specialty boards the capability of consulting with the Committee, defensible and cost effective recertification processes appropriate for each board can be devised that will meet their specific needs. The SRC also recommends, as a cost-effective measure, that the administration of exams be on a pre-determined cycle (i.e., two to four years). It is incumbent upon the board to notify all of its certificants of the new change in administration of the exam. Additionally, it is recommended that, during the transition period, candidates can take their recertification exam up to two years prior to their expiration date. The recertification period may begin the day after the expiration date of the current certificate.] 2004

Res. 7-I/2004 - APPEALS FOR AOA BOARD – PROPOSED GUIDELINES
The American Osteopathic Association has approved the following guidelines for appeals before the AOA Board of Trustees:

Background
The Bylaws of the American Osteopathic Association ("AOA") charge the Board of Trustees (the "Board") with the responsibility to "[d]ecide finally all questions of an ethical or judicial character." (Article VIT, Section 1, h.). In addition, the Bylaws specifically identify several judicial and quasi-judicial issues that the Board of Trustees may be called upon to resolve, including reinstatement of an individual's membership (Article IT, Section 2a); revocation, suspension or probation of an individual's membership (Article IT, Section 3); waiving dues for members in a hardship situation (Article ill, Section 2b); removal of organizational officers (Article VIT, Section Ig); suspension, probation or revocation of the charter of affiliation of a divisional society or specialty affiliate (Article VIT, Section 1h); and ethical misconduct of a member (Article VIT, Section 1h). Additionally, the Board may hear appeals from decisions made by the Bureau of Osteopathic Education, Bureau of Osteopathic Specialists, Bureau of Healthcare Facilities Accreditation and other bureaus and departments.

Due to regulatory requirements of the US Department of Education, the Board has no authority to consider or act on appeals from actions of the Commission on Osteopathic College Accreditation.

Purpose of Hearing and Appeal Process.
Due Process. The appeal and hearing process is intended to assure the osteopathic profession, the osteopathic medical community and the public that actions are not taken by the AOA without affording the affected party with due process (i.e., notice of the action taken and an opportunity for review).

Nature of Review

A. Issues for Which the Board Provides Initial Review. The Board serves as the sole reviewing entity within the AOA for the following issues: (1) removal of officers; and (2) suspension, revocation or probation of the charter of a divisional society or other affiliated organization. In addition, the Board may choose to review issues of alleged ethical misconduct or grossly unprofessional behavior of a member or have such issues reviewed by the Committee on Ethics.

B. Scope of Appellate Review. The Board of Trustees has authority to review procedural questions concerning an action taken by the AOA and/or the merits of the underlying action.

C. Potential Decisions/Scope of Relief on Appeal. In deciding appeals, the Board of "Trustees shall have authority to affirm or overturn the action of an underlying Committee, Councilor Bureau or Department. Where appropriate, the Board may also defer further action until the next meeting and ask that the appellant, appellee, and/or AOA staff locate additional information to aid in its decision. As part of its decision, the Board has the discretion to determine other relief that may be appropriate for the situation (e.g., supervision, oversight, etc.).

Right to Hearing or Appeal By the Board of Trustees.

A. Mandatory Review. Under the Bylaws and Basic Documents, there is an absolute right to appeal to the Board of Trustees from the following actions: (1) actions of the Bureau of Osteopathic Education (CCME, PTRC, COPT, COPTI Appeal Committee); (2) actions of the Bureau of Healthcare Facilities Accreditation; (3) reinstatement of membership; (4) actions concerning the status of an individual's membership (i.e., revocation, suspension, placement on probationary status, or censure); (5) removal of an officer; (6) revocation, suspension or probation of the charter of an affiliated organization; and (7) review of the record from a member's suspension from a divisional society or affiliated organization.

   Except as otherwise specified, requests for a hearing on an issue of mandatory review should be submitted to the Executive Director at least 45 days before the next meeting of the Board of Trustees. The request for review should include a description of the background and issues surrounding the appeal.

B. Discretionary Review. For all other matters, including actions of the Bureau of Osteopathic Specialists, review by the entire Board of Trustees is discretionary.

The Executive Committee will determine whether decisions will be reviewed by the full Board of Trustees. Except as otherwise specified, requests for a hearing and/or appellate review should be submitted to the Executive Committee of the Board of Trustees, care of the Executive Director, at least 60 days before the next meeting of the Board of Trustees. The request for appellate review should include a one- or two-page statement of the background and issues surrounding the appeal. The Executive Director will advise the individual or entity submitting a request for an appeal of the Executive Committee's decision. If the Executive Committee agrees to hear an appeal, the appellant shall be given the option of submitting an additional position statement or allowing the initial submission to the Executive Committee to serve as the Position Statement.

Pre Appeal Procedure.

A. Notice to Appellant and Appellee. The appellant, appellee and other interested parties shall be given written notice of the place, date and time at which the appeal shall be heard along with a copy of the Protocols and Guidelines for Appeals.

B. Position Statements. Appellants and appellees shall have the right to submit a position statement and documentation in support of the position. Position Statements and documentation shall be submitted to the ADA's Department of Administration no later than 30 days prior to the Board meeting. Position statements should be limited to no more than 20 pages double-spaced).

C. No Discovery. Position statements and documentation should be based on information in the appellant or appellee's possession. There is no discovery phase or process associated with the appeal, including discovery from the ADA or other parties.

D. Representation by Counsel. Parties may choose to be represented by legal counsel for any or all phases of the appeal. In the event that a party chooses to be represented by counsel, notice must be provided to the ADA at least 30 days prior to the appeal hearing, including the attorney's name, law firm name, address and telephone number.

Appeal Procedure.

A. Appeal Hearing. The appeal hearing shall consist of the following phases:

1. Position Statements. The appellant(s) and appellee(s) shall each have 15 minutes in which to present their side of the appeal. The appellant shall present the first statement, followed by the appellee.

2. Questions. The Board shall have 20 minutes in which to ask questions of the appellant, appellee or other interested parties.

3. Closing Statement. The appellant(s) and appellee(s) shall each have 5 minutes in which to make a final statement to the Board. The appellee shall present the first closing statement, followed by the appellant.

B. Witnesses. An appeal is not a forum for presentation of witnesses. Where a party believes that information from a witness may be useful to the Board's consideration, testimony may be presented by means of an affidavit.

C. Record/Transcription. The Board shall arrange for a stenographer or other service to make an official transcript of the appeal hearing. Upon request, the ADA shall provide Appellants and Appellees with a copy of the transcript. Appellants and Appellees are not permitted to retain their own transcriptionists.

D. Attendance at Appeal. Appellants and Appellees are encouraged to attend appeal hearings in person. However, where attendance is not possible because of cost or scheduling complications, the appeal may be conducted with the appellant and/or appellee present by telephone or other means of communication. Appellants and appellees may also choose to not attend and have the Board decide an appeal based solely on written materials or ask to have the hearing deferred until a later date within the next year at which the appellant can attend in person.

E. Attendance of Outside Parties. The Appeal shall be conducted as part of an Executive Session of the Board. Appeals and other Hearings are not open to the public.

Post Appeal Procedure.

A. Deliberations. Following the appeal, the Board shall deliberate in Executive Session.

B. Notice of Decision. All interested parties shall be advised in writing of the Board's decision within 30 days of the decision.

C. Final Action/No Reconsideration. The Board of Trustees decision on an appeal represents the AOA's Final Decision. There is no procedure for Reconsideration.

Waiver of Rules.

Appellants and Appellees may request that the Board waive one or more of the procedural rules set forth in the Protocols and Guidelines. Requests for waivers shall be submitted to the AOA Executive Director no later than 30 days prior to the designated hearing time. The President shall have authority to decide whether to grant a waiver. 2004

Res. 8-I/2004 - ANTI-TRUST COMPLIANCE POLICY

The American Osteopathic Association has approved the following Anti-Trust Compliance Policy:

The American Osteopathic Association's (AOA) policy is to comply strictly with all laws and regulations applicable to its activities. From time-to-time, the AOA's activities involve meetings, discussions and cooperative efforts among individuals and organizations that are business competitors. Additionally, the AOA acts as an accrediting authority for osteopathic medical educational programs (predoctoral, postdoctoral and continuing medical education) and health care facilities and administers a board certification program for osteopathic physicians in 18 primary care and medical specialty disciplines. Therefore, it is essential for the AOA to emphasize the ongoing responsibility of the Association, its affiliates and its members in achieving compliance with federal and state antitrust laws.

Through this Policy statement, the Board of Trustees emphasizes the ongoing commitment of the AOA to compliance with the antitrust laws. This Policy shall apply to all of the AOA's trustees, officers, committee members, divisional societies, specialty colleges and affiliated organizations that participate in the AOA's activities. To emphasize its commitment to compliance and remind individuals and organizations of its importance, the AOA shall distribute this Policy statement to all AOA Board members, officers, bureau, council and committee members, divisional societies, specialty colleges and other affiliated organizations. This statement shall also be available at all AOA meetings.

Antitrust Background

Antitrust laws are intended to benefit consumers by promoting competition. Competition benefits consumers by driving down the cost of goods and services and encouraging competitors to innovate and provide better quality of goods and services. Under federal and state antitrust laws, competitors are not permitted to "restrain competition" by means of formal or informal agreements and practices that affect the price, production, or distribution of products. The laws may be enforced by the Justice Department, Federal Trade Commission and/or private legal action. In order to deter conduct, the penalties for violation of antitrust laws are severe.

Responsibility for Antitrust Compliance

The AOA staff and legal counsel review scheduled programs and activities to ensure their conformity and compliance with the antitrust laws and shall take appropriate steps to avoid discussion topics and activities that are improper or could have unintended implications. Moreover, no trustee, officer, nor AOA member, whether acting in an individual capacity or as a committee, councilor bureau member shall be authorized to propose or to implement on behalf of the AOA any program, agreement, or other activity that violates state or federal antitrust laws.

Individuals and organizations that participate in ADA meetings and events share equally in the responsibility for ensuring antitrust compliance. They should be aware of the types of conduct that could be found to be anticompetitive and adhere to guidelines designed to avoid it. Accordingly, ADA divisional societies, affiliates and members should exercise appropriate discretion and judgment by avoiding all discussions and activities that involve or may involve improper subject matter and/or procedures.

The following procedures are intended to provide guidance regarding conduct at ADA meetings and events:

Meeting Procedures

ADA meetings frequently involve discussions and activities of individuals and entities that are usually competitors, thereby creating an environment where improper discussions and agreements could arise.

Consequently, at AOA meetings, the following issues will not be discussed without review and approval of legal counsel:

1. Pricing issues, such as the prices charged to consumers and/or third- party payors for medical services, including current or future prices; increases or decreases in prices; the standardization or stabilization of prices. For example, there should not be discussions concerning physicians' current or future fee schedules or costs and other financial matters that could affect fees. Nor should there be any discussion concerning fair income levels from a practice.
2. Issues regarding specific vendors or groups or classes of patients. For example, participants at an event or meeting should not discuss plans or other intentions to boycott or otherwise refuse to work with a particular HMO, PPO, third-party provider or with specific groups or classes of patients.

No recommendations or actions should be taken with regard to antitrust-sensitive subjects without the advice of the AOA's legal counsel.

As part of the effort to ensure compliance with antitrust laws and protect the AOA, AOA members and affiliated organizations from potential liability, AOA meetings shall be conducted consistent the following procedures:

1. A written agenda that identifies the purpose of the meeting and the anticipated topics of discussion will be prepared and distributed prior to the meeting.

2. Meetings should not take place unless properly called. Secret ("rump") meetings and sessions should be avoided.
3. Following each meeting, accurate minutes shall be prepared and distributed to the participants. The minutes shall be approved at the next meeting of the committee. .
4. Participants should consult with their own legal counselor ADA staff before raising any matter or making any statement that may involve competitively sensitive information.
5. If a participant raises a topic of doubtful legality for discussion, that person should be advised that the subject is not proper for discussion. Where there are concerns about a topic of discussion, such concerns should be brought to the attention of the Chair and appropriate staff persons from the AOA (i.e., the Executive Director, Associate Executive Director or General Counsel) as soon as possible.
6. Persons with concerns about discussion during a meeting shall bring the concerns to the attention of the individual presiding over the meeting as soon as possible. If the discussion or activity is not terminated or otherwise resolved satisfactorily, the concerned person should leave the meeting and advise appropriate staff persons from the AOA of the concerns.

Compliance with these guidelines involves not only avoiding potential antitrust violations, but also avoiding any actions that could be construed as a violation of the antitrust laws. These guidelines only provide an overview of prohibited actions. Specific questions should be directed to your own legal counselor the AOA's legal counsel. 2004

Res. 17-M/2005 - COMPETENCY-BASED EVALUATION PAPERWORK FOR FAMILY PRACTICE

All resident Competency-Based Evaluations be kept on site at the family practice residency program only for review by the family practice inspector. 2005

Res. 26-M/2005 - EXPERT WITNESS

The American Osteopathic Association has approved the following policy paper as its position on expert witness. - See HOD Policy H289-A/08

Res. 39-M/2005 - AOA CRITERIA FOR OSTEOPATHIC RURAL REFERRAL CENTER (ORRC)

The American Osteopathic Association has approved the following revised AOA criteria for defining a hospital as osteopathic for purposes of the hospital being designated by CMS as an osteopathic rural referral center:

1. The facility is accredited by the Healthcare Facilities Accreditation Program (HFAP) of the American Osteopathic Association (AOA), and has osteopathic physicians on its medical staff admitting or treating patients; and/or
2. The facility is a site for AOA approved graduate osteopathic medical education programs (internship or residencies).

[NOTE: In 2003 AOA staff applied for and received recognition of AOA as the "gatekeeper" for defining a hospital as Osteopathic for Purposes of Being Designated by the CMS as an Osteopathic Rural Referral Center (ORRC). Achieving designation as an osteopathic rural referral center may net individual hospitals a million dollars or more.

Currently an institution applying for recognition as an osteopathic hospital must meet one or both of the following two criteria:

- The facility is accredited by the Healthcare Facilities Accreditation Program (HFAP) of the American Osteopathic Association (AOA), and/or
- The facility is a site for AOA approved graduate osteopathic medical education program (internship or residencies).
- To date no facility accredited by HFAP has failed to have DOs on staff. However the potential still remains. Therefore, the Bureau of Healthcare Facilities Accreditation recommends adoption of the revised criteria as indicated above.] 2005

Res. 43-M/2005 - PROFESSIONAL LIABILITY INSURANCE REFORM

The American Osteopathic Association reaffirms professional liability insurance reform as its top legislative priority at both the Federal and state levels; will continue to support medical liability reform legislation at the Federal and state level that includes the six principles (limitations on non-economic damages, limitation on attorney contingency fees, collateral source reform, joint and several reform, periodic payment of future damages, and statute of limitation reform) adopted and ratified by the AOA House of Delegates; will continue to support programs aimed at increasing the involvement of its members and the patients they serve in this effort; will increase its efforts to promote the need for medical liability reforms to the public through EveryPatientCounts.org and other media sources; and will continue to devote significant personnel and financial resources to achieve the enactment of professional liability insurance reform principles adopted and ratified by this House of Delegates. 2005

Res. 55-M/2005 - REPRESENTING OSTEOPATHIC PHYSICIANS' INTERESTS IN QUALITY AND REIMBURSEMENT

The American Osteopathic Association endorse in concept the use of quality measures as a method to improve patient care; endorses the Clinical Assessment Program for physicians' offices as a method to measure quality in physicians' offices and develop incentives for physicians to participate; and will aggressively represent osteopathic physicians' interests in pay-for-performance and tiered networks to ensure that all such reimbursement systems are based on methodologies that are sound, fair, and equitable to osteopathic physicians. 2005

Res. 56-M/2005 - NATIONAL HEALTH INFORMATION INFRASTRUCTURE

The American Osteopathic Association supports efforts to ensure all patient populations, especially those in rural and underserved communities, benefit from the development and implementation of health information technology (HIT); will continue to educate policymakers that the adoption of information technology, which results in access to care without a patient appearing before a physician should not lead to a decreased recognition of a physician's extensive training, skill, and work that is used to treat a patient, and continue to advocate for appropriate reimbursement for the work involved in that service; recommends that existing or proposed federal laws and regulations should not impede the adoption and utilization of health information technologies; notes that the appropriate bureaus, boards,

and affiliates of the AOA work in collaboration with one another to foster the adoption of these technologies in all practice settings; and will work with the National Coordinator for Health Information Technology and other interested entities to promote, among other things, the adoption and implementation of technologies to improve the quality and safety of the health care delivery system; EHR information dissemination to clinicians; efforts to protect patient privacy; and, system-wide interoperability. 2005

Res. 43-A/2005 - OSTEOPATHIC GRADUATE MEDICAL EDUCATION – HEALTHY PROFESSION 2015, CALL FOR RESPONSIBLE GROWTH IN

The American Osteopathic Association will lead a campaign to establish quality osteopathic programs in every state and specialty; and invite the Association of American Colleges of Osteopathic Medicine (AACOM), the Association of Osteopathic Directors and Medical Educators (AODME), the colleges of osteopathic medicine (COMs), Osteopathic Postdoctoral Training Institutions (OPTIs), specialty colleges, state societies, and osteopathic foundations to be full partners in this campaign; urge individual osteopathic physicians to participate in this effort by becoming preceptors and mentors, initiating development of new programs, and taking leadership positions such as Directors of Medical Education and Program Directors; and urge that a Medical Education Summit be held in the fall of 2005 to build a comprehensive strategic model of responsible growth in osteopathic graduate medical education. 2005

Res. 47-A/2005 - OSTEOPATHIC CONTINUING CERTIFICATION

The American Osteopathic Association adopts the term "Osteopathic Continuing Certification" as the official terminology for the process through which all osteopathic physicians certified through the Bureau of Osteopathic Specialists maintain their board certification. 2005

Res. 2-I/2005 - PHYSICIAN COMPARATIVE UTILIZATION AND PROFILING

The American Osteopathic Association has adopted the following ten principles on physician comparative utilization and physician profiling.

1. Comparative utilization or physician profiling should only be used to show conformity with evidence-based guidelines.
2. Comparative utilization or physician profiling data should only be disclosed to the physician involved. If comparative utilization or physician profiling data were to be made public, assurances should be in place that ensures rigorous evaluation of the measures to be used by practicing physicians and that only measures that are deemed sensitive and specific to the care being delivered are used.
3. Physicians should be compared to other physicians with similar practice mix in the same geographical area. Special consideration must be given to osteopathic physicians whose practices mainly focus on the delivery of osteopathic manipulative treatment (OMT). These physicians should be compared with other osteopathic physicians that provide OMT to their patients.
4. Measures within the reports should be clearly defined and developed with broad input to avoid adverse consequences. Where possible, measures should be evidenced-based and vetted by relevant physician specialty or professional societies.

5. Efforts to encourage efficient use of resources should not interfere with the delivery of appropriate, evidence-based, patient-centered health care. Furthermore, the program(s) should not adversely impact the physician-patient relationship or unduly intrude upon physicians' medical judgment. Additionally, consideration must be given to the potential overuse of resources as a result of the litigious nature of the health care delivery system (i.e., defensive medicine).
6. Practicing physicians must be involved in the development of measures and the reporting process. Clear channels of input and feedback for physicians must be established throughout the process regarding the impact and potential flaws within the measures and program.
7. All methodologies, including those used to determine case identification and measure definitions, should be transparent and readily available to physicians.
8. Use of appropriate case selection and exclusion criteria for process measures and appropriate risk adjustment for patient case mix and inclusion of adjustment for patient compliance/wishes in outcome measures, need to be included in any physician specific reports. To ensure statistically significant inferences, only physicians with an appropriate volume of cases should be evaluated. These factors influence clinical or financial outcomes.
9. The measure constructs should be evaluated on a timely basis to reflect validity, reliability and impact on patient care. In addition, all measures should be reviewed in light of evolving evidence to maintain the clinical relevance of all measures.
10. The osteopathic profession should have representation on any committee, commission, or advisory panel, duly charged with developing measures or standards to be used in this program. 2005

Res. 3-I/2005 - PHYSICIAN QUALITY REPORTING AND PAY-FOR-PERFORMANCE

In an effort to support the establishment of an appropriate pay-for –performance methodology that will reflect the quality of care provided by physicians and improve patient health outcomes, the American Osteopathic Association (AOA) adopts the following principles on quality reporting and pay-for-performance:

1. The AOA supports the establishment of quality reporting and/or pay-for-performance systems whose primary goals are to improve the health care and health outcomes of the Medicare population. The AOA believes that such programs should <u>not</u> be budget neutral. Appropriate additional resources should support implementation and reward physicians who participate in the programs and demonstrate improvements. The AOA recommends that additional funding be used to establish bonus payments.
2. The AOA believes that to the extent possible, participation in quality reporting and pay-for-performance programs should be voluntary and phased-in over an appropriate time period. The AOA acknowledges that failure to participate may decrease eligibility for bonus or incentive-based reimbursements, but feels strongly that physicians must be afforded the option of not participating.
3. The AOA recommends that physicians have a central role in the establishment and development of quality standards. A single set of standards applicable to all physicians is not advisable. Instead, standards should be developed on a specialty-by-specialty basis, applying the appropriate risk adjustments and taking into account patient compliance. Additionally, quality standards should not be established or unnecessarily

influenced by public agencies or private special interest groups who could gain by the adoption of certain standards. However, the AOA does support the ability of appropriate outside groups with acknowledged expertise to endorse developed standards that may be used.

4. The AOA does not support the exclusive use of claims-based data in quality evaluation. Instead, the AOA supports the direct aggregation of clinical data by physicians. Physicians or their designated entity would report this data to the Centers for Medicare and Medicaid Services (CMS) and/or other payers.
5. The federal government must adopt standards prior to the implementation of any new health information system. Such standards must ensure interoperability between public and private systems and protect against exclusion of certain systems. Interoperability must apply to all providers in the health care delivery system, including physicians, hospitals, nursing homes, pharmacies, public health systems, and any other entities providing health care or health care related services. These standards should be established and in place prior to any compliance requirements.
6. The AOA encourages the federal government to reform existing Stark laws in order to allow physicians to collaborate with hospitals and other physicians in the pursuit of electronic health records (EHR) systems without fear of prosecution. This will promote widespread adoption of EHR, ease the financial burden on physicians, and enhance the exchange of information between physicians and hospitals located in the same community or geographic region.
7. The AOA supports the establishment of programs to assist all physicians in purchasing health information technology (HIT). These programs may include grants, tax-based incentives, and bonus payments through the Medicare physician payment formula as a way to promote adoption of HIT in physician practices. While small groups and solo practice physicians should be assisted, programs should not expressly exclude large groups from participation.
8. The AOA supports the establishment of programs that allow physicians to be compensated for providing chronic care management services. Furthermore, the AOA does not support the ability of outside vendors to provide such services. 2005

Res. 4-I/2005 - MEDICARE PHYSICIAN PAYMENTS – SUSTAINABLE GROWTH RATE (SGR)

The American Osteopathic Association (AOA) adopts the following five principles on quality reporting, pay-for-performance, and physician reimbursements:

1. The AOA continues to seek the elimination of the Sustainable Growth Rate (SGR) methodology and establishment of a new payment methodology for physicians in the Medicare program. The new payment methodology should be equitable, predictable, stable, and accurately reflect the costs associated with providing care.
2. The AOA supports, in concept, new payment methodologies that will reward physicians for providing quality services.
3. The AOA supports, in concept, new payment methodologies that will reward physicians for providing care in rural and other underserved communities.
4. The AOA strongly supports additional short-term payment adjustments that will prevent projected cuts in years 2006 through 2012.
5. The AOA supports the administrative or Congressional removal of physician-administered drugs from the SGR methodology. 2005

Res. 6-I/2005 - AOA MATCH HARDSHIP IN DUAL ACCREDITED PROGRAMS
AOA leadership should be given authority to develop guidelines and recommend policy at the Education Summit to meet the needs of emerging states and osteopathic graduates while maintaining the integrity of a separate AOA Match; and that amendments to current policy or new policy recommendations from the Education Summit be submitted directly to the Board for final action at its 2006 mid-year meeting. 2005 – **See Res. 39-M/2006**

Res. 39-M/2006 - RESOLUTION FOR PROGRAM APPROVAL FOR RESIDENTS TRAINING IN A DUAL TRACK PROGRAM AT THE TIME OF AOA APPROVAL
Policy of the American Osteopathic Association notes that any osteopathic physician who has successfully completed an AOA-approved internship with its rotational equivalents and subsequently enrolls in a postgraduate training program that becomes accredited by AOA while that osteopathic physician is enrolled in the training program, shall automatically be considered to have spent their entire training time in an AOA-approved program; and that an osteopathic resident who is enrolled in an ACGME-accredited training program at the time it becomes AOA-accredited shall be given all the rights and privileges that would accrue to any resident in any AOA program. 2006

Res. 43-M/2006 - CME WAIVER FOR OSTEOPATHIC PHYSICIANS AFFECTED BY HURRICANE KATRINA IN ALABAMA, LOUISIANA AND MISSISSIPPI
Hurricane Katrina significantly impacted coastal and inland areas of Alabama, Louisiana, and Mississippi. Mail service was suspended indefinitely for some locations. Based on ZIP Code information, the American Osteopathic Association (AOA) has determined there are three osteopathic physicians in the state of Louisiana affected by Hurricane Katrina and 23 in the state of Mississippi. Based on this disaster, the AOA has approved the following policy on behalf of those DOs: (1) CME requirement for the 2004-06 CME cycle be reduced to 50 CME hours for the osteopathic physicians who reside in the adversely affected regions of the states of Alabama, Louisiana, and that a minimum of 12 hours of the 50 CME hours shall be in Category 1-A and the remaining 38 hours in any combination of Categories 1-A, 1-B, 2-A or 2-B. 2006

Res. 54-M/2006 - CHANGE DEFINITION OF AN EMERGING STATE SOCIETY
The American Osteopathic Association (AOA) has changed the definition of an emerging state society to societies that have 300 or fewer AOA physician members. 2006

Res. 56-M/2006 - CATEGORY 1-A CME
The American Osteopathic Association (AOA) has approved the following policy regarding Category 1-A continuing medical education (CME): (1) will work to ensure that there are sufficient Category 1-A programs to meet the continuing medical education needs of AOA members; (2) the AOA will maintain the current 30-hour requirement for Category 1-A CME each 3-year CME cycle and that resources be provided by the AOA to assist sponsors

in improving the quality and variety of Category 1-A programs; and (3) will develop a series of articles to be submitted for publication to The DO to educate and inform osteopathic physicians and sponsors on the goals and intent of Category 1-A CME credit. 2006

Res. 57-M/2006 - CATEGORY 1-A CME CREDIT VIA THE INTERNET
The American Osteopathic Association (AOA) has experience in providing live interactive programs on the Internet and would like to assist Category 1-A sponsors in the development of programs of this type. Therefore, the AOA will partner with Category 1-A CME sponsors to offer live 1-A CME credit via the Internet; and that the CME event must meet AOA guidelines, including the 1-A faculty requirement, and that to be awarded credit for Internet CME, osteopathic physicians must complete a CME quiz with a passing grade of 70% or better. 2006

Res. 62-M/2006 - COALITION ON HEALTH SYSTEM REFORM - AAFP
The American Osteopathic Association (AOA) strongly believes that health care coverage for all is needed to facilitate access to quality health care in order to improve the individual and collective health of society; and, endorses the Draft Principles developed through the American Academy of Family Physicians (AAFP) Coalition on Health System Reform, that include:

- Health care coverage for all is needed to ensure quality of care and to improve the health status of Americans.
- The health care system in the United States must provide appropriate health care to all people within US borders, without unreasonable financial barriers to care.
- Individuals and families must have catastrophic health coverage to provide them protection from financial ruin.
- Improvement of health care quality and safety must be the goal of all health interventions, so that we can assure optimal outcomes for the resources expended.
- In reforming the health care system, society must respect the ethical imperative of providing health care to individuals, the responsible stewardship of community resources and the importance of personal health responsibility.
- Access to and financing for appropriate health services must be a shared public/private cooperative effort, and a system which will allow individuals/employers to purchase additional services or insurance.
- Cost management by all stakeholders, consistent with achieving quality health care, is critical to attaining a workable, affordable, and sustainable health care system.
- Less complicated administrative systems are essential to reduce costs, create a more efficient health care system, and maximize funding for health care services.
- Sufficient funds must be available for research (basic, clinical, translational, and health services), medical education, and comprehensive health information technology infrastructure and implementation.
- Sufficient funds must be available for public health and other essential medical services to include, but not be limited to, preventive services, trauma care, and mental health services.
- Comprehensive medical liability reform is essential to ensure access to quality health care. 2006

Res. 14-A/2006 - MILITARY CME WAIVER – OSTEOPATHIC PHYSICIANS CALLED TO ACTIVE DUTY

The American Osteopathic Association (AOA) has approved the following: Osteopathic physicians serving in the uniformed services during the 2004-2006 CME cycle (ending December 31, 2006), who are engaged in active military operations, will be granted a waiver of their AOA CME requirement for membership if that physician is CME deficient at the end of the current CME cycle; and that any osteopathic physician, other than career military personnel, who is called to active duty, emergency need duty, military operation, or placed on standby, and is CME deficient for the 2004-2006 cycle shall have their entire CME requirement waived. 2006

[NOTE: This waiver is for purposes of AOA membership only. The osteopathic physician must still meet all requirements for licensure, board certification, etc. as determined by those respective boards, or apply to those respective boards for waivers. Career military personnel who are not on active duty but are out of the country may avail themselves of the current military waiver with a prorated reduction in required credits.]

Res. 16-A/2006 - CERTIFICATION REPORTING

Policy of the American Osteopathic Association notes that all specialty boards be required, upon notification, to submit certification pass rate performance to its affiliated specialty college on an annual basis, each January, collated between first time and all examinees and among subspecialty sections of the major specialty, as reflected by the examination; and that any specialty board failing to submit such data to their specialty college and/or any specialty college failing to submit certification data to the OPTI academic officers, DMEs and program directors be cited by the AOA for poor educational practice, with such citation to be reported publicly. 2006

Res. 19-A/2006 - RESTRUCTURING OF THE OSTEOPATHIC INTERNSHIP

The defining mark of an osteopathic physician is in the teaching and utilization of osteopathic principles and practice and not the completion of an internship. Although it is felt that the rotating internship has been valuable and an educational enhancement to all osteopathic physicians, its benefit is no longer effective and is only utilized by 40-45% of all osteopathic graduates. Therefore, the American Osteopathic Association has developed the following restructure of the osteopathic internship:

(1) terminating the mandatory requirement for a free-standing, unattached, independent osteopathic rotating internship for all graduates, and be it recognized that all residencies have a specific required first year; (2) all first year residents (OGME-1) accepted into specific residency specialties that require a 1st year specialty program shall be known as "interns" in their respective specialty residency (family practice, medical, surgical, obstetrical, or any other osteopathic residency); (3) all other first year residents, whether in programs that are not attached to an AOA residency or in programs that require a traditional rotating first year, shall be known as "traditional interns"; (4) the terms "specialty track" and "special

emphasis" be eliminated; (5) medical and surgical specialty colleges develop rotational requirements designating the medical or surgical model as an entry requirement for their specialty as an option; and (6)that the traditional internship for those students selecting such, or which fulfills the needs of any specialty designating the traditional internship as a first-year requirement would include:

1. Internal Medicine – 2 months
2. Family Practice – 1 month
3. General Surgery – 1 month
4. Pediatrics – 1 month
5. Women's Health (OB and/or office Gyn) – 1 month
6. Emergency Medicine – 1 month
7. Selectives – 4 months
8. Elective – 1 month
9. Integrated OPP/OMM throughout all rotations

Explanatory Statement: This new structure will still maintain administrative direction from a DME together with residency directors. Internship training validation for licensure will include completion of an AOA OGME-1 year (1st year residency for most). All specialty colleges will be consulted regarding approved number of positions, which may remain as intern positions or reallocated as residency positions, to prevent any potential hospital reimbursement loss or loss of CAP numbers.

Res. 2-I/2006 - REVISED RESOLUTION FOR PROGRAM APPROVAL FOR RESIDENTS TRAINING IN A DUAL TRACK PROGRAM AT THE TIME OF AOA APPROVAL

Policy of the American Osteopathic Association notes that effective February 2006, any osteopathic physician who has successfully completed an AOA-approved internship with its rotational equivalents and subsequently enrolls in a postgraduate training program that becomes accredited by AOA while that osteopathic physician is enrolled in the training program, shall automatically be considered to have spent their entire training time in an AOA-approved program; an osteopathic resident who is enrolled in an ACGME-accredited training program at the time it becomes AOA-accredited shall be given all the rights and privileges that would accrue to any resident in any AOA program; each program, regardless of the number of approved positions, will receive an automatic temporary approval of up to the number of DOs in the program at the time of approval until completion of training for those DOs in the program at that time. For all training years thereafter, only the approved number of positions will be accepted. 2006

Res. 16-M/2007 - INTERNSHIP / RESIDENCY INTEGRATION

Policy of the American Osteopathic Association notes that effective July 1, 2007, no new internship application will be accepted for approval action without at least one simultaneous residency application. 2007

Res. 25-M/2007 - CONTINUING MEDICAL EDUCATION (CME) FINANCIAL SUPPORT RECEIVED BY PHARMACEUTICAL COMPANIES THAT PRODUCE GENERIC MEDICATIONS

The American Osteopathic Association encourages pharmaceutical companies that produce generic medications to financially support continuing medical education provided via programs, lectures and journals. 2007

Res. 27-M/2007 - PHYSICIAN AND PATIENT EDUCATIONAL MATERIALS RECEIVED BY PHARMACEUTICAL COMPANIES THAT PRODUCE AND/OR MARKET GENERIC MEDICATIONS

The American Osteopathic Association encourages pharmaceutical companies that produce and/or market generic medications to provide educational materials about their products to both physicians and patients. 2007

Res. 54-M/2007 - EXPANDED ACCESS TO EMERGING STATE SERVICES

The American Osteopathic Association has created a formal process under which a divisional affiliate that does not fall within the definition of emerging state can petition the AOA for temporary access to the AOA's emerging state services because of special circumstances and/or hardships; the formal process includes an evaluation procedure that will allow the AOA to gauge the achievements of the petitioning divisional affiliate after receiving the special services; and the AOA will routinely review the petition and evaluation processes to ensure the program is addressing the needs of struggling divisional affiliates. 2007

Res. 55-M/2007 – PATIENT CENTERED MEDICAL HOME

The American Osteopathic Association endorses the following Joint Principles of the Patient-Centered medical Home; and recommends the inclusion of the patient-centered medical home concept in future physician payment formulas with private and public payers.

Introduction

The Patient-Centered Medical Home (PC-MH) is an approach to providing comprehensive primary care for children, youth and adults. The PC-MH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

The AAP, AAFP, ACP, and AOA, representing approximately 333,000 physicians, have developed the following joint principles to describe the characteristics of the PC-MH.

Principles

- Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.
- Physician directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.
- Whole person orientation – the personal physician is responsible for providing for all the patient's health care needs or taking responsibility for appropriately arranging

care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

- Care is coordinated and/or integrated across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.
- Quality and safety are hallmarks of the medical home:
  - Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.
  - Evidence-based medicine and clinical decision-support tools guide decision making
  - Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
  - Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met
  - Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication
  - Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
  - Patients and families participate in quality improvement activities at the practice level.
- Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.
- Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:
  - It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
  - It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
  - It should support adoption and use of health information technology for quality improvement;
  - It should support provision of enhanced communication access such as secure e-mail and telephone consultation;
  - It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
  - It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit,

as described above, should not result in a reduction in the payments for face-to-face visits).
- It should recognize case mix differences in the patient population being treated within the practice.
- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements. 2007

Res. 59-A/2007 - OSTEOPATHIC CONTINUING
The American Osteopathic Association endorses the attached Osteopathic Continuing Certification document, which outlines one process for incorporating performance measurement and improvement into osteopathic continuing certification. 2007

Goals
The Bureau of Osteopathic Clinical Education and Research (BOCER) developed this document to examine methods of incorporating practice performance measurement and improvement into the board certification process.

Background
Continuous certification is a process that provides the practicing physician with the opportunity to constantly evaluate and improve their knowledge base ensuring that they are incorporating evidence based medicine into their practice as the science of evidence-based medicine evolves. In addition, concepts such as disease management, patient safety and continuous quality improvement are embedded in the continuous certification process to ensure that osteopathic physicians involved in the program are providing quality patient centered care.

Current Environment of Measurement in Healthcare Delivery
There has been an increasing focus on the use of measures to improve patient care and reward physician clinical performance in several venues. These can be classified by the following categories:

Quality Improvement is demonstrated by physicians engaged in the continuous quality improvement loop of identifying opportunities to improve patient care, development of a systematic method of acting on the identified opportunity gap, implementation of the plan to improve and re-measurement. This model uses both process measures, which evaluate the interaction between healthcare providers and patients including diagnosis and treatment of disease, and outcome measures, the results of the intervention between patient and healthcare delivery and measured by changes in clinical, financial, patient perceived and functional outcomes of the patient care. Examples of this category include the National Committee for Quality Assurance Health Plan Employer Data and Information Set (HEDIS) program and the AOA's Clinical Assessment Program in residencies, both of which have demonstrated improvement in healthcare delivery over time in providers engaged with these programs.

Pay for Performance is an increasing focus of employers, private insurers and government as a method of reforming healthcare delivery. Concerns regarding payment disincentives for delivery of patient- centered care have been raised by most entities paying for healthcare in America. The current payment system is seen as encouraging procedures and interventions, which may not be evidenced based, at the expense of cognitive systematic patient centered care. In its place these entities are developing payment systems that better align physician incentives with both evidenced based processes of care and patient outcomes. Although the techniques used by pay-for-performance initiatives are in their infancy, the center of all of these systems involves objective measures of the delivery of healthcare at an institution or physician level. Ignoring these initiatives will place osteopathic physicians at a disadvantage.

Maintenance of Certification is required by the certifying allopathic boards. All member boards of the American Board of Medical Specialties (ABMS) have agreed to implement a maintenance of certification program by the year 2010. There are four steps to a "Maintenance of Certification" process: 1) professional standing (licensing); 2) lifelong learning and self-assessment; 3) demonstration of cognitive expertise (examination process) and 4) practice performance assessment. Steps 1-3 are already present in current osteopathic requirements. However step 4 can be addressed in various modalities, including the CAP. The practice performance assessment of the CAP evaluates physicians in their clinical practice according to specialty-specific standards for patient care. Physicians demonstrate that they can assess their quality of care which is compared to their peers and national benchmarks. Physicians then apply interventions to improve patient care and then re-access that care. This type of quality improvement activity is being seen as a natural inclusion covering evolving competencies in healthcare delivery of Practice Based Learning and Systems Based Practice.

The increasing calls from State medical boards, Federal and private insurance programs, employers and the public necessitate a response from the osteopathic profession. Osteopathic Continuous Certification can form the foundation for the response to all stakeholders and, ultimately lead to better patient care and a level playing field for evaluation of osteopathic care nationally. The absence of a response to these demands from the profession leaves osteopathic physicians at risk for perceived lower quality and lower payment.

<u>Components of Osteopathic Continuous Certification</u>

Building on the tenets originally envisioned in the American Osteopathic Accreditation Program (AOAP), Osteopathic Continuous Certification contains the following components, the last two of which are consistent with the Institute of Medicine's six aims to improve quality in American healthcare by making care safe, effective, patient-centered, timely, efficient and equitable:

1. Written examination testing the osteopathic physician's knowledge base relative to the rapidly advancing field of medicine. This exam includes a practical session evaluating knowledge of osteopathic practice and principals.
2. Demonstrations of continuous learning and professional conduct. This component of the continuous certification process is satisfied by the completion of a minimum of 120 hours (150 for AOBFP) of approved and documented AOA Continuing Medical Education credits within a three-year period, at least 50 hours of which shall be in their general specialty (Category I or II), and some amount will be "Certifying CME" (defined below) which will require testing, approved by the certifying board. Professional conduct is assured by retention of professional license in the state in which the physician practices and membership in national professional organizations.
3. Demonstration of evidenced based practice. This portion of recertification evaluates the application of evidence-based medicine within the practitioner's field of practice focusing on clinical entities the physician sees most frequently within their patient population. This is achieved by participation in the AOA Clinical Assessment Program (CAP). Fulfillment of this component is achieved by participation in the CAP; achievement of specific levels of performance is not a requirement for completion.
4. Evaluation of competencies inpatient-centered care. This portion of recertification is evaluated by a survey of the practitioners progress towards:
    a. Adoption of electronic records that improve care delivery but not reduce productivity.
    b. Developing tools to manage and measure progress in the treatment of patient populations. This section evaluates the practice use of registries and systematic clinical information management techniques such as e-prescribing and automated reminders.
    c. Use of disease management techniques within clinical populations. This section evaluates the practice connectivity with community, healthcare and patients with chronic disease on a continuous basis maximizing the effectiveness of physician management by using a series of resources to achieve optimal patient outcomes.

Operational aspects of Osteopathic Continuous Certification

Current re-certification timelines provide an opportunity to take a written exam and osteopathic practical every 6-10 years, depending on the specialty. Moving to a continuous certification program would continue to provide the physicians an opportunity to take the written exam with the addition of completing performance practice assessment using the AOA CAP.

The required CAP component of Osteopathic Continuous Medicine Certification would include completion of a set number of modules over the period of certification. The modules are currently completed using the DO-Online Web-based entry tool and office-based abstraction of medical records. As issues of interoperability are resolved and more physicians adopt electronic medical records, the CAP will enable electronic data submission on clinically similar cohorts using standardized definitions.

The completion of CAP submissions would provide evidence to satisfy requirements for continuous certification. Performance within the module would not be used as the criteria for certification.

Current and anticipated (7/30/07) CAP Modules:

- Practice Assessment of electronic medical records, registry capability, and disease management;
- Diabetes Mellitus;
- Coronary Artery Disease;
- Women's Health;
- Hypertension and Metabolic Syndrome;
- Chronic Obstructive Pulmonary Disease (7/30/07); and
- Asthma (7/30/07).

Timeline of Implementation

Implementation of Osteopathic Continuous Certification would occur January 1, 2008 on a voluntary basis with the expectation that all practitioners due for re-certification would be offered an opportunity to enter a pathway of continuous certification. The following points will be considered in a model for implementation of the Osteopathic Continuous Certification:

- The re-certifying exam and practical would continue to occur every 6-10 years depending on the requirement of the specialty board;
- 120-150 hours of CME activity, as required by the specialty board, would be completed over a 3-year period;
- One applicable CAP module will be completed every two years;
- Certifying CME content would be clinically focused and of adequate breath to cover clinical entities that practitioners commonly treat. The rigor of the content would be at a higher level than currently provided practitioners by enduring materials and would be governed by the Certifying Board. The use of certifying CME could be tied to performance within CAP module. For example, a practitioner scoring low on risk adjusted control of glycosylated Hemoglobin in diabetics within their practice would be required to complete Certifying CME covering glucose management. The CME materials would cover pharmacological management of glucose as well as models of patient and population management such as behavioral modeling and use of systematic community resources to help patients achieve goals;
- Other potential models of certifying CME that can be incorporated include:
    - Learning through clinically directed Assessment Modules covering current care;
    - Learning through Assessment of current care delivery; and
    - Assessment of content through structured written test and practicum;
- Physicians requiring exemption or modification of Osteopathic Continuous Medicine Certification:
    - Non-practicing physicians;

    - Retired physicians;
    - Physicians in non-patient care such as Administration, Medical Teaching, or Research; and
- There are non-CAP activities that are very similar to the current structure of CAP but lacking an osteopathic component. These activities would have to be considered for satisfying the certification requirement: NCQA, AAFP, ABIM and subspecialty supported activities i.e. METRIC, PIM, HEDIS.

Description of Current AOA Clinical Assessment Program (CAP)

The Clinical Assessment Program (CAP) for Physicians is a web-based performance measurement program developed by the American Osteopathic Association that analyzes data abstracted directly from patient medical records. Originally designed to measure clinical practice in residency training programs, CAP was extended to the physician's office in December 2005. Three measure sets, including Diabetes, Coronary Artery Disease and Women's Health Screening, were developed using evidence-based guidelines that represent state-of-the-art professional standards of care. These guidelines track patient outcomes in order to improve the quality of care and are comparable to other ambulatory care measure sets. Physicians who participate in CAP receive 20 hours of AOA Category 1-B CME credit for each measure set.

CAP for Physicians

The CAP for Physicians measures current clinical practices in the physician's office and compares the physician's outcomes measures to their peers and national measures.

Goals

- To provide a structure for quantitative evaluation of current osteopathic care provided individually and in the aggregate by osteopathic physicians.
- To identify where quality-of-care improvements can be made in osteopathic physician's offices and provide educational interventions.
- To provide osteopathic physicians with information on how they are treating their populations.

Measure sets

Performance in CAP is measured by abstraction of required data elements from patient's medical records by the physician. Data elements include demographic information and clinical information. Clinical indicators selected for measurement represent evidence-based clinical practice standards derived from large randomized controlled clinical trials, single controlled observational studies, or expert consensus. Each data dictionary includes a measurement on the completion of an osteopathic structural examination. The measure sets include Coronary Artery Disease, Diabetes Mellitus, and Women's Health Screening.

Diabetes Mellitus

- Use of glycosylated hemoglobin (HgbA1c)
- Frequency of Foot exams
- Screening and treatment of microalbuminuria

- Assessment and control of hyperlipidemia
- Assessment and control of hypertension
- ACE Inhibitor use for hypertension/proteinuria
- Vaccinations
- Osteopathic Assessment and Treatment

Coronary artery disease

- Aspirin use in ideal patients
- Smoking cessation counseling
- LDL levels evaluated & LDL control
- Beta blocker use in ideal patients
- ACEI and ARB use in ideal patients
- Warfarin use to reduce stroke in Afib patients
- Kidney Function in Patients with CAD
- Screening patients for depression
- Osteopathic assessment of patients

Women's Health

- Cervical Cancer Screening
- Breast Cancer Screening
- Chlamydia Screening
- Osteoporosis Screening
- Osteopathic Assessment and Treatment

How the CAP works

- Physicians can participate by going to www.DO-Online.org, entering their AOA ID number and password, and then clicking on *CAP for Physicians*.
- Participants select one to three measurement sets.
- Medical records are selected based on specific patient parameters such as diagnostic criteria, patient inclusion and exclusion criteria, and sampling technique.
- Participants abstract data from 20 patient records for chart review.
- Data is entered online through the website.
- Participants receive a performance analysis report, comparing their performance with other participants and national benchmarks (e.g., NCQA's HEDIS measures).
- Physician selects and implements an educational intervention(s) designed to improve performance.
- 20 additional charts are abstracted and entered into the database to generate a comparison report.
- Physicians receive 20 hours of AOA Category 1B CME credit for participation. Each of the three measure sets is eligible for an additional 20 CME hours.

CAP for Residency Programs

To identify opportunities for the incorporation of evidence-based measures into practice, the AOA launched a pilot project of CAP in 2000 with family practice residency programs. Diabetes, women's health screening, childhood immunizations, and diagnosis and treatment

of low back pain were the four clinical conditions evaluated, encompassing over 30 indicators. Eleven family practice residency programs representing 94 residents in training reported on 1,541 patients under their care.

With the success of the pilot study, the AOA developed the CAP to encompass additional measures and a greater number of residency training programs. The eight measure sets include diabetes, coronary artery disease, women's health screening, childhood immunizations, asthma, COPD, hypertension and metabolic syndrome, and acute low back pain. In July 2003, the American College of Osteopathic Family Physicians (ACOFP) mandated that all family practice residency programs participate in the CAP as a requirement of their accreditation. The American College of Osteopathic Internists began requiring their residency programs to participate in the CAP as of July 2005. Over 200 residency programs will be contributing data to the CAP over the next two years.

With over three years of data collection through the CAP, data on residency programs that are currently re-measuring performance are demonstrating improvements in patient care. The following tables show 14 family practice residency programs contributing data from 2003-2005 (baseline) compared to the first 6 months of 2005-2007 (re-measure). The Percent Change indicates the level of improvement for these 14 programs in both processes of care and outcomes of care.

PROCESSES OF CARE						
	N	FOOT EXAM DONE	HGBA1C DONE	ACEI WITH HYPERTENSION	LDL SCREEN	OPTH EXAM RECOMMENDED
ALL CAP 2003-2005	3149	57.13%	92.32%	65.74%	84.34%	37.41%
BASELINE	672	49.40%	90.63%	75.10%	82.44%	59.97%
REMEASURE	777	61.78%	94.47%	85.58%	86.74%	61.13%
PERCENT CHANGE		25.04%	4.24%	13.95%	5.22%	1.94%
HEDIS 2004			86.50%	52.00%	91.00%	51.00%

OUTCOMES OF CARE					
	N	LDL < 100	HTN CONTROL	HGBA1C < 7%	Patient Level Indicator LDL<100, BP<130/80, HgbA1c <7%
ALL CAP 2003-2005	3149	40.76%	30.05%	42.75%	6.90%
BASELINE	672	44.22%	33.03%	44.44%	7.12%
REMEASURE	777	45.65%	34.11%	45.58%	8.81%
PERCENT CHANGE		3.23%	3.26%	2.56%	23.75%
HEDIS 2004		40.20%			

The CAP data registry is also being used for research purposes resulting in the submission of several research abstracts over the last two years. These are entitled:

Effect of Insurance Type and Patient Compliance on control of Cardiovascular Risk Factors in Diabetic Patients treated in Family Practice Residency Programs

Use of a Hypertension Registry to Identify Patients at High Risk for Cardiovascular Events

Risk Adjustment in Ambulatory HgbA1c Outcomes in Diabetes Mellitus,

Methods of Quantifying Resource Utilization of a Medicare Cohort Receiving Care in a Residency Clinic – Teaching Population Management

All or None Process and Outcome Indicators of Diabetes Care in a National Sample of Resident Physicians

The CAP is HIPAA compliant. It has been developed to collect no identifiable patient information and meets the HIPAA privacy regulation for "de-identification of protected information" set forth in 45 CFR Sec. 164.514(b)(2). All physician-specific data is confidential and will only be made available to the physician or their delegate. 2007

Res. 60-A/2007 - PROGRAM CONTINUING APPROVAL FOLLOWING PROBATION

The American Osteopathic Association believes that any program which has received a one-year probationary approval may receive no more than three (3) year continuing approval after its next on-site review. 2007

Res. 16-I/2007 - MULTIPLE POSITIONS ON GOVERNING BOARDS

Policy notes that the affiliated organizations of the American Osteopathic Association should not allow individuals to have multiple votes or exercise undue influence on a governing board by virtue of having multiple positions. 2007

Res. 17-M/2008 - NAMING OF SPECIALTY AFFILIATES
The name by which a specialty affiliate is known within the American Osteopathic Association (AOA) must clearly reflect both the character and purpose of that organization and provide a description of that organization's makeup (e.g., the majority of members of a specialty affiliate that uses the term "surgery" or "surgeons" in its name should be physicians who practice in a surgical specialty). Therefore; the AOA has developed the following structure for the naming of specialty affiliates:

(1) the terms "Academy" and "College" are used in the names of specialty organizations that are approved by the AOA for postdoctoral residency training; (2) the terms "Association" and "Society" are used in the names of specialty organizations that have common goals or interests or are subgroups within a larger entities that are not necessarily involved in educational issues; (3) the terms "Academy" and "College" shall be considered synonymous when used in the name of an AOA specialty affiliate; (4) the terms "Society" and "Association" shall be considered synonymous when used in the name of an AOA specialty affiliate; (5) the AOA shall determine the name by which all specialty organizations seeking specialty affiliate status are known using these naming guidelines; (6) the existing specialty affiliates shall be encouraged to change their names consistent with these guidelines within a three-year timeframe; (7) the existing specialty affiliates that do not change their names after three years shall be known by a name determined by the AOA applying these guidelines. 2008

Res. 23-M/2008 - IMPLEMENTATION OF OSTEOPATHIC CONTINUOUS CERTIFICATION PROCESS BY 2012
The AOA approves the recommendation to mandate that all AOA Boards implement a continuous certification process for osteopathic physicians; and that this process shall be named "Osteopathic Continuous Certification" (OCC); and that all AOA Osteopathic Certifying Boards shall have this process operational no later than 2012. 2008

Res. 28-M/2008 - AMENDMENT TO BOARD ELIGIBILITY REQUIREMENTS FOR AOA BOARD CERTIFICATION
The AOA approves: (1) the recommendation of having candidates complete the entire certification process within the six-years of initial board eligibility with an opportunity for candidates to petition their certifying board to reenter the process one additional time; (2) the recommendation to not allow further efforts to become certified if candidates do not complete the certification process at the conclusion of the reentry process.

The following recommendations for the Board Eligibility Process include:
1. A candidates for certification will have six years to be board eligible and complete the certification process.
2. At the end of six years of board eligibility, if the candidate has not obtained final certification, the candidate may petition the board to reenter the certification process. The board will grant the candidate the ability to reenter the process. The candidate must begin at the beginning of the process and must start at the next available administration of the exam. The candidate will have two attempts to pass each step of the examination

process. If a failure of any of the steps occur, the candidate must repeat that failure at the next available administration.
3. After exhausting the above process the candidate is not eligible to continue the process.
4. In order for a candidate to be eligible to reenter the certification process a candidate must re-petition the board. The board will establish criteria that must be met prior to granting re entry. The reentry process needs to be submitted and approved by the SRC of the BOS. The applicant upon approval of the board will follow the same process as outlined in number 2. If the candidate is unsuccessful in this attempt, there will be no further opportunities to become certified.
5. Certifying boards may have more stringent requirements in the limitation of time in which a candidate for certification must complete the entire certification process. 2008

Res. 45-M/2008 - REUNION TASK FORCE FINAL REPORT

The American Osteopathic Association will focus on public relations and marketing activities to attract ACGME-trained. 2008

Background

At its July 2007 meeting, the American Osteopathic Association (AOA) Board of Trustees discussed an email from an AOA member recommending consideration of an amnesty for those osteopathic physicians who went astray to bring them back under a presidential executive pardon. In response, the AOA Trustees recommended that the AOA President form a Reunion Task Force to study this issue (see Attachment 1).

The AOA President Peter B. Ajluni, DO, appointed the following members to the Reunion Task Force: Carlo J. DiMarco, DO, AOA President-elect, Chair; Ronald E. Ayres, DO; Mitchell Kasovac, DO; Anthony A. Minissale, DO; George Mychaskiw, DO; Eugene A. Oliveri, DO, Michael I. Opipari, DO; David S. Pucci, DO; and William E. Shiels, II, DO.

Charge

The Reunion Task Force held its first conference call on September 10, 2007. The Task Force defined its charge: To develop an amnesty to accept into AOA membership those Dos who entered ACGME training. Amnesty implies that an act was committed in which a pardon is needed to restore the relationship.

Requirements for Membership

There are two requirements for membership in the AOA. Candidates must: 1) be a graduate of a college of osteopathic medicine approved by the American Osteopathic Association (AOA), and 2) be eligible for licensure as an osteopathic physician and/or surgeon or shall be in a training program, which is a prerequisite for his licensure (see Attachment 2).

In addition to the requirements to obtain AOA membership, there are requirements for maintenance of membership: Continuing medical education (CME); Annual dues payment; and Adherence to the AOA Code of Ethics.

CME Since the early 1970s, the AOA has supported quality practice by requiring its members to maintain and enhance their scientific knowledge by participating in CME programs. The AOA currently requires members to obtain 120 hours of continuing medical education (CME) credit every three years. Of the 120 CME hours, 30 hours must be in Category 1-A, which is formal didactic lectures given by primarily osteopathic physicians. In addition to its educational content, the 30 hours of Category 1-A has the ancillary benefit of reminding members of the osteopathic tenets. The remaining 90 hours of required CME may be in any category of credit, which recognizes that osteopathic physicians may wish to obtain some or the majority of their CME in non-osteopathic programs. Members with AOA certification have additional continuing educational requirements.

The AOA records the CME obtained by each member in 3-year increments or cycles. The current three-year CME cycle began January 1, 2007, and ends December 31, 2009. Members who begin in mid-cycle are given a pro-rated CME requirement. Members CME records are available on the AOA's website, www.DO-Online.org, and can either be printed from the website or obtained via fax, email or postal service from the AOA Division of CME.

The AOA's CME requirement as a condition to maintain membership parallels the AOA's 501c(3) tax status. The AOA is recognized by federal agencies as an educational organization involved in the medical education of osteopathic physicians.

Dues Members must pay annual dues to maintain membership. The dues structure is:

Category	Rate
Full dues	$590
3rd year in practice	$443
2nd year in practice	$295
1st year in practice	$148
Military	$500
Retired	$ 90
Intern and resident	$ 60
Associate and Allied	$ 90

Members who fail to pay their dues on time are made non-members after a period of suspension in which they have time to pay their dues bill.

Code of Ethics Members must adhere to the AOA Code of Ethics. The Code of Ethics specifies an osteopathic physician's relationship with the patient, community, pursuit of life-long learning, and relationship with pharmaceutical companies, to name a few. Members who are alleged to have violated the Code of Ethics go before the AOA Committee on Ethics for a hearing.

Residency Training and Membership

There are two major types of residency training programs in the United States today: AOA-approved residency programs and Accreditation Council on Graduate Medical Education (ACGME) approved programs. Osteopathic physicians train in either an AOA-approved program or an ACGME-approved program.

The choice of residency training program is not a condition of AOA membership. Of the 36,561 active AOA members in September 2007, 24,665 (or 67%) had osteopathic training, 10,128 (or 28%) had ACGME training, and the remainder had military, public health and other residency training. A DO who enters an ACGME-approved program is as eligible for AOA membership as a DO who enters an AOA-approved program.

Table 1: Match Statistics

	2000	2001	2002	2003	2004	2005	2006	2007
Graduates Needing Internship	2479	2569	2639	2670	2819	2908	2886	3173
AOA Positions Filled	1459	1463	1470	1440	1451	1481	1502	1267
AOA Positions Filled + Military	1507	1521	1505	1488	1611	1650	1713	1483
Total Not Entering AOA or Military Training	972	1048	1134	1182	1208	1258	1173	1690

Table 1 shows Match statistics for the years 2000 – 2007. The data show that the number of graduates not entering AOA training has grown from 972 DOs in 2000 to 1,690 DOs in 2007; many of whom are entering ACGME-approved training programs.

However, there is a relationship between AOA membership and type of residency training. ACGME-trained DOs are less likely to join the AOA as members than DOs who trained in osteopathic residency programs. This, however, does not mean that ACGME-trained DOs are less welcome or need a pardon as an amnesty would imply.

Educational Policies

The AOA Board of Trustees has adopted a number of education policies to accommodate ACGME-trained DOs. These policies were created to encourage and enhance AOA membership by ACGME-trained DOs. Resolution 42 addresses equivalence of ACGME-training with the AOA rotating internship. Resolution 56 allows osteopathic physicians with allopathic certification to enter the AOA certification process. None of these policies is a requirement for AOA membership.

Approval of Allopathic Training as an AOA Approved Internship (Resolution 42)

The AOA has established procedures to have ACGME training approved as equivalent to osteopathic training. The traditional rotating internship has been viewed as an essential element of a well-rounded education. The rotating internship was designed to give DOs a

broad understanding of medicine before entering specialty training. Five state medical licensure boards continue to require osteopathic physicians to complete an AOA-approved 1st training year, equivalent to an internship.

Resolution 42, adopted by the AOA Board of Trustees in July 2000, allows ACGME-trained Dos to apply to have their ACGME training approved as equivalent to the AOA internship year. The application requires a list of the rotations the resident completed, an explanation of the reason he/she did not enter an AOA rotating internship program, and a release to allow the AOA to conduct primary source verification. There is no application fee for Resolution 42, nor is AOA membership a requirement for this service.

Beginning July 2008, there will be multiple types of AOA-approved 1st training years. This benefits not only osteopathic residents but also ACGME residents because there will be more types of AOA-approved 1st training years with which to compare their ACGME training (see Table 2).

Table 2: New Forms of the Rotating Internship Beginning July 2008

Option 1: OGME 1-R (Residency) Specialties who chose this option will start trainees as a first year resident. In the current internship system, they are known as "specialty track internships." Curriculum has been developed by all specialties that include components of the rotating internship plus rotations in the specialty. Specialties that chose OPTION 1 include:

- Anesthesiology
- Family Practice and FP/EM
- Integrated Family Practice and Neuromusculoskeletal Medicine.
- Emergency Medicine
- Internal Medicine
- General Surgery, Neurological Surgery, Orthopedic Surgery and Urological Surgery
- Internal Medicine/Pediatrics
- Obstetrics and Gynecology
- Otolaryngology Facial Plastic Surgery
- Pediatrics
- Internal Medicine/Emergency Medicine

Option 2: OGME 1-P (Preliminary) Specialties who chose this option will start trainees in an internship program that is located or affiliated with the specialty. In the current internship system, they are known as "special emphasis internships." Trainees are actually matching into their first year of residency, which starts immediately following the internship. Specialties that chose OPTION 2 include:

- Diagnostic Radiology,
- Neurology
- Neuromusculoskeletal Medicine/Osteopathic Manipulative Medicine

- Ophthalmology
- Pathology (currently no programs)
- Psychiatry
- Radiation Oncology

Option 3: OGME 1-T (Traditional) Specialties who chose this option will require a trainee to complete a traditional rotating internship before they can enter their specialty. Specialties that chose OPTION 3 include:

- Dermatology
- Occupational/Preventive Medicine (very few training programs)
- Physical Medicine and Rehabilitation (very few training programs)
- Proctology (no training programs – one fellowship)

Since 2000, DOs have submitted 1,828 Resolution 42 applications to the AOA. Of these, 1,153 DO's have received approval of their 1st year as equivalent to an osteopathic internship; 21 have been denied or withdrawn their applications; and, 654 applications are in process. Of those who have received approval, 835 (72% of the 1,153) have an "Active" membership status.

The AOA has had policies to grant equivalency to ACGME training for more than a decade. Predecessors to Resolution 42 include Resolution 22, adopted in July 1996, Resolution 31, adopted in February 1997, and Resolution 19, adopted in July 1998. While database records are not available on Resolutions 22 and 31, a total of 210 applied for Resolution 19 of which 109 are AOA members.

Certification Eligibility for Dos with ABMS Certification (Resolution 56) Resolution 56, adopted in 2004 and as amended in October 2004 allows DOs who have been certified by the American Board of Medical Specialties (ABMS) for at least five years to obtain AOA certification. Less than 200 Dos have gone through Resolution 56 to be AOA certified. AOA certification requires AOA membership.

Re-entry Pathway The "Re-entry" Pathway (Resolution 6, February 1999 and later amendments) was developed for Dos who have completed ACGME-training but have not completed the requirements for an AOA-approved internship. It allows these DOs to sit for AOA certification. This option is available only for DOs who have started training on or before October 31, 1999, and is for board eligibility only. Sixty-four DOs have completed this process.

These educationally-related resolutions were created because the osteopathic profession lacked sufficient numbers of postdoctoral training positions for its graduates. Attachment 3 shows the graduation numbers as well as numbers of internship positions available. In addition, beyond internships, the osteopathic profession has insufficient numbers of residency training positions to handle all Dos seeking such training.

Table 3: Education and Certification Policies

What	Who is it for	What it does	More Information
Resolution 42	ACGME-trained DOs	Mechanism to allow approval of ACGME training as equivalent to an AOA Rotating Internship	www.do-online.org/index.cfm?PageID=sir_appforms
Resolution 56	DOs who have been ABMS certified for at least 5 years	Allows ABMS-certified DOs to enter the AOA certification without having ACGME training approved as equivalent to osteopathic postdoctoral training. This process does not confer approval of ACGME training as equivalent to AOA internship or residency training.	www.do-online.org/index.cfm?PageID=sir_appforms
Re-entry Pathway	DOs who entered ACGME training prior to October 31, 1999 and have had their residency training approved by the AOA.	DOs who have approved residency training may enter AOA certification. This does not require approval of an AOA internship year.	www.do-online.org/index.cfm?PageID=sir_appforms
Approval of Federal/Military Internship Training	DOs who enter Federal or Military training	Approval of training as equivalent to an AOA rotating internship	www.do-online.org/index.cfm?PageID=sir_appforms
Approval of ACGME or Federal Residency Training	DOs who enter ACGME or federal residency training	Approval of training as equivalent to osteopathic specialty training	www.do-online.org/index.cfm?PageID=sir_appforms

Discussion

The Reunion Task Force discussed membership requirements and the educationally-related resolutions. The AOA has adopted a number of education policies over the past decade to encourage DOs into AOA membership. The Task Force believes that the resolutions have met with some success. Approximately 72% of those completing Resolution 42 are members of the AOA. However, the Task Force noted that only 1,828 of the 9,665 graduates who did not enter AOA training since 2000 have applied for Resolution 42.

The Task Force agreed that we must preserve the quality of the osteopathic educational system. However, the Task Force noted several times that what may be needed is a good public relations or marketing campaign. The AOA needs to demonstrate that we have open arms for the DOs in ACGME-training.

Based on the facts, the Reunion Task Force concludes that an amnesty is not needed – that is; ACGME or AOA trained DOs are equally eligible for AOA membership.

** ** ** **

Email from AOA member

Subject A meaningful tribute to our recently departed president

Greetings,

Many eloquent words of well earned praise and sincere admiration have been recently paid to a great doctor and a dedicated leader. He was committed to the success of the AOA and to great patient care rendered by the D.O.s he so effectively represented.

What better long term tribute could we offer up to his name than a one time "Reconciliation offer" to those Osteopathic physicians who, for what ever reason (and there are indeed many legitimate reasons ...to include the administrative debacles I suffered through as a military resident, and there are, no doubt, many poor and selfish reasons).

What if you offered a "Presidential Amnesty" to those D.O.s who went astray and bring them back into the fold under John's presidential executive pardon?

We could (1) radically increase our membership numbers (a politically good thing), (2) mend some fences (a politically wise thing) , and make new friends out of old adversaries (a common sense thing), and (4) help restore the Osteopathic family (something John would have wanted).

This would cost us no moral high ground or political capital as all members returning from the "dark side" would still have to comply with our established requirements. If anyone was so obstinate or stupid to complain we can have them take it up with John.

Food-for-thought. Consider the editorial in last month's JAOA about being estranged form the profession. We have an opportunity to make things right and to celebrate a great man's passage with a long-term benevolent action.

Excerpt from the AOA Constitution and Bylaws

Section 2-Membership Requirements

a. Applicants for Regular Membership
An applicant for regular membership in this Association shall be a graduate of a college of osteopathic medicine approved by the American Osteopathic Association and shall be eligible for licensure as an osteopathic physician and/or surgeon or shall be in a training program, which is a prerequisite for his licensure.

Application shall be made on the prescribed form and shall be accompanied by payment of the appropriate dues amount.

Unless specifically noted, an applicant whose completed application and payment of appropriate dues has been received and processed shall be enrolled as a regular member. An applicant whose membership in this Association has previously been withdrawn for reasons other than failure to meet CME requirements or non-payment of dues, or who has previously been convicted of a felony offense or whose license to practice has at any time been revoked, shall be further required to obtain the endorsement of the secretary of the divisional society in the state, province, or foreign country in which the applicant resides (or the endorsement of the secretary of the uniformed services divisional society in the case of applicants currently serving in the uniformed services of the United States), or, lacking this endorsement, an applicant who is in good standing in his community shall provide letters of recommendation from three members of the Association and provide a personal written statement as to why membership in the Association should be extended or restored. Such information and application shall be carefully reviewed by the Committee on Membership, which shall make an appropriate recommendation for reinstatement to the Board of Trustees.

An applicant whose license to practice is revoked or suspended, or who is currently serving a sentence for conviction of a felony offense, shall not be considered eligible for membership in this Association.

THE AOA INTERN REGISTRATION PROGRAM STATISTICS: 2001-2007

AOA Department of Education, Division of Postdoctoral Training

Data and projections were updated on September 18, 2007

will be published Feb/March 2008

Summary of AOA Match Statistics

Criteria for the Match in YEAR:	2002		2003		2004		2005		2006		2007	
Graduates of the current year	2602		2628		2769		2826		2814		3103	
Previous Grads	37		42		50		82		72		70	
Total graduates needing internship	2639	100.0%	2670	100.0%	2819	100.0%	2908	100.0%	2886	100.0%	3173	100.0%
Total Participants in AOA Match	1392	52.7%	1371	51.3%	1296	46.0%	1344	46.2%	1319	45.7%	1449	45.7%
Total Matched (by NMS)	1291	48.9%	1273	47.7%	1205	42.7%	1240	42.6%	1196	41.4%	1267	39.9%
{Total Matched / Total Participants}	0.927		0.929		0.930		0.923		0.907		0.874	

Participants who were Unmatched	101	3.8%	98	3.7%	91	3.2%	104	3.6%	123	4.3%	181	5.7%
Non-Participants in AOA Match	1212	45.9%	1251	46.9%	1363	48.4%	1395	48.0%	1356	47.0%	1508	47.5%
Plus Military →	35	1.3%	48	1.8%	160	5.7%	169	5.8%	211	7.3%	217	6.8%
Total Post-Match (by AOA)	179	6.8%	167	6.3%	246	8.7%	241	8.3%	306	10.6%	0	0.0%
Total Positions Filled	1470	55.7%	1440	53.9%	1451	51.5%	1481	50.9%	1502	52.0%	1267	39.9%
Total Positions Filled + Military	1505	57.0%	1488	55.7%	1611	57.1%	1650	56.7%	1713	59.4%	1483	46.7%

Internship Program Capacities and Utilization

	2002	2003	2004	2005	2006	2007
Approved (by ECCOPT/PTRC)	2473	2659	2616	2652	2704	2688
Funded (self-reported to NMS)	1989	2130	2147	2165	2206	2189

Filled Positions (total)	1470		1440		1451		1240		1196		1267	
{Funded positions – unfilled positions}	519		690		696		925		1010		922	
{Total filled / Funded}	0.739		0.676		0.676		0.573		0.542		0.579	
Current year's graduates	2602		2628		2769		2826		2814		3103	
{Approved positions – current grads}	-129		31		-153		-174		-110		-415	
%{{approved – graduates} / approved}		-5.2%		1.2%		-5.8%		-6.6%		-4.1%		-15.4%
{Funded positions – approved}	-484		-529		-469		-487		-498		-499	
%{{funded-approved} / approved}		-19.6%		-19.9%		-17.9%		-18.4%		-18.4%		-18.6%
{Funded positions – current grads}	-613		-498		-622		-661		-608		-914	
% {{funded – current grads} / funded}		-30.8%		-23.4%		-29.0%		-30.5%		-27.6%		-41.8%

Res. 2-A/2008 - AOA CATEGORY 1-A CME CREDIT FOR OSTEOPATHIC SPECIALISTS / SUBSPECIALISTS

The American Osteopathic Association affirms the value of AOA Category 1-A CME credits; encourages its Category 1 CME Sponsors to explore and implement on-line, interactive AOA Category 1-A CME programs as well as to develop other innovative approaches to deliver relevant, high quality AOA Category 1-A CME for subspecialty certificate holders; and that those Category 1 CME Sponsors having recognized specialty and/or sub-specialty certificate holders numbering less than 250 members the ability to satisfy AOA Category 1-A CME requirement using ACCME Category 1 credits that will sunset in the following manner

CME Cycle	ACCME Category 1 Credits
2007 – 2009	20 credits
2010 – 2012	15 credits
2013 – 2015	10 credits
2016 – ONWARD	0 CREDITS

Explanatory Statement: This policy is an effort to allow the time necessary to explore and develop quality osteopathic subspecialty CME as an outreach to those osteopathic physicians with unique educational needs and to encourage their AOA and specialty college membership. 2008

Res. 6-A/2008 - UNIFORM TRAINING STANDARDS FOR CONJOINT TRAINING PROGRAMS

The American Osteopathic Association has approved that a single uniform training standards for establishment of subspecialty programs in an area common to more than one primary specialty and leading to conjoint Certification of Added Qualifications, be developed and required, in accordance with the attached process.

1. The specialty colleges seeking the establishment of a conjoint training program shall establish a conjoint Education and Evaluating Committee. The Committee shall be composed of 1-2 members from each participating specialty college. The Committee shall have a minimum of 4 members.
2. The Committee shall be supported in a method that is agreed upon by each participating specialty college including a mechanism for future entry by additional specialty colleges. The participating specialty colleges shall sign a letter of agreement outlining the purpose, functions, frequency and method of meetings, administrative arrangements, financing and other relevant issues to ensure the smooth functioning of the Committee.
3. The function of the conjoint Education and Evaluating Committee must include: 1) program review; 2) administration of site visits; 3) recommendations on the equivalence of training by DOs who entered ACGME training to the AOA Program and Trainee Review Council; and 4) recommendations on the training standards to the AOA Council on Postdoctoral Training.
4. It is the responsibility of each participating specialty college to obtain a signed letter of agreement from their respective certifying board to participate in a conjoint examination committee.
5. The training standards must include a list of educational and training prerequisites that a candidate must have completed in order for that individual to enter a conjoint training program.

6. Training programs shall not be designated as coming from one particular specialty college. All residents or fellows meeting the prerequisites are eligible to apply for a training position regardless of the primary specialty of the program director.
7. Any specialist, who is trained, qualified and recognized (Certified/CAQ) may serve as a Program Director. Any DO who has passed an examination and received a Certification/CAQ in the conjoint specialty is equally qualified as a similar DO from a different participating primary specialty.
8. Any specialty college wishing to become a sponsor in a conjoint training specialty and to permit that specialty's physicians to enter the conjoint training program, may do so at any time, subject to the same requirements and responsibilities as the original participating sponsors on the conjoint education and evaluating committee. Entry into the specific conjoint specialty is also dependent on approval of the BOS for that specialty board to become a member of the conjoint certification board. 2008

Explanatory Statement: A consistent educational experience is necessary for all candidates participating in a conjoint examination in the same specialty area and for the same CAQ. Conjoint training and certification currently exists in Addiction Medicine and Sports Medicine and is being developed in Sleep Medicine and Hospice/Palliative Care Medicine and in Hyperbaric Medicine as well

Res. 37-A/2008 - BUREAU ON INTERNATIONAL OSTEOPATHIC MEDICAL EDUCATION AND AFFAIRS – WHITE PAPER III [See Res. 13-M/2010]
The American Osteopathic Association (AOA) recognizes that it and many of its members, component societies, and institutions desire or need to interact with various governmental and regulatory bodies, scientists, educational institutions, and health care practitioners within the international community. It also appreciates that different languages, cultures, customs, and health practices make communication more difficult and increase the potential for miscommunication. The AOA therefore desires, in all interactions and communications, that information gathering, education, collaboration, and cooperative ventures be conducted in a professional and ethical manner that accurately represents osteopathic medicine as practiced in the United States.

To this end, the AOA has developed this White Paper and stresses the responsibility of integrating ethics and respect for the known history, authority, and relationships currently governing international health and medical policy when communicating information concerning the AOA and the osteopathic profession in the United States to individuals or organizations unfamiliar with same outside the US border.

HISTORY & PURPOSE

The AOA has sought input and recommendations from its Bureau on International Osteopathic Medical Education and Affairs (BIOMEA) since its formation as a Council in 1996. Furthermore, the BIOMEA interacts directly with the AOA Board of Trustees to formulate and issue pertinent "White Papers" as informational pieces to describe the scope, direction, and activity of the AOA in the international arena.

In 2000, BIOMEA's initial recommendations were approved and an International White Paper was issued. The initial White Paper focused upon ethical interactions between components of the AOA and those international healthcare practitioners and organizations having significant relevance to the osteopathic profession worldwide. Topics included:

1. AOA Official Interactions
2. Interactions with International Governmental Officials and/or Health/Medical Regulatory Bodies
3. Interactions with International Colleges of Medicine or Osteopathy or Their Graduates
4. American Osteopathic Rights in International Settings
5. International "Osteopathic" Rights in the United States
6. International Membership in the AOA

The second White Paper (2005) reaffirmed conclusions reached in the first White Paper (2000) while providing additional background, insight, and direction for expanding and building upon other international interactions. In particular, the second White Paper focused on the following topics related to international directions by the AOA and its members:

1. Communication
2. Identity
3. Politics & Diplomacy
4. Research & Education
5. Service
6. Resources

The second White Paper also initiated an addendum of *Potentially Significant International Organizations & Groups,* in an attempt to identify organizations and groups within and outside the United States with which the AOA may have contact or correspondence in discussing international osteopathic curricula, accreditation, certification, and/or licensure.

The purpose of this third International White Paper (2007) is to review and update previous White Papers and to describe the current and anticipated scope and activity of the American Osteopathic Association in the international arena. It is also intended as an informational document to provide relevant background and perspective for the AOA and its members for responsible decision-making relative to international education, research, practice and health policy. While not all inclusive, the perspective and principles delineated in this third International White Paper should serve as guidelines for most international interactions.

PREAMBLE

For those in the United States of America, involvement in global health has grown beyond the moral, humanitarian motives made by individual practitioners and institutions wishing to contribute to the healthcare needs of populations in underserved nations. Now, for a variety of personal and practical reasons, U.S. physicians and physicians-in-training are also looking at educational and

practice opportunities outside the United States. Osteopathic (DO) and Allopathic (MD) medical students increasingly seek safe and meaningful international educational opportunities; many desire assurance that their earned degrees will prepare them for the future implications of globalization.

Great challenges and tremendous opportunities in the field of healthcare have also been created by globalization. We are experiencing an increased permeability of our borders to travel-related illnesses and to diseases thought to have been eradicated in the United States of America and we fear that our public health infrastructure may be ill-prepared for intentional or unintentional introduction of biologic agents capable of creating epidemic illness. Conversely, international colleagues' experiences, approaches, and knowledge have never been more readily accessible.

As borders between countries, information, and economies lose their traditional relevance, the need to understand and interact with international healthcare colleagues and policy makers grows. In an accelerating fashion, health policy decisions and evidence-based experience in medical, surgical, manual, and other healthcare fields outside our national borders directly impact our own internal patient populations and the practices of our osteopathic medical graduates. The impact on healthcare providers, educators, researchers, and policy makers brought about by such globalization necessitates coordinated decisions based upon a clear understanding of the global picture.

The need to think and act globally to assure the quality of healthcare practitioners – both osteopathic and allopathic – crossing borders (e.g., between Canada and the United States or within the European Union) must embrace responsible health policy considerations as it impacts access, safety, and portability. To this end, the AOA expanded its involvement with international groups and organizations and has encouraged ambassadors from the AOA or its practice affiliates to interact with global healthcare entities such as the World Health Organization, the World Osteopathic Health Organization, the Fédération Internationale de Médecine Manuelle, the Global Health Council and the Osteopathic International Alliance. These interactions have resulted in numerous processes to evaluate international curricula and educational standards and prompted efforts to define and develop uniform educational and/or licensure standards relative to osteopathic medicine. Such involvement has greatly expanded the perspective and understanding of numerous health policy makers around the globe and within the AOA membership itself concerning the osteopathic profession. In particular, these efforts have raised awareness of the global role of the AOA in health care policies and principles and its commitment to distinctive contributions to high quality medical care (health systems change, access, reliability, and patient protections).

Globalization is affecting the osteopathic profession, but it is not solely an economic or trade phenomenon; it is a convergence of cultures. It leads inevitably to continuous cultural evolution and an increase in quality standards. The processes of which should be undertaken with humility and an understanding of the national and professional cultures involved.

INTRODUCTION

The osteopathic medical profession originated in rural America in 1892. Almost immediately graduates emigrated to other countries. Historically, national boundaries and practice rights served

to create cultural divergence within the osteopathic profession. As a consequence, the osteopathic philosophy, science, and art have evolved differently over time on numerous continents with varying impact on healthcare delivery in each country. In some countries, the philosophy, science and art of osteopathy needed to operate in a limited spectrum-of-practice setting, linked or not to parallel standards of medical diagnosis and treatment. In some countries, selected elements of the osteopathic culture were transferred in post-graduate or specialty training settings to full spectrum-of-practice physicians simply as "manual medicine" skills. In yet other countries, these full-spectrum manual medicine physicians seek to expand their understanding of the osteopathic philosophy, science and art. As a consequence of divergence, the recognition of what it means to practice "osteopathically" has become blurred and confusion abounds in both public and professional settings. This confusion complicates efforts by the profession to convey the contribution of knowledge and service they are committed to make in promoting health and fighting disease.

Cultural divergence in healthcare arenas is now being replaced by convergence. This is a direct consequence of increasing transportation, communication, and information exchange and is seen in the proliferation of national organizations committed to establishing global vision statements and strategic plans that include their international role. Such collaboration is also seen from stakeholders within the osteopathic arena. A number of international organizations, including the Osteopathic International Alliance, the European Register of Osteopathic Physicians, and the World Osteopathic Health Organization, have recently been constituted to address similar issues.

The role that responsible US healthcare organizations can and should play in this convergence of cultures is no longer speculative. The Institute of Medicine's *America's Vital Interest in Global Health* (IOM, 1997) makes a strong case for the importance of global health and the USA's ability and responsibility to foster it. To this end, the Association of Academic Health Centers established a Division of Global Health in 1998 and, in its published *Global Dimensions of Domestic Health Issues (2000),* makes commitments to seek strategic collaborations with other organizations to improve health and health policy internationally. Likewise in 1996, traditionally national organizations such as the American Osteopathic Association constituted the Bureau on International Osteopathic Medical Education & Affairs (BIOMEA).

BIOMEA is currently charged with reporting to the AOA Board of Trustees. Its current mission is stated as follows:

The mission of the Bureau on International Osteopathic Medical Education and Affairs (BIOMEA) is to provide organizational leadership that promotes the highest standards of osteopathic medical education and practice throughout the world and facilitates positive interactions between the AOA, AOA affiliates, and international healthcare organizations. The purpose is to ensure the continued contribution of the American model of osteopathic medicine in the United States (U.S.) and internationally.

BIOMEA seeks to facilitate those public and professional interactions, which increase the understanding and advancement of osteopathic medicine as a complete system of medical care. BIOMEA will promote the osteopathic philosophy that combines the needs of the patient with the current practice of medicine, surgery, and obstetrics,

emphasizes the interrelationships between structure, function, and provides an appreciation of the body's ability to heal itself.

This third White Paper combines and updates the first two White Papers, and represents the dramatic and rapid changes that have occurred as a consequence of globalization, outreach by the AOA and its members, and international events. The structure and function of the third International White Paper focus on the following topics related to international interactions and directions by the AOA and its members:

1. AOA Official Interactions
2. Interactions with International Governmental Officials and/or Health/Medical Regulatory Bodies
3. Communication
4. Identity
5. Politics & Diplomacy
6. Research & Education
7. Interactions with International Colleges of Medicine or Osteopathy or Their Graduates
8. American Osteopathic Rights in International Settings
9. International "Osteopathic" Rights in the United States
10. International Membership in the AOA
11. Service
12. Resources

The periodically updated addendum, *Potentially Significant International Organizations & Groups,* identifies organizations and groups within and outside the United States with which the AOA and its members may have contact or correspondence in discussing international osteopathic curricula, accreditation, certification, and/or licensure.

AOA Official Interactions

The AOA itself shall be directly represented only by those it has authorized to do so. No interactions by an unauthorized individual, college, specialty organization, or institution should imply a specific AOA status or endorsement, nor be allowed to be represented as such.

The AOA Bureau on International Osteopathic Medical Education and Affairs (BIOMEA) is charged with informing and educating AOA leadership and representatives; gathering, investigating, and recommending policy relative to international osteopathic medical education and affairs; maintaining information used in training international ambassadors and representatives; and serving as a repository for information related to the aforementioned activities. AOA members and affiliates are encouraged to contact BIOMEA and its members and staff with information, recommendations, international contacts, and potential directions for the AOA in meeting its international agenda.

INTERACTIONS WITH GOVERNMENTAL OFFICIALS AND/OR HEALTH/ MEDICAL REGULATORY BODIES

Interactions carried on by individuals, colleges, specialty organizations or other U.S. osteopathic institutions to discuss osteopathic medicine should be accomplished in a careful, professional, and ethical manner, accurately representing the American model of osteopathic medicine. Information detailing the international contact name, preferably including telephone, fax, and e-mail information, title and synopsis of discussion, may be sent to the AOA Division of State Government & International Affairs, 142 East Ontario, Chicago, Illinois 60611, Phone (312) 202-8000. While it is not always possible to do so, an advanced call to the AOA may be beneficial and is encouraged.

In dealing with international governmental officials, or health and medical regulatory bodies, the following points may be conveyed:

1. The AOA seeks to better understand the status of international medical communities in the areas of education, research, and health care delivery.
2. The AOA seeks to encourage international recognition, understanding, and acceptance of the American D.O. degree.
3. The AOA seeks to advance international recognition and value for osteopathic philosophy, as well as its practice and educational standards.
4. The AOA will actively offer assistance and guidance, upon request, to nations or official organizations wishing to provide for the licensure/registration and practice rights of osteopathic physicians educated in colleges of osteopathic medicine accredited by the AOA Commission on Osteopathic College Accreditation (COCA).
5. BIOMEA will, upon request, assist COCA regarding the legitimate authorities or programs from other countries in the development of colleges of osteopathic medicine or osteopathic graduate medical education programs when such entities clearly demonstrate the capacity to be accredited by COCA.

COMMUNICATION

The AOA recognizes the need for accurate and ethical communication in relation to international issues, particularly in light of differences in language and culture.

Information into and out of the United States is capable of both supporting a rapidly growing evidence-base for wise healthcare decisions and of confounding appropriate decisions with misinformation. The AOA is dedicated to providing accurate information related to the contributions of its members and the osteopathic approach. To this end, the following elements have been agreed upon:

1. The AOA will act as a clearinghouse for information concerning international applications of the philosophy, science, and art of osteopathy and osteopathic medicine.
2. The AOA will also contribute information to the Osteopathic International Alliance (OIA) clearinghouse so that it may also serve as a credible, reliable international source of information, and contribute to the *Glossary of Osteopathic Terminology* as well as interested governmental, regulatory, and Non-Governmental Organization (NGO) bodies.

3. The Bureau on International Osteopathic Medical Education & Affairs (BIOMEA) will identify persons available to translate Bureau materials into various languages, starting with French, German, and Spanish and eventually all official UN languages.
4. The AOA recognizes the efforts of the American Association of Colleges of Osteopathic Medicine (AACOM) and the Educational Council on Osteopathic Principles (ECOP) to maintain a peer-reviewed *Glossary of Osteopathic Terminology* and encourages an accurate translation into other languages that it might serve as a universal language reference for osteopathic and manual medicine education, research, and clinical discussions.
5. Members of the AOA will refrain from representing the AOA or its official position without the express permission of the AOA.
6. Members of the AOA are encouraged to educate the public as well as healthcare colleagues about the manner in which the philosophy, science, and art of osteopathic medicine are practiced in the United States of America.
7. The AOA charges BIOMEA to continue to plan and provide an international seminar and forum for the profession at the annual meetings to update AOA members on international issues, the activities of their colleagues, and the AOA's progress abroad on their behalf.

IDENTITY

The AOA recognizes the need to identify and educate international organizations, governmental authorities, and leaders concerning the benefits of osteopathic philosophy, science, and art in promoting/maximizing health while limiting disease and dysfunction.

To this end, the following directions are supported:
1. The AOA will actively seek to provide communication and/or representation to key international bodies with the expressed intention of communicating the scope of osteopathic philosophy and practice and the potential for the osteopathic profession to contribute to health and preventive medicine throughout the world.
2. The AOA will work specifically with the Pan-American Health Organization (PAHO) and the World Health Organization (WHO) in demonstrating the ability of the osteopathic profession to contribute to health and wellness in the Americas.
3. Wherever possible, the AOA will interact with and educate key international leaders and international bodies about the osteopathic profession with the expressed intention of expanding opportunities whereby graduates of AOA-accredited schools (or the American osteopathic profession as a whole) could make positive contributions.
4. The AOA will specifically interface with the International Association of Medical Regulatory Authorities (IAMRA), International Federation of Manual Medicine (FIMM), the Osteopathic International Alliance (OIA), the Pan-American Health Association (PAHO), the World Osteopathic Health Organization (WOHO) and others who seek to identify and contribute to areas of overlapping missions.
5. The Bureau on International Osteopathic Medical Education and Affairs (BIOMEA) and its representatives will aspire to collaborate with international colleagues and organizations to obtain unlimited medical and surgical practice rights internationally for osteopathic physicians.
6. BIOMEA will develop a Network Database (accessible to AOA members) of individual Dos and affiliates around the world, who are willing to assist other DO expatriates.

POLITICS & DIPLOMACY

The AOA embraces its unique position as representing American trained osteopathic physicians and surgeons, the largest group of osteopathic practitioners in the world and its historic link to the birthplace of the entire osteopathic profession. However, the AOA also recognizes the sovereignty of healthcare licensure and delivery systems in other nations as well as the evolutionary differences in osteopathic education and scope of practice that occurred when osteopathy emigrated to other countries. Above all, the AOA acknowledges the need to be geographically and culturally sensitive in interacting within the international healthcare arena.

To this end:

1. The American Osteopathic Association's *"Statement of Healthcare Policies and Principles"* notes that as an organization it is dedicated to placing patients first and protecting the patient/physician relationship. This position of the AOA extends beyond U.S. borders and will serve as a template for policy relating to political and health policy considerations internationally.
2. The AOA accepts its role and ability to provide organizational leadership unifying osteopathic medical education & practice throughout the world. It maintains the AOA Bureau on International Osteopathic Medical Education & Affairs (BIOMEA) to recommend liaison and policy to this end.
3. The AOA supports the growth of the Osteopathic International Alliance (OIA) as an umbrella organization of internationally governmentally recognized organizations made up of osteopaths, osteopathic physicians and surgeons, and/or manual medicine physicians who value and promote the osteopathic approach.
4. The AOA will continue to contribute to the development of qualified AOA International Ambassadors to serve as knowledgeable and effective liaisons for the osteopathic medical profession in international affairs and policy.
5. The AOA will maintain & enhance contacts with international organizations including, but not limited to the Canadian Osteopathic Association (COA), European Union (EU), Fédération Internationale de Médecine Manuelle (FIMM), Global Health Council (GHC), International Association of Medical Regulatory Authorities (IAMRA) Pan American Health Organization (PAHO), U.S. Agency for International Development (USAID), World Bank (WB), World Health Organization (WHO), and World Osteopathic Health Organization (WOHO).
6. The AOA will work with the Federation of Medical Regulatory Authorities of Canada [FMRAC], Federation of State Medical Boards [FSMB], and International Association of Medical Regulating Authorities [IAMRA] so as to reach as many ministries of health as possible.
7. The AOA will develop and maintain affiliates outside the U.S.A. who qualify for appropriate representation in the AOA House of Delegates.

RESEARCH & EDUCATION

The AOA is committed to contributing to the expansion, dissemination, application, and integration of the evidence-base for healthcare practices generally, including the field of manual/neuromusculoskeletal medicine that constitutes one of the distinctive cornerstones of the osteopathic profession.

To this end, the following directions are supported:

1. Wherever possible, the AOA will encourage collaboration and/or wide international dissemination of the findings of research related to the promotion of health including palpatory diagnosis and manual medicine approaches; the relevance of somatic dysfunction and its reduction in affecting health promotion and disease prevention; and outcomes research documenting patient satisfaction and the clinical safety, cost-effectiveness, and efficacy of osteopathic clinical approaches (or manual-medicine integrative approaches).
2. The AOA will delineate pathways by which members of the AOA and representatives of the AOA Council on Research, Bureau of Osteopathic Clinical Education and Research (BOCER), and/or AACOM may effectively interact with international medical and osteopathic institutions and organizations, through the OIA, to plan, foster, and/or participate in collaborative research advancing osteopathic and/or 123athleen123uloskeletal medicine.
3. The AOA will seek to identify and collaborate with institutions having the potential and desire to develop osteopathic medical education that would, at a minimum, parallel the educational standards adopted by the AOA. Furthermore, it will charge BIOMEA to encourage, promote & offer assistance to the AOA Commission on Osteopathic College Accreditation (COCA) in anyway necessary.
4. The AOA will delineate the pathway or pathways by which representatives of the AOA, AOA specialty colleges, BOE, and/or COCA may (upon request) effectively and responsibly consult with/for international medical and osteopathic institutions and organizations to evaluate, improve, and/or coordinate educational standards and evaluation between countries and/or educational bodies.
5. The AOA is a resource to AACOM, Educational Council on Osteopathic Principles (ECOP), and other organizations for information on international research and education.
6. The AOA will delineate the pathway or pathways by which an international educational institution might apply for and attain appropriate accreditation in order to graduate osteopathic physicians completely versed in the osteopathic philosophy, science, and art. Unless otherwise assigned, BIOMEA might be charged to evaluate applications with respect to the international implications, risks, and benefits of each application relative to the AOA's international strategic plan.
7. The AOA will encourage specialty colleges and colleges of osteopathic medicine to develop member training opportunities outside the U.S.A., including but not limited to undergraduate/post-graduate fellowships, CME programs, and international exchanges.
8. Professional seminars, lectures, workshops and other educational meetings concerning osteopathic medicine or surgery should promote understanding of healthcare content generally within the scope of practice or education of those attending the course as should osteopathic graduate medical education (OGME).
9. To ensure that the highest quality of osteopathic medical care is made available to all Americans, the AOA acknowledges the value of international contributions made to the field, either individually, by groups, or by organizations and will record these findings in a Network Database. This Database will have available the current international research, activities, and contributions of osteopathic and manual medicine groups to healthcare. This Network Database will, where possible, maintain a record of cost-efficacy analyses and outcomes of these approaches.
10. Communications and written materials should clearly state that education about the philosophy, science, and/or art of osteopathy or osteopathic medicine does not alone create an osteopathic practitioner or entitle an attendee to claim such.

INTERACTIONS WITH INTERNATIONAL COLLEGES OF MEDICINE OR OSTEOPATHY OR THEIR GRADUATES

Interactions by individuals, colleges of osteopathic medicine, osteopathic specialty organizations or other U.S. osteopathic institutions to advance the understanding of the science, art, and practice of osteopathic medicine in the United States, are encouraged at international colleges of medicine or osteopathy, as well as with their students and graduates.

To this end:

1. Such interactions should always be accomplished in a careful, professional, and ethical manner, accurately representing the American model of osteopathic medicine. Lectures, discussions, and/or demonstrations are typically appropriate for international audiences and should be used responsibly to advance understanding. Members of the AOA, its affiliates, and AOA accredited institutions and programs, should refrain from the hands-on teaching of osteopathic manipulation treatment, injection, diagnostic or therapeutic surgical and/or diagnostic or therapeutic invasive procedures to individuals who do not, or will not upon graduation, have the complete foundation to responsibly master or possess the legitimate scope of practice to apply said skills or procedures.
2. With regard to continuing medical education (CME) at, or organized by, international colleges of medicine or osteopathy, it should be made clear that the AOA recognizes continuing medical education programs in other countries only when such programs meet the continuing medical education requirements of the AOA. Only the AOA shall determine when a CME program qualifies for AOA recognition.
3. Programs, including CME and Continuing Professional Development (CPD) programs, organized by U.S. osteopathic organizations to advance the understanding of the science, art, and/or practice of osteopathic medicine which might include students or graduates of international colleges of medicine or osteopathy, must clearly indicate to these individuals that they may not falsely advertise their participation in said program. International osteopathic ethics limit claims, written or verbal, regarding participation in such programs, to statements of attendance at a specific educational or scientific meeting. U.S. osteopathic physicians who teach in such programs shall make this clear to both the organizers and participants.

AMERICAN OSTEOPATHIC RIGHTS IN INTERNATIONAL SETTINGS

The AOA Commission on Osteopathic College Accreditation (COCA) is recognized in the United States by the Federal government and its Department of Education, Department of Health and Human Services, and related governmental entities, as the official accrediting agency for all U.S. colleges of osteopathic medicine. The AOA is the body that recognizes and approves osteopathic graduate medical education and continuing medical education. The AOA, through its Bureau for Osteopathic Specialists, is the body responsible for the specialty certification of osteopathic physicians.

To this end:

1. The degree, Doctor of Osteopathy (D.O.), or Doctor of Osteopathic Medicine (D.O.), when granted by an AOA accredited college of osteopathic medicine, is considered in all 50 states, the

District of Columbia, and territories, to be eligible for full medical licensure, equal in all rights, privileges, and responsibilities as those physicians holding the degree Doctor of Medicine (M.D.).
2. In the United States, physicians with an AOA recognized D.O. degree may serve as physicians in all capacities and are fully reimbursed at the same level and for the same services as those with the M.D. degree. They may practice in state, private and governmental hospitals as well as in out-patient settings.
3. American osteopathic physicians, by virtue of their education and AOA certification(s), have valuable skills to offer patients wherever they may be accorded the right and privilege to practice their healing arts.
4. The AOA has no jurisdiction internationally, but is willing and anxious to assist members of the AOA in representing their credentials to government agencies, departments of health, or other professional institutions.
5. As officers in the Medical Corps of the U.S. Uniformed Services, osteopathic physicians have for many years served on military bases around the world. Several osteopathic physicians hold, or have held, high-ranking positions, such as the Surgeon General of the United States Army and the Assistant Secretary of Defense for Health Affairs.
6. American osteopathic physicians and colleges are active in international humanitarian and missionary work in numerous countries. DOCARE International is an AOA affiliated osteopathic organization that coordinates and delivers humanitarian work. Osteopathic clinicians are also providing international humanitarian and missionary care through their churches, communities, specialty colleges, service and other organizations.

INTERNATIONAL "OSTEOPATHIC" RIGHTS IN THE UNITED STATES

It is the unwavering position of the AOA that the only type of licensure for D.O.s in the United States is one reflecting a full scope of medical practice. For all licensure as a D.O. in every state in the United States, the D.O. must be a graduate of an AOA accredited college of osteopathic medicine. No state issues a "limited license" to any practitioner, either an American citizen or an international citizen, wishing to practice osteopathy or osteopathic medicine in the United States.

To that end:

1. Where state laws permit, internationally-trained manual therapeutic practitioners, or "non-physician osteopaths," may observe or even work in a physician's office. Such individuals may only interact with patients, however, to the extent allowed by the statutes of that state; while under the supervision of an attending physician, or his/her staff. In no case may the international practitioner attempt to represent his or her degree as equal to an American D.O. degree. Likewise, the interaction with a client may never be represented as, or implied to be, an osteopathic examination or treatment.
2. "Non-physician osteopaths," or those practicing manual therapy may, within specific guidelines, participate in U.S. osteopathic educational or research activities organized by AOA members, colleges, specialty colleges, institution, or other affiliates. AOA guidelines are specific to the situation. For example, the "non-physician osteopath", or manual therapist, may be employed under the supervision of an American D.O. to assist in teaching osteopathic manipulative treatment (OMT) techniques at an osteopathic college or in a CME program. In such cases, however, it must be clearly stated to students or attendees that said individual is not a physician.

Neither may an internationally trained "non-physician osteopath", or manual therapist, be counted amongst those osteopathic medical faculty members required for AOA-approved CME credit.

3. International Doctors of Medicine (M.D.) who have earned a "diploma or specialty in manual medicine (osteopathic)" or its equivalent in their medical pre-doctoral or post-doctoral training, may not represent themselves in the United States as osteopathic practitioners.
4. Those international M.D./D.O. physicians whose D.O. was granted by a non-AOA accredited international osteopathic college may not represent themselves as osteopathic practitioners in the United States, nor may they use their internationally obtained D.O. diploma or degree in the United States in any professional capacity. To advertise to the public that they are D.O.s is a violation of the state medical licensing laws, rules and regulations in the United States, as well as a violation of the AOA Code of Ethics.
5. International M.D. or M.D./D.O. practitioners may or may not be eligible to sit for allopathic licensure in the United States. Such a decision is outside the purview of the AOA. These physicians may not however represent themselves as an osteopathic physician, D.O., in the United States as there is no provision for sitting for an American osteopathic test, or obtaining an osteopathic medical license except by graduation with a "D.O." degree from an AOA-accredited college of osteopathic medicine.
6. International institutions, organizations, or programs seeking AOA accreditation or recognition must meet all AOA guidelines for the appropriate and pertinent osteopathic medical programs.

INTERNATIONAL MEMBERSHIP IN THE AOA

American educated and trained D.O.s living and/or practicing abroad may join the American Osteopathic Association under the same guidelines as those osteopathic physicians living and/or practicing in the United States. Costs of AOA membership are specified in annual publications of the AOA and may reflect an additional cost for processing and mailing internationally. International M.D. and M.D./D.O. practitioners living and/or practicing abroad or those who have moved to the United States from abroad are eligible for "AOA International Physician Membership" status.

To this end:

1. Membership requires completion and acceptance of the "International Physician Application" of the AOA, along with a letter of recommendation from a member of the AOA who can attest to the ethical character and professional qualifications of the applicant. This category is only open to those international physicians with a license for full-scope medical practice as a physician in their country of citizenship.
2. The membership category "International Physician Membership" is a non-voting category designed to identify individuals wishing to receive educational, research, and similar pertinent information from the AOA. Such members may not hold office in the AOA or any of its affiliate organizations. Membership in this category may not be publicized or claimed to represent any level of professional qualification; nor may such membership be used to imply additional skills, knowledge, or other status beyond that for which they qualify.

SERVICE

The AOA represents over 61,000 fully licensed osteopathic physicians in the United States who are dedicated to promoting health and treating disease. Osteopathic physicians' contributions in

primary care and the distinctive osteopathic philosophy are widely recognized by health policy makers in the United States and by leaders in rural and underserved areas. The AOA believes that these attributes could contribute to the betterment of health and healthcare internationally.

To this end:

1. The AOA will continue aiding American Dos in humanitarian and mission work by facilitating international governmental permission to bring in medical teams and supplies and to provide osteopathic medical and surgical care.
2. The AOA will encourage international recognition of AOA-accredited Dos by developing a systematic method of contacting the various ministries of health (MOH) to apprise them of the unique education, high standards and full practice rights of physicians of osteopathic medicine thus accredited.
3. The BIOMEA will continue collaborating with the OIA and other international organizations to facilitate humanitarian and mission work.
4. The AOA will delineate pathways through which members of the AOA and representatives of AACOM, DOCARE International, SOMA, and other international osteopathic outreach groups may effectively collaborate with national and international medical, osteopathic, and humanitarian institutions and organizations to promote health and provide/facilitate access to quality care in underserved international sites.

RESOURCES

The AOA has committed resources to address the many acute national issues of its members in the United States, Canada and throughout the world. The AOA acknowledges that its members function in a global society and that our next generation of osteopathic physicians demonstrates significant interest in making international commitments on behalf of the profession.

To this end:

1. The AOA will conduct periodic assessments of AOA member needs and desires regarding internationally-oriented member services; and prioritize input from its student and post-graduate representatives.
2. The AOA will prioritize contacts and develop criteria for deciding what countries & organizations should be the focus of AOA activity.
3. The AOA will charge BIOMEA to recommend policies and procedures on international osteopathic medicine to the Bureau of Osteopathic Education & the AOA Board of Trustees.
4. The AOA will enhance and maintain electronic and Internet capabilities to allow for easy access of international network database information.

ADDENDUM: Selected U.S. and International Organizations & Groups

This addendum lists selected organizations and groups which the AOA either maintains active interactions with or are/may be potentially significant partners in conducting the functions and achieving the missions of the AOA, particularly as related to international issues. This list is not complete but will continue to be expanded as other organizations and groups are identified. See also the AOA document: entitled *AOA-Involved International Organizations* located at: http://www.osteopathic.org/files/lcl_intlorglist.pdf

Note that the Chart below is arranged by the abbreviation most commonly used to identify the group or organization. When known, websites as well as the group's scope of influence are listed.

Following the chart are descriptions or mission statements of certain organizations or groups with which the AOA or its members are most likely to come into contact.

Organizational abbreviations & names, location and scope of influence:

ABBREVIATION	**OFFICIAL NAME & WEBSITE**
AACOM	American Association of Colleges of Osteopathic Medicinewww.aacom.org/
AAMC	Association of American Medical Colleges www.aamc.org/
AAO	American Academy of Osteopathy www.academyofosteopathy.org
AAOE	American Association of Osteopathic Examiners http://www.aaoe-net.org/about.html
AAOM	American Association of Orthopaedic Medicine http://www.aaomed.org
ACCME	Accreditation Council for Continuing Medical Education www.accme.org
ACGME	Accreditation Council for Graduate Medical Education www.acgme.org
ACOFP	American College of Osteopathic Family Physicians www.acofp.org/
AFMM	Australian Faculty of Musculoskeletal Medicine http://www.biziworks.com.au/afmm
AFO	Akademie für Osteopathie
AMA	American Medical Association www.ama-assn.org/
AëMM	See DGMM-AMM http://www.aemm-aerzteseminar-berlin.de
AOA-US	American Osteopathic Association www.osteopathic.org/
AOA (2) or AOA-AU	Australian Osteopathic Association www.osteopathic.com.au/
AOA (3) AOA-FR	Association des Ostéopathes d'Anjou http ://www.osteopathie-France.net/Information/aoa.htm

AOB	Académie d'Ostéopathie de France – or – Belgian Register of Osteopaths
AOI	Association of Osteopaths in Ireland
APO	Associacao de Portuguese de Osteopatas
AROP	Associacao e Registo dos Osteopatas de France
ASMM	Australian Society of Musculoskeletal Medicine http://www.musmed.com
BAO	Bundes Arbeitsgemeinschaft Osteopathie
BCOA	British Columbia Osteopathic Association of Canada
BIMM	British Institute of Musculoskeletal Medicine http://www.bimm.org.uk
BIOMEA	Bureau on International Osteopathic Medical Education & Affairs (AOA) www.osteopathic.org/index.cfm?PageID=ost_intl
CaRMS	Canadian Resident Matching Service www.carms.ca
CBSA	Chiropractors Board of Southern Australia (also Board for osteopaths) http://www.cbsa.saboards.com.au/
CEESO	Centre Europeen d'Enseignment Superieur de l'Osteopathie http://www.ceeso.com/
CFPC	College of Family Physicians of Canada www.cfpc.ca
	Chiropractors & Osteopaths Board of ACT E-mail: 129athleen.taylor@act.gov.au
CORB	Chiropractors and Osteopaths Registration Board of Tasmania E-mail: corb@regboardtas.com
CPSO	College of Physicians and Surgeons of Ontario http://www.cpso.on.ca/
COA - or – COA-CND	Canadian Osteopathic Association For information regarding training and/or practice in Canada, please contact Ted Findlay, D.O., President, Canadian Osteopathic Association at tfindlay@telus.net, or contact the College of Physicians and Surgeons of the targeted province. www.osteopathic.ca
COCA	Commission on Osteopathic College Accreditation (formerly Bureau of Professional Education) http://www.aoa-net.org/Accreditation/accreditation.htm
COCA (2)	Chiropractic & Osteopathic College of Australia www.coca.com.au/
COMLEX	Comprehensive Osteopathic Medical Licensing Examination for the NBOME www.nbome.org/

CORPP	Commission for Osteopathic Research, Practice and Promotion http://www.corpp.org/home.jsp
CROMA	Costa Rican Osteopathic Medical Association
DAAO	Deutsch-Amerikanischen Akademie für Osteopathie (German-American Academy of Osteopathy) (A subgroup of German and Austrian physicians emphasizing osteopathic education and the standards of EROP; physicians include members of the MWE (a subgroup of the DGMM) and of OAMM (Vienna & Graz) www.daao.info/index.html
DGCO	Deutsche Gesellschaft für Chirotherapie und Osteopathie
DGMM	Deutsche Gesellschaft für Manuelle Medizin (German Society for Manual Medicine) – The FIMM national society manual medicine umbrella organization (with component parts AëMM, FAC, and MWE) representing approximately 5000 German manual medicine physicians www.dgmm.de/
DGMM-AMM	Deutsche Gesellschaft für Manuelle Medizin (German Society for Manual Medicine) – (DGMM component society based in Berlin) http://www.aemm-aerzteseminar-berlin.de
DGMM-FAC	Deutsche Gesellschaft für Manuelle Medizin – Forschungsgemeinschaft für Arthrologie und Chirotherapie (DGMM component society based in Hamm-Boppard) http://www.dgmm-fac.de/
DGMM-MWE	Deutsche Gesellschaft für Manuelle Medizin (German Society for Manual Medicine) – Manuelle Wirbelsäulen- und Extremitätentherapie (Dr. Karl-Sell-Ärzteseminar based in Isny-Neutrauchburg) www.aerzteseminar-mwe.de
DGOM	Deutsche Gesellschaft für Osteopathische Medizin (German Society for Osteopathic Medicicne) – (A subgroup of the FAC emphasizing osteopathic education and the standards of EROP; FAC is a subgroup of the DGMM) www.dgom.info/
	DOCare International www.docareintl.org
	Doctors Without Borders www.doctorswithoutborders.org
DROM	Deutsches Register Osteopathischer Medizin
DVOM	Deutscher Verband für Osteopathische Medizin http://www.dvom.de/
ECFMG	Educational Commission for Foreign Medical Graduates www.ecfmg.org
ECOP	Educational Council on Osteopathic Principles (a component group of AACOM reporting to US COM deans) http://www.aacom.org/people/group-page.asp?Group=9

EFO	European Federation of Osteopaths Fédération Européenne des Ostéopathes www.e-f-o.org
EOU	European Osteopathic Union Email: europeanosteopathicunion@email.it
EROP	European Register of Osteopathic Physicians www.erop.org/ www.erop.org/addons/idea_of_erop.pdf
EU	European Union
FAC	See DGMM-FAC http://www.dgmm-fac.de/
FAIMER	Foundation for the Advancement of International Medical Education and Research http://www.faimer.org/index.html
FeSIO	Federazione Sindacala Italiana Osteopati http://www.fesios.it/
FEMMO	Fédération Francophone des Enseignements de Médecine Manuelle-Ostéopathie (Federation of the Lesson of Manual Medicine Osteopathy) – Umbrella organization made up of 21 French, Belgian, and Swiss groups http ://www.femmo.org/referentiel.pdf http://www.femmo.org
FIMM	Fédération Internationale de Médecine Manuelle -OR- International Federation for Manual/Musculoskeletal Medicine -OR- Internationale Gesellschaft für Manuelle Medizin Composed of 30 national physician-only professional organizations representing approximately 13,000 manual medicine physicians; the USA is represented by the AAO www.fimm-online.com
FIMM IAMM Or FIMM Academy	FIMM International Academy of Manual / Musculoskeletal Medicine ("FIMM Academy") http://www.fimm-online.com/pub/en/index.cfm;jsessionid=6430f9272d85$3FU$3Fl?u=4D5F040A03747E72050479070905090309057907 7F720F08048
	Federation of Italian Osteopaths Federazione Sindicale Italiana Osteopati
FLEX	Federal Licensing Exam
FMRAC	Federation of Medical Regulatory Authorities of Canada – (Formerly Federation of Medical Licensing Authorities of Canada [FMLAC]) http://www.fmrac.ca/index.cfm
FOA	Finnish Osteopathic Association – or – Suomen Osteopatiayhdistys

FORE	Forum for Osteopathic Regulation in Europe http://www.forewards.eu/
FOS	Fédération des Ostéopathes Suisses www.foh.ch
FSMB	Federation of State Medical Boards www.fsmb.org/
FSO-SVO	Fédération Suisse des Ostéopathes – Schweizer Verband der Osteopathen – or – Swiss federation of osteopaths http://www.svo-fso.ch/FSO-SVO_english/FSO-SVO_gb.htm
GBMM	Groupement Belge de Médecine Manuelle http://www.gbmm.be
GHC	Global Health Council www.globalhealth.org/
GHEC	Global Health Education Consortium http://www.globalhealth-ec.org/
GMC	General Medical Council of the UK http://www.gmc-uk.org/
GNRPO	Groupement Nationale Représentatif des Professionnels de l'Ostéopathie/Groepering Nationaal en Representatief voor de Professionele Osteopaten www.gnrpo.be
GosC	General Osteopathic Council (U.K.) http://www.osteopathy.org.uk/
	Heart to Heart International http://www.hearttoheart.org/
IAMRA	International Association of Medical Regulating Authorities http://www.iamra.com/
IAO	International Academy of Osteopathy http://www.iao.be/eng/welcome.htm www.iao-iao.com
IFMSA	International Federation of Medical Students' Associations (over 1 million medical and osteopathic medical students in 88 countries) http://www.ifmsa.org/
IFMSA-USA	International Federation of Medical Students' Associations – USA http://www.ifmsa-usa.org/about.htm
IMC	International Medical Corps http://www.imcworldwide.org/
IMED	International Medical Education Directory http://imed.ecfmg.org/main.asp
INHPR	Institute for National Health Policy and Research
IOA	Irish Osteopathic Association
JOF	Japan Osteopathic Foundation www.osteopathy.gr.jp
LCME	Liaison Committee on Medical Education http://www.lcme.org/

MCC	Medical Council of Canada http://www.mcc.ca/
MCNZ	Medical Council of New Zealand http://www.mcnz.org.nz/
MRSO	Swiss Register of Osteopaths or Schweizerische Register der Osteopathen or Le Registre Suisse des Ostéopathes or Il Registro Svizzero degli Osteopati www.osteopathy.ch
MWE	See DGMM-MWE www.aerzteseminar-mwe.de
NAO	Norwegian Association of Osteopathy – or – Norsk Osteopati Forbund www.osteopati.org
NBME	National Board of Medical Examiners www.nbme.org
NBOME	National Board of Osteopathic Medical Examiners www.nbome.org/
NFOM	Norsk Forbund for Osteopatisk Medisin (Norway) – or – Norwegian Association of Osteopathic Medicine
NGO	Non-Governmental Organization
NZAMSM	New Zealand Association of Musculoskeletal Medicine http://www.musculoskeletal.co.nz
NZOC	New Zealand Osteopathic Council www.osteopathiccouncil.org.nz/index.html
ÖÄMM	**Österreichische Ärztegesellschaft für Manuelle Medizin (ÖÄMM)** The FIMM national society representing Austria http://www.manuellemedizin.org/index.html
	Osteopaths Board of Queensland www.osteoboard.qld.gov.au
OCNZ	Osteopathic Council of New Zealand http://www.osteopathiccouncil.org.nz/
OdF	**Ostéos de France** http://www.osteos.net/
ÖGO	Österreichische Gesellschaft für Osteopathie (Austria) – or – Australian Osteopathic Association www.oego.org
OGME	Osteopathic Graduate Medical Education
OHHPF	Osteopathic Heritage Health Policy Fellowship
OIA	Osteopathic International Alliance www.oialliance.org/
OOA	Ontario Osteopathic Association
	Osteopathic Registry Board of New South Wales www.osteoreg.health.nsw.gov.au
	Osteopaths Registration Board of Victoria www.osteoboard.vic.gov.au

	Osteopaths Registration Board of Western Australia E-mail: egbank@bigpond.com
OSGHF	Osteopathic Student Global Health Forum www.osghf.org
PAHO	Pan-American Health Organization www.paho.org/
	Physicians for Humanity www.physiciansforhumanity.org
RCPSC	Royal College of Physicians and Surgeons of Canada http://rcpsc.medical.org/main_e.php
ROA	Russian Osteopathic Association http://www.rsom.ru/eng/roa/
ROB	Register of the Osteopaths of Belgium - or – Register voor de Osteopaten van België – or – Registre des Ostéopathes de Belgique www.osteo-rob.be
ROCH	Registre des Ostéopathes de la Confédération Helvétique
ROD	Register der Traditionellen Osteopathen in Deutschland (Germany)
ROE	Registro de Osteópatas de Espana (Spain) www.osteopatas.org
ROF	Registre des Ostéopathes de France www.osteopathie.org
ROI	Registro degli Osteopati dÍtalia http://www.roi.it
ROR	Register of Osteopaths of Russia www.osteopathy.ru
RSO	See MRSO (Swiss)
SAGOM	Swiss Society of Osteopathic Medicine http://www.sagom.ch
SAMM	Association Suisse de Médecine Manuelle http://www.samm.ch/index.cfm ?id=525&l=2
SAOM	Swiss Association of Osteopathic Medicine – Schweizer Verband für Osteopathie www.saom.ch/
SEMOYM	Société Espagnole de Médecine Manuelle (Spain) http://www.semoym.org
SFDO	Syndicat Français Des Ostéopathes www.sfdo.info
SFMM	Société Française de Médecine Mécanique – (French Company of Mechanical Medicine) http://sfmm.free.fr
SFMOTM	Société Française de Médecine Orthopédique et de Thérapeutiques Manuelles (A component society of the Société Française de Médecine physique et de Réadaptation)
SFO	Société Française d'Osteopathie

	http ://monsite.wanadoo.fr/sfo.net/ http ://sf.osteopathie.free.fr
SMMOF	Syndicat De Medecine Manuelle – Osteopathie De France – The site of the trade union of the doctors of Manual Medicine Osteopathy http://www.medecins-osteo.org/
SNO	Syndicat National Des Ostéopathes http://www.snof.fr/ and see http://www.osteopathie-France.net/Information/asso_charte.htm
SNOF	Syndicat National Des Ostéopathes de France http://www.snof.fr/ and see http://www.osteopathie-france.net/Information/asso_charte.htm
SOF	Svenska Osteopatförbundet (Sweden) www.osteopatforbundet.se
SOFMER	Société Française de Médecine physique et de Réadaptation http://www.sofmer.com/generalites/presentation_generale.htm
SOFMMOO	Société Française de Médecine Manuelle Orthopédique et Ostéopathique (French Society of Orthopaedic and Osteopathic Manual Medicine the FIMM national society representing France) http://www.sofmmoo.com/english_section/7_coccyx/coccyx2000.pdf
SOMA	Student Osteopathic Medical Association http ://www.studentdo.com/
SPOQ	Syndicat Professionnel Des Ostéopathes de Québec http://www.cpmdq.com/htm/synosteopathe2.htm
SRO	Swiss Register of Osteopaths – see MRSO
UFOF	L'Union Fédérale des Ostéopathes de France See http://www.osteopathie-france.net/Information/asso_charte.htm
UN	United Nations http://www.unsystem.org/ http://www.un.org/english/
Unitec	Unitec School of New Zealand www.unitec.ac.nz/
USAID	US Agency for International Development www.usaid.gov/
USMLE	United States Medical Licensing Exam www.usmle.org/
VOD	German Osteopathic Association www.osteopathie.de
WHO	World Health Organization www.who.int/en/ , www.who.int/medicines/organization/trm/orgtrmstrat.htm www.who.int
WOHO	World Osteopathic Health Organization www.woho.org
Wonca	World Organization of Family Doctors www.globalfamilydoctor.com

World Bank	World Bank www.worldbank.org/

Res. 40-A/2008 - COMPONENTS OF OSTEOPATHIC CONTINUOUS CERTIFICATION

The American Osteopathic Association approves the following components that will comprise Osteopathic Continuous Certification:

Proposed Components of Osteopathic Continuous Certification (OCC) Process
Component I. Unrestricted Licensure
Component II Lifelong Learning/Continuing Medical Education Component
Component III-Practice Performance Assessment *(CAP or some similar process for clinical assessment*)
Component IV-Cognitive Assessment Component *(requires a SECURED proctored exam)*
Component V- Continuous AOA Membership Requirement

Explanatory Statement: In February 2008 the AOA Board of Trustees approved the BOS recommendation to mandate that all AOA Boards will implement an OCC process by 2012. The BOS is now presenting the five components that will comprise OCC for approval of the Board of Trustees. 2008

Res. 44-A/2008 - AMENDMENT TO BOARD ELIGIBILITY REQUIREMENT FOR AOA BOARD CERTIFICATION

The Board of Trustees approve the BOS recommendation to have the new board eligibility process become effective July 1, 2009; and that the effective date be widely communicated through the JAOA, the DO, the AOA Websites and through special notification to all osteopathic medical schools, osteopathic training programs and all specialty affiliates.

Explanatory Statement: To ensure that the profession and interested parties are aware of the newly approved AOA board eligibility process before it comes effective, the BOS Assembly voted to have that process become effective July 1, 2009 to ensure at least a one year window of notification of the change. 2008

Res. 45-A/2008 - FACULTY DEVELOPMENT

The American Osteopathic Association accepts the recommendations of the AOA Board Task Force on Faculty Development, as follows:

1. Should all Clinical Faculty participate in faculty development?

   Every attempt should be made to make the opportunity for all clinical faculty to participate in faculty development achievable. To this end, it is important for each level of the

osteopathic educational continuum to make available multiple opportunities to achieve/maintain educational competencies, appropriate to that level.

Each level of the osteopathic educational continuum must develop and maintain an Officer/Champion to facilitate faculty development programs.

These programs should include both face-to-face and online/electronic faculty development modules, approved by the OPTI, to which the clinical faculty member is appointed. These programs would, preferably, but not necessarily have to be live and interactive. This is particular important due to the ever-increasing number of time constraints on clinical faculty members.

These modules should provide testing of concepts, as determined by the needs of education, at each level of the continuum (OPTI, DME, Residency Program, Clinical Faculty Member, and Resident).

They should also assure that educational objectives are met and desired competencies are achieved.

The online programs should provide for the ability for the clinical faculty participant to be able to print certificates of participation and achievement of competency in each module and should be able to be tracked electronically by the OPTI. This should be available at all levels to ease monitoring and reporting work.

2. Should Category 1A Continuing Medical Education credits be granted for participation in online Faculty Development modules?

   In an attempt to facilitate the continuing education of clinical faculty in a variety of venues and to increase the opportunities for the ability to achieve educational competencies, the task force recommended that the AOA Committee on Continuing Medical Education should approve the granting of category 1a CME credits for completion of faculty development modules. The modules must be approved by the OPTI. These modules should be developed in cooperation with or by the OPTI's, AACOM, the Specialty Societies, and the AODME (e.g. AODME Self Assessment Tool, AACOM/ECOP modules).

3. Should the AOA Develop an Office of Faculty Development?

   Faculty Development must occur at all levels of the osteopathic educational continuum and there must be documentation at all levels that it is occurring.

   This has been done by establishing and maintaining standards. The OPTI's and four Specialty Colleges currently require faculty development programs, which require documentation of attendance and evaluation of the program. The task force concluded that the AOA not establish an Office of Faculty Development, but that there be an

officer/champion responsible for faculty development, appointed at each level of education (OPTI, DME, Residency Programs). The OPTI should be the nexus for faculty development, drawing upon the expertise at all levels of the continuum, especially from the Colleges of Osteopathic Medicine, which sponsor each OPTI. The OPTI Faculty Development Officer would have the responsibility of facilitating and coordinating clinical faculty development activities within their OPTI. The COPTI and Specialty College standards should be maintained and/or modified to require the development of clinical faculty development competencies and facilitate the development of easily accessible opportunities for clinical faculty to achieve and maintain those competencies and to be appointed or maintain their clinical faculty status. These standards and competencies should be *monitored by the COPTI and PTRC/COPT, and be reported upon to the Bureau of Osteopathic Education.* Every attempt should be made to invite potential clinical faculty to explore and participate in osteopathic medical education.

4. Should the AOA seek Title VII funding for the Faculty Development Continuum and Faculty Development Programs?

The AOA should continue to advocate for and facilitate funding for the development of innovative programs for the Osteopathic Faculty Development Continuum. These grants should be developed in collaboration with AACOM, AODME, and HRSA. 2008

Res. 46-A/2008 - AOA SUPPORT OF THE INTERNATIONAL FEDERATION FOR MANUAL / MUSCULOSKELETAL MEDICINE (FIMM)

The American Osteopathic Association supports the continued involvement of osteopathic medicine and osteopathic physicians in the FIMM. 2008

Res. 55-A/2008 - TIME LIMITATION FOR APPEALS

The following policy applies to Appeals before the AOA Board of Trustees:

- An appeal to the Board of Trustees Appeals Committee must be initiated within twenty-four months of the underlying decision(s);
- The appellant must complete the appeal process within twelve months of having provided notice of intent to appeal to the Board of Trustees Appeal Committee;
- The the only exception to these time requirements shall be upon demonstration of actual inability to pursue such appeal within the allotted time frame due to circumstances beyond the appellant's control (e.g., stationed overseas, physical incapacity, etc.). 2008

Explanatory Statement: This resolution will be implemented on a going-forward basis (i.e., not retroactive). The current appeal process does not provide a specific time limitation for pursuing an appeal to the Board of Trustees. Consequently, decisions of the AOA's constituent Bureaus, Councils and Committees are being called into question years after the decision was made. Additionally, some appellants who initially decided not to pursue an appeal have made requests to re-initiate their appeals years after having given initial notice of intent to appeal. This resolution

establishes a requirement for appeals to be commenced within 24 months of the underlying decision(s) and for appellants to complete the appeal process within 12 months of having provided notice of intent to appeal. The resolution also recognizes an exception where appellants are physically unable or otherwise incapable of pursuing an appeal due to events beyond their control.

Res. 6-I/2008 - LETTER OF OGME-1 COMPLETION FOR OPTION 1 TRAINEES – HISTORICAL INFORMATION

Option 1 Training Institutions must issue a standard letter (NOT A CERTIFICATE) to each Option-1 trainee upon successfully completing his/her OGME-1 year. A copy of the letter should be sent to the OPTI and the letter reads as follows:

To whom it may concern:

This letter is to verify that (John Doe), DO successfully completed all requirements of an American Osteopathic Association (AOA) approved OGME-1 year at (osteopathic institution). The program dates for Doctor (doe) were (contract start date - contract end date).

If you have any questions, please feel free to contact me at (phone number).

Sincerely,

(Director Of Medical Education)

Res. 8-I/2008 - INTERIM REPORT OF THE CERTIFICATION FEE TASK FORCE

Introduction

In December 2007, the American Osteopathic Association (AOA) held a Summit meeting with the leadership of the osteopathic specialty colleges. The overarching goal of this high-level meeting was to discuss ways to enhance relations between the AOA and the specialty colleges. The participants at this meeting included the presidents, president-elects, and executive directors of the specialty colleges as well as the members of the Executive Committee of the AOA Board of Trustees.

The rising cost of postdoctoral activities was among the issues discussed at the Summit meeting. Specialty college representatives expressed concern that their postdoctoral costs were increasing, leaving less dues revenue for member services. Of particular concern was the perception of 'unfunded mandates' where the AOA establishes a new postdoctoral rule or procedure without commensurate revenue to support those new requirements. While appreciated, specialty college representatives indicated that the annual $15 fee per certified member is inadequate remuneration.

The discussion at the Summit led to the submission of Resolution 50, M/08, to the AOA Board of Trustees at its February 2008 meeting. Resolution 50, which was approved, called for the creation of a Certification Fee Task Force to:

1) Review the purpose and structure of the certification fee mechanism as it currently exists; examine the adequacy and equity of the current certification fee in reflecting the demands placed on the certifying boards, specialty colleges and AOA department of education;

2) Review the fee amount and distribution to determine whether it is sufficient to meet the current and future needs of the profession; and
3) Make recommendations, by the October 2008 Board of Trustees meeting, on revisions which should be made.

Then AOA President Peter B. Ajluni, DO, appointed members to the Certification Fee Task Force in March 2008. In response to the American College of Osteopathic Surgeons, AOA President Carlo J. DiMarco, DO, appointed a surgical representative to the Task Force in August 2008.

Activities

The Certification Fee Task Force has held two conference calls, one on July 1, 2008 and the second on October 2, 2008. The first conference call reviewed financial data from a survey sent to the specialty colleges. The second conference call was to discuss expansion of the scope of activity to include certifying boards and to agree on the next steps of the Task Force.

The Task Force reviewed the results of a survey that asked the specialty colleges to provide structural and financial data on their postdoctoral training costs. The Task Force reviewed the details of the survey responses and concluded that the data were too dissimilar to draw conclusions.

Remuneration to the Specialty Colleges

The Task Force reviewed the current remuneration to the specialty colleges. Each certified osteopathic physician pays an annual fee to support the ongoing costs of certification. In 2001, the AOA Board of Trustees approved a $15 certification fee increase with the proceeds to go to the specialty colleges to support their postdoctoral activities. This remuneration was intended to offset some of the specialty college postdoctoral costs but was not intended to cover all their costs. The certifying boards also receive $15 per certified member each year.

Over the past three years, the AOA has forwarded approximately $985,000 to the specialty colleges (see Table 1).

Table 1: Certification Fee Revenue Per Specialty College

Specialty College	2006	2007	2008	Total
Anesthesiology	7,723.56	8,012.10	7,699.95	23,435.61
Dermatology	4,022.78	4,245.48	4,378.27	12,646.53
Emergency Medicine	27,330.46	23,303.68	23,634.98	74,269.12
Family Physicians	149,019.90	157,369.05	157,733.78	464,122.73
Internal Medicine	35,848.89	39,569.69	39,896.07	115,314.65
Nuclear Medicine	1,245.05	1,200.06	1,260.14	3,705.25
Neurology & Psychiatry	6,643.68	4,170.54	9,512.84	20,327.06
Obstetrics & Gynecology	10,351.29	12,018.41	12,143.53	34,513.23
Neuromusculoskeletal Medicine	5,608.30	6,643.54	7,135.16	19,387.00
Ophthalmology & Otolaryngology	9,193.75	8,741.12	9,460.46	27,395.33
Orthopedic Surgery	11,110.55	12,052.87	12,390.48	35,553.90
Pediatrics	18,803.96	11,616.61	10,369.74	40,790.31
Pathology	1,576.15	915.05	4,946.53	7,437.73
Preventive Medicine	3,424.91	3,521.89	7,814.41	14,761.21
Physical/Rehab Medicine	3,091.49	2,944.95	4,204.65	10,241.09
Surgery	13,035.43	14,225.22	14,445.05	41,705.70
Radiology	8,862.60	9,525.96	19,739.76	38,128.32
Proctology	390.01	300.03	360.05	1,050.09
	317,282.76	320,376.25	347,125.85	984,784.86

Source: AOA Department of Finance

Survey of the Specialty Colleges

The Task Force reviewed the results of a survey on the postdoctoral costs of the specialty colleges. The cost variance between the specialty colleges was significant, even when examining the per trainee cost. Some of the variance may be due to the differences in definitions, possible double

costing, and other errors. Some of it may be due to some specialty colleges having better practices than others. Some may be due to economies of scale. The Task Force concluded that the specialty colleges should be surveyed a second time with a request for more defined financial information with which to make better comparisons.

Certifying Boards

In 2003 and 2004, the certifying boards' finances were exhaustively studied by a Certification Task Force. The study spawned the establishment of a Finance and Administration subcommittee within the Bureau of Osteopathic Specialists to monitor the finances of the certifying boards. It also encouraged cost saving activities, such as the ability to place examinations in dormant status to reduce the costs associated with maintaining psychometrically-sound examinations and the requirement to have stronger economic justifications before creating new examinations that cost as much as $50,000 to develop.

As a result of this exhaustive 2003-2004 study, the Task Force initially thought it prudent to focus its attention on the needs of the specialty colleges. However, over the past several months, specialty college representatives have urged the Task Force to include the certifying boards in the study. Of particular concern are the unknown costs associated with osteopathic continuous certification.

In addition, there was recognition that perhaps the entire postdoctoral/certification process may need reengineering, which would require inclusion of the certifying boards in the study. In October, 2008, the Task Force agreed to expand the scope of its study to include certifying boards. It also agreed that, as recommendations are formulated, it was imperative to meet with the specialty colleges as a group and meet with the specialty boards as a group.

Conclusion and Next Steps

The Certification Fee Task Force discussed the steps needed to obtain additional funding for the certifying boards and specialty colleges. It was agreed that the AOA Board of Trustees will not approve a funding increase without clear justification. Thus a goal is to collect accurate cost data that justifies a fee increase.

Accurate financial data is key. The Certification Fee Task Force noted that the financial data it had collected from the specialty colleges was inconsistent. Specialty colleges provided cost data in a variety of ways, making it difficult to compare costs among the specialty colleges. The Certification Fee Task Force agreed that it needed more accurate financial information.

Reviewing processes, reducing duplication, reengineering operations, seeking new revenue streams were concepts discussed by the Task Force. Anticipating new cost burdens, such as maintenance of certification, was discussed. It was suggested that perhaps the whole postdoctoral process needs to be housed within the AOA for cost efficiency.

The Certification Fee Task Force agreed that it was important to meet with the specialty colleges as a group and the certifying boards as a group to review the financial data and to discuss ways to

streamline operations. The Task Force agreed to combine these meetings with existent meetings, such as AOA's midyear meeting, in order to reduce costs.

The Task Force agreed to take a resolution forward to the AOA Board of Trustees to acknowledge the inclusion of the certifying boards in the study and the need to meet with the specialty colleges as a group and the certifying boards as a group as this study progresses.

Res. 9-I/2008 - UNIFORM STANDARDS
The "Uniform Standards Review Working Group Policies Proposal" be accepted and approved as policy; by the October 2009 AOA Board meeting, the AOA standards-setting bodies other than the Commission on Osteopathic College Accreditation (i.e., BHFA, BOS, CCME, COPT, and COPTI) be asked to compare their documents to the "Uniform Standards Review Working Group Policies Proposal" template and develop similar templates for their standards and either recommend changes in their standards-setting documents or explain the reasons for the variation.

Introduction:
The American Osteopathic Association (AOA) is actively engaged in the process of standard setting and the subsequent enforcement of standards through accreditation and certification processes. These activities take place within the context of hospital and health facilities accreditation, across the continuum of osteopathic medical education (i.e., predoctoral, postdoctoral and continuing osteopathic medical education) and in the numerous board certification programs.

There is considerable variation in the AOA's standard-setting, accreditation and certification processes. The processes used within one bureau/council/committee ("governing entity") are not followed in others. The variation is found across the full range of a governing entity's processes, from issues of appointment and composition to the process used for developing standards to the process by which accreditation and certification decisions are made and appeals conducted. This is not surprising. The processes have developed independently and within different governing entities to suit the needs, purposes and circumstances of each particular governing entity. However, the variation could also be a concern because the AOA could be challenged as to why a process used to develop or enforce standards in one area is not used in another area.

At the interim meeting in 2006, the Board of Trustees created the Uniform Standards Review Working Group (USRWG) and gave it responsibility to study the AOA's accreditation, certification and standard setting processes. The USRWG included leadership of the governing entities involved in standard-setting, certification and accreditation programs. The goals of the USRWG were first, to identify the processes used to set standards and conduct accreditation and certification activities within the AOA and other organizations and second, to establish a set of recommended practices. It should be emphasized that the USRWG's goal is not to mandate implementation of certain processes. Different governing entities work in different areas and, consequently, may use certain processes to produce the best outcome. Rather, the USRWG's goal is to identify processes and have each governing entity consider the implementation of the recommended practices. It is anticipated

that the standards-setting processes of the governing entities will converge over the next several years and, where divergence occurs, the AOA can identify and explain the reasons for the variation.

Purpose of the Uniform Standards Review Working Group Policies:
Nearly all of the accrediting and certification functions of the osteopathic profession are under the auspices of the American Osteopathic Association. This connection puts such functions under a higher level of scrutiny than if each were free-standing because the AOA, unlike a free-standing accreditor, could be questioned as to why one of its accreditation/ certification processes does not include certain protections or steps that are included in others. Accordingly, having a uniform template for such operations is highly desirable and this work is presented in that spirit.

Process Enforcement:
While a uniform template will be suggested, the accreditation/certification process should be tailored to fit the goals, needs and circumstances of each governing entity. Governing entities may "opt out" of specific aspects of the Uniform Standards Review policies with permission of the American Osteopathic Association (AOA) Board of Trustees upon presentation of reasons why it is appropriate for that specific entity to do so.

Definition of Accreditation:
Accreditation verifies compliance with accepted standards to assure the development and delivery of threshold qualifications that reflect and promote excellence in education and healthcare delivery of our publics while constantly striving for quality improvement.

In a parallel process, certification promotes excellence in education leading to excellence in health care delivery.

Mission of Governing Entity:
Every governing entity should have a mission statement approved by the AOA Board of Trustees which codifies the over-arching focus and philosophy of that entity. The mission statement should be reviewed periodically and published on the appropriate website, as well as provided to all institutions/programs prior to inspections. The accreditation/certification process should be consistent with the governing entity's mission.

Premise of Evaluations:
Evaluations of institutions/programs should be summative to ensure that they meet threshold standards for approval of the institution/program.

The governing entity must have processes in place to give formative recommendations to institutions/programs to move them in the direction of achieving quality improvement.

As part of the evaluation process, the institution/program should be evaluating its own processes continuously and be able to offer its rationale, goals and approach to implement the improvements to achieve excellence.

Appointment to the Governing Entity:

Criteria:

1. The governing entity should include:
    a. Members of the regulated group
    b. Members of the applicable educating group
    c. Experts in the area
    d. Public Members (see below)
2. Stakeholder representation is to be a consideration, but as a representative democracy and not as a pure democracy.
3. Learners in osteopathic predoctoral and postdoctoral levels should be included as appropriate.

Term Length:
Long enough to learn the workings of the governing entity and short enough to bring in new perspectives. More frequent, shorter terms are advisable.

Term Limits:
It is recommended that the governing entity consider term limits, keeping in mind the balance between the benefits of steady hands/institutional wisdom with the importance of bringing new ideas and perspectives into the mix through turnover.

The chair should evaluate the performance of each member at regular intervals and make recommendations for possible re-appointments.

Number of Governing Entity Members:
Large enough for diversity and small enough to be functional, which is generally considered to be between 9 and 15.

Public Members:
Public members should be considered for appointment based upon their specific expertise. Public members are to assist the governing entity in fulfilling its role as "protector" of the public.

Orientation for New Governing Entity Members:
An orientation shall be conducted by staff for all new governing entity members following a protocol approved by the existing governing entity members.

Standards:

Premise of Standards:
Standards should be written at a threshold level that reflects excellence in education and healthcare delivery, while encouraging quality improvement.

Development and Structure:
1. Standards should be clear, measurable, beneficial and achievable.
2. Each standard should articulate an independent aspect that can be evaluated.

3. Standards should state what must be accomplished and the purpose for the standard should be clear.
4. A standard should be a positive declarative sentence in the third person.
5. Standards are rules, not guidelines.
6. Standards provide an objective measurement of performance.
7. A crosswalk should be maintained to provide examples for governing entities, evaluators/inspectors and those being inspected.
8. For tracking purposes, all standards must be named and referenced by name in preference to numbers.
9. Proper terminology for standards (requirements) is "must" or "shall."

Rubric for Meeting Standards:

The content structure of the rubric should include the following:

1. What will be measured;
2. How it will be measured;
3. Defined process to obtain/record the information/results; and
4. Rubrics can be applied in the evaluation process as well as the summary of findings and recommendations for an institution/program.

Scoring Tool for Compliance with Standards:

1. Standards shall be judged "met, not met, or exceeds."
2. The level of performance of the standards must be tied to the number of years of award.
3. Previous award determinations should affect the current award determination if the deficiencies identified are continuing from prior inspections. Additionally, this history should affect the award determination if new deficiencies are identified in such numbers that the institution has effectively exchanged new deficiencies with old one that remain in a corrective action mode.

Periodic Review of Standards for Update and Revision:

1. Each governing entity should establish a regular interval for scheduled standards review and update (may vary from 2 to 5 years).
2. Every substantive update and revision should be prepared and accompanied by an explanatory rationale and anticipated cost.
3. Every update/revision and rationale should be posted on the appropriate website and sent by email and hardcopy to all identified constituents for public comment prior to enactment.
4. The comment period prior to final approval must be specified by policy as appropriate to the type of governing entity and allow for meaningful input from key stakeholders and the public at large.
5. The time segment prior to implementation must be specified by policy as appropriate to the type of governing entity.
6. Every update/revision and rationale should be posted on the appropriate website and sent by email and hardcopy to all identified constituents prior to enactment.
7. All new and revised standards are to be implemented on July 1 unless there is a pressing need for a different implementation date with justification.

8. All entities are encouraged to evaluate and research their processes to add to the body of literature in accreditation.
9. The implementation date must be clearly marked on the title page of the document.

Appeals Process:

The accreditation and certification process must include access to an appeal process. The appeal process must include access to review first, within the AOA Board of Trustees' departmental structure in which the decision was made and, second, if necessary, a subsequent appeal through the AOA Board of Trustees' appeal process.

The initial accreditation or certification decision of a governing body should provide affected institutions, programs or individuals with a written document containing all specific details on the basis for a decision, including any standards that are not met so that the individual, program or institution is provided with notice of the alleged deficiency or deficiencies that led to a decision.

Appeals are not for a "de novo" review of the issue. The purpose of the appeal is to correct factual and/or procedural errors and is not to second-guess the judgment of the governing entity. The appeal committee of the governing entity must consider appeals made on the basis of:

1. A substantive factual error(s) that led to the challenged decision; or
2. Failure to follow established process and procedures (e.g., conflict of interest, no quorum, inspectors did not have requisite expertise, etc.) that affected the challenged decision; or
3. An outcome from the governing entity that is not consistent with prior decisions using the same standards.

Appeals must be supported by documentation of the factual and/or procedural error. Appeals may not be based on new information or documentation. Information/ documentation must have been available and provided during the initial review decision.

Requests for appeal should be reviewed by the chair of the appeal committee in consultation with the Secretary of the bureau, council or committee that made the challenged decision to determine if it meets the requirements for appeal, as outlined above. A decision to not allow appeal can be reviewed through the AOA Board of Trustees appeal procedure.

An appeal committee of a governing entity should be comprised of individuals who are familiar with the standards at issue, but dispassionate in the appeal. Bureau/council/ committee members who voted on or otherwise participated in the decision in question must **not** serve on the appeal committee.

The appeal should proceed soon after the challenged decision. Each governing entity should set a time in which the appeal must be brought and should balance the need to provide the affected individual/program/institution with sufficient time to prepare an appeal with the need to implement accreditation/certification decisions. The appeal procedures should allow an appellant no more than 180 days from receipt of a decision or discovery of an appealable error to request an appeal. The

appeal committee shall reply within 21 days of receiving an appeal and provide the appellant with an outline of the plan for hearing in revealing the appeal or advising the appellant that the appeal petition does not meet the criteria for appeal.

The appeal process should be structured so that the governing entity's appeal committee would conduct a hearing and reach a decision within 180 days after the appeal is approved by the Chair to go forward. Possible decisions on an appeal include: affirmation of the governing entity's decision; or overturning the governing entity's decision. If an appeal committee votes to overturn the decision of the governing entity, it may be appropriate for it to also refer the matter back to the governing entity for further consideration. It is the obligation of the parties to the appeal to provide information that will allow the appeal committee to resolve the issue before it. However, in rare circumstances, it may also be appropriate for the appeal committee to defer decision and request additional information.

Reconsideration Process:
Appeals are limited to the circumstances set out above. Governing entities may also provide a reconsideration procedure that allows for consideration of new information.

Requests for reconsideration are to be reviewed by the same governing entity responsible for the initial decision and can be based on new information. An appellant has the option of entering the appeal process if the reconsideration fails. Where a reconsideration process is provided, an appeal committee may direct that an appeal petition based on new information or documentation back to the governing entity, which will have the option of accepting the reconsideration which may include the presentation of new information.

Application of this Program:

This uniform standards review policies program applies to the following governing entities:

Committee on Continuing Medical Education;
Council on Osteopathic Postdoctoral Training;
Council on Osteopathic Postdoctoral Training Institutions;
Program and Trainee Review Council;
Bureau of Osteopathic Specialists and their specialty boards; and
Bureau of Healthcare Facilities Accreditation

The American Osteopathic Association/Commission on Osteopathic College Accreditation is a governing entity under the auspices of the American Osteopathic Association but not subject to the appellant structure under the AOA Board of Trustees. While this governing entity is fully aware of this program, this entity is not bound by the administration of the program through the AOA Board of Trustees.

Res. EC4-M/2009 - TEXAS COLLEGE OF OSTEOPATHIC MEDICINE

The American Osteopathic Association will suspend all payments to the Osteopathic Research Center until the situation has been resolved to the AOA Board of Trustees' satisfaction; stands in support of the 2001 Texas legislation that prohibits the University of North Texas' Board of Regents from offering an MD degree; will communicate to the Chancellor of the University of North Texas and the President of the University of North Texas Health Science Center and Board Of Regents its opposition to an MD degree at University of North Texas; and asks AOA members who oppose the MD option at TCOM to make financial contributions directly to the Texas Osteopathic Medical Association, which has created the "TCOM Dedicated Fund" to finance its research and advocacy in support of osteopathic medicine in Texas. 2009

Explanatory Statement: In 2002, the AOA, the American Association of Colleges of Osteopathic Medicine and the American Osteopathic Foundation formally established the osteopathic profession's first Osteopathic Research Center (ORC) at TCOM and have provided more than $1.75 million in financial support to the ORC from 2002 to 2008.

In 2006-07, the AOA Council on Research awarded two 2-year grants to the University of North Texas Health Science Center for $87,630 and $79,000. In 2008-09, the AOA Council on Research awarded one 1-year grant and two 2-year grants to UNTHSC for $49,900 (1 year grant), $100,000 (2-year grant), and $99,307 (2 year grant). For the 2009-2010 grant cycle, UNTHSC has submitted five grant requests totaling $450,000. 2009

Res. EC5-M/2009 - ADVISORS, CONSULTANTS AND OBSERVERS TO BUREAUS, COUNCILS AND COMMITTEES

The AOA approves the following definitions and explanations for the Advisor / Consultant / Observer positions:

- Advisors – Advisors are individuals from within the AOA osteopathic family who have expertise on issues relevant to the activities of bureaus / councils / committees. Advisors serve solely in an advisory capacity and do not have authority to vote. Where appropriate, advisors shall receive the same compensation as is provided to other bureau / council / committee members.

- Consultants – Consultants are individuals from outside the AOA osteopathic family who have expertise on issues relevant to the Bureau / Council / Committee, but are brought in on a paid basis. As with advisors, Consultants hold non-voting positions. Consultants shall be compensated based on the terms of a contract or other agreement with AOA to serve as an independent contractor / consultant.

- Observers – Observers are individuals or representatives of other organizations which have an interest in the subject matter discussed. Because the subject matter is so important to that group, they are included on the distribution list and may send an "observer", who shall be a non-voting member and may only address the bureau, council or committee with the consent of the Chair. AOA shall not pay for the travel costs or other expenses for observers or provide them with honorarium for attending the meeting.

Positions currently designated as Advisors based upon a position held with the AOA structure shall be re-designated as non-voting ex-officio members of the bureau / council or committee; Current advisors and consultant positions not redesignated as non-voting, ex-officio positions as a result of this Resolution shall be eliminated; and advisors and consultants can be added to Bureaus, Councils and Committees, but must be approved as a budget adjustment by action of the Finance Committee on recommendation of the Budget Adjustment Committee.

Explanatory Statement: This resolution provides definitions and explanations for the positions of "advisor", "consultant", and "observer" on an AOA bureau, council or committee. Certain advisory positions are redesignated as non-voting, ex-officio members of the bureau, council or committee. Finally, the resolution calls for the elimination of all slotted advisor and consultant positions and specifies that advisors and consultants shall be added only with approval of the AOA Finance Committee on recommendations of the Budget Adjustment Committee. 2009

Res. EC6-M/2009 - LONG RANGE OVERVIEW OF AOA STRUCTURE

The Committee on AOA Governance and Organizational Structure will work in concert with the AOA Committee on Strategic Planning to conduct a long-range review of the AOA's organizational structure; this overview include an in-depth, benchmarked analysis of the structure, jurisdiction and value of each AOA bureau, council and committee, and its input, relation and value to the AOA's strategic plan; the review shall also consider from a cost-benefit perspective the numerous bureaus, council and committees as measured against the committee structure of comparable professional associations and offer appropriate recommendations as to where the AOA's organizational structure can be streamlined without damaging the quality of the work product; and the Committee on AOA Governance and Organizational Structure and the Committee on Strategic Planning will provide reports of their progress at appropriate intervals. 2009

Res. 8-M/2009 - FINAL REPORT OF THE TASK FORCE FOR CONJOINT CERTIFICATION OF ADDED QUALIFICATIONS (CAQ) COMMITTEES – HISTORICAL INFORMATION – AMENDED BY RES. 6-A/2011

Introduction

In the last several years, there has been confusion on how Conjoint CAQs should be operated. This confusion has led to misunderstandings between certifying boards as to their respective specific roles within the Conjoint CAQ Process. The Bureau of Osteopathic Specialists (BOS) determined that the administrative processes of the Conjoint CAQs were in need of substantial revision to ensure their optimal operation. It is also important for all members of our profession to understand the structure of the Conjoint Certification Process, which includes the specialty colleges, conjoint training committees, the Program Training Review Council and the Council on Postdoctoral Training (COPT), under the administration of the Bureau of Osteopathic Education (BOE), and specialty certification boards, conjoint certification committees under the administration of the Bureau of Osteopathic Specialists (BOS), supported by staff in the American Osteopathic Association (AOA) Department of Education. AOA support staff in the Division of Certifying

Board Services under the Department of State Specialty and Socioeconomic Affairs manages the work of the conjoint certification committees.

In an attempt to correct this confusion, in November 2007, the BOS reactivated the Task Force for the Conjoint CAQs. Its primary goal was to study and develop a workable operational plan to help conjoint exam committees function more efficiently. This Task Force developed a more specific framework that recommends the concept of centralizing the operations of all Conjoint CAQs through the AOA Division of Certifying Board Services, ensuring consistency and neutrality of operations. Under the proposed framework, the Division of Certifying Board Services will assume responsibility for managing conjoint certifying examination operations.

Article I – Purpose

The purpose of this document is to help members of our profession better understand the Conjoint Certification Process, which includes an education arm and an examination arm. The two arms should be separate in structure and basic activity and should not overlap or influence the other's function. However, they should complement each other with understanding and communication to enable a smooth-functioning Conjoint Certification Process.

This document will define the policies and procedures by which the Conjoint CAQ Committees can operate successfully. These policies and procedures will be formulated and managed by the Conjoint CAQ in conjunction with the appropriate primary Board. The BOS will approve the policies and procedures, as well as expedite, direct and guide its activities. This set of Operating Policies and Procedures shall be effective as of March 1, 2009.

The approval of certifications issued through the Conjoint Certification Process lies with the individual conjoint exam committees and the BOS. The approval of conjoint fellowship standards lies with the AOA Council on Postdoctoral Training (COPT) and the approval of training complete lies with the Conjoint Education and Evaluating Committee and is acknowledged by inclusion in the AOA database.

Article II – General Procedures

The Conjoint CAQ Committee will comply with all applicable provisions noted under Rules of Procedure as outlined in the Handbook of the AOA Bureau of Osteopathic Specialists (BOS). Any conjoint exam committee that existed prior to the approval of this document may petition the BOS to be permitted to continue with their current process. The petition should demonstrate that:

- the process of their present exam committee is working well;
- changing the current process to comply with this document would create an undue hardship; and
- the Conjoint Exam Committee will bring the process into compliance with this document during the next revision of their procedures.

This must occur no later than 5 years from the date of their petition.

Article III – Mechanism to Establish a Conjoint Certification Examination Committee to Issue a CAQ in a New Subspecialty Area in Conjunction with Respective Specialty Certifying Board(s)

In order to form a Conjoint CAQ Examination, the interested parties must submit a formal written request and complete an application. The application must include the anticipated number of trainees that are both eligible to take the proposed examination and desire to participate in the program. These materials must be submitted to the Executive Committee of the BOS to help determine the viability of, the justification and the demand for an ongoing certification program in said subspecialty. In order to be certain the program has a chance for financial success, the data must also be reviewed by the BOS Committee on Administration and Finance. This will help maintain the longevity of the new Conjoint Certification Process.

If this proposal is adopted, it would be recommended that the AOA add another full time position to assist the Division of Certifying Board Services of the AOA because the Division of Certifying Board Services is not currently staffed or financed to accommodate the above mentioned services. Please refer to Articles "IV – Specialty Boards Requesting an Assignment of Jurisdiction," "V – Protocol to Establish A Conjoint Exam Committee for Certification of Added Qualification" & "VI – Protocol for Withdrawal from Conjoint CAQ, Reestablishing Participation on Committee or Dissolution of Conjoint CAQ Certification" of the BOS Handbook for guidelines pertaining to the remainder of the process for establishing a CAQ.

Article IV – Mechanism to Withdraw

Any Specialty Certifying Board withdrawing from the Conjoint CAQ must present the reasons for withdrawal in writing to both the Conjoint CAQ and the BOS Executive Committee. The withdrawing specialty board must provide a plan for recertification of its diplomates. The Conjoint CAQ must send a letter to the BOS Jurisdiction Committee stating that the Conjoint CAQ will continue the recertification for the currently certified members of the withdrawing Specialty Certifying Board. In addition, any funds generated as a result of the recertification will stay with the Conjoint CAQ, not the withdrawing Specialty Certifying Board. The Conjoint CAQ will reimburse the withdrawing Specialty Certifying Board the cost for expenses associated with the continuous maintenance of the CAQ.

SECTION 1. REQUIREMENTS OF SPECIALTY CERTIFYING BOARD

Any Specialty Certifying Board withdrawing from the Conjoint CAQ Examination Committee must:

A. Present (in writing) the reasons for withdrawal to both the Conjoint CAQ Examination Committee and the Executive Committee of the BOS.
B. Provide a plan for recertification of its diplomates.
C. Issue certificates of certification and recertification for those eligible candidates from the withdrawing specialty certifying board's specialty (see ARTICLE IX).
D. Continue to send representation to the conjoint CAQ Examination Committee for that specialty as long as there are active diplomates from that board's specialty area.

SECTION 2. REQUIREMENTS OF CONJOINT CAQ EXAMINATION COMMITTEE
The Conjoint CAQ Examination Committee must send a letter to the Jurisdiction Committee of the BOS stating that the Conjoint CAQ Examination Committee will continue the recertification for the currently certified members of the withdrawing Specialty Certifying Board.

SECTION 3. FEES
Any funds generated as a result of the recertification will stay with the Conjoint CAQ Examination Committee, not the withdrawing Specialty Certifying Board. The Conjoint CAQ Examination Committee will reimburse the withdrawing Specialty Certifying Board the cost for the issuance of certificates for continuous maintenance of the CAQ.

Article V – Conjoint CAQ

Membership
Section 1. – Appointment of Members Participating Specialty Certifying Boards are responsible for appointing one representative and one alternate representative to serve as members on the Conjoint CAQ. The participating Specialty Certifying Board's representative and alternate must be certified by their respective Specialty Certifying Board.

Ideally, the representatives on the Conjoint CAQ will have a CAQ in the secondary specialty being managed by the Conjoint CAQ. In the cases of newly developing Conjoint CAQs, this CAQ membership requirement will not be feasible. All Conjoint CAQ representatives must have completed an item writing training program within two (2) years of being appointed to the Conjoint CAQ.

Section 2. – Term of Membership. The length of membership is nine (9) years. The term of membership may be extended upon approval of the Conjoint CAQ and the respective Specialty Certifying Boards.

Section 3. – Responsibility of Members. The Conjoint CAQ is responsible for the management of the committee, policy decisions, procedures, enforcement of the policies and procedures as well as item writing, item banking and other items relative to the examination construction.

Section 4. – Provision for Resignation. If a member of the Conjoint CAQ resigns, it is the responsibility of the member's Specialty Certifying Board to appoint a new representative to complete the term on the Conjoint CAQ.

Section 5. – Officers Officers of the Conjoint CAQ shall include a Chairperson, Vice-Chairperson, Secretary and Treasurer. In order to promote equity for the participating Specialty Certifying Boards and their representatives on the Conjoint CAQ, the leadership may be rotated amongst the participating Specialty Certifying Boards. In cases where there are fewer represented participating Specialty Certifying Boards than leadership positions, then a rotating schedule for the Chairperson should be followed in order to provide parity amongst the participating Specialty Certifying Boards.

Section 6. – Terms of Office. To efficiently accomplish these objectives, a slate of Conjoint CAQ Committee Officers is elected for a three (3) year term with elections occurring every three (3) years. The Conjoint CAQ should develop a mechanism to rotate the Chair and Vice-Chair positions amongst the Specialty Certifying Board representatives.

Section 7. – Qualifications for Item Writers Item writers must be certified by their respective Specialty Certifying Board and must hold a CAQ in the specialty being managed by the Conjoint CAQ. In the case of a newly developing Conjoint CAQ Examination, this CAQ requirement will not be feasible. In those instances in which item writers do not hold a CAQ in the specialty being managed by the Conjoint CAQ, but are considered subject experts in their respective fields, the Officers of the Conjoint CAQ have the authority to approve/disapprove all materials submitted by these subject experts.

Section 8. – Representation and Voting Privileges on the Bureau of Osteopathic Specialists
The Conjoint CAQ does not have formal representation or voting privileges on the BOS. However, the specific participating Specialty Certifying Boards will represent the interests of the Conjoint CAQ during the BOS meetings.

Article VI – Meetings
Section 1. – Annual Meeting The Conjoint CAQ Committee (specialty specific) shall hold at least (1) one annual meeting; and additional meetings as necessary, to transact business.

Section 2. – Special Meetings Special meetings, deemed necessary for the transaction of business, of this Conjoint CAQ may be called by the Chair of the Conjoint CAQ or by a majority vote of the total membership of the Conjoint CAQ. Notice of the meeting shall be mailed (electronically or postal) to each member of the Conjoint CAQ by the Secretary or Treasurer of the Conjoint CAQ (assisted by the AOA Division of Certifying Board Services, if necessary) not less than thirty (30) days prior to the proposed meeting date.

Section 3. – Quorum For the transaction of business at any meeting of the Conjoint CAQ, a simple majority of members shall constitute a quorum. For the transaction of business at any meeting of a two (2) member Conjoint CAQ, both members must be present. In a situation where a Conjoint CAQ consists of two (2) members, and if both members cannot agree, the Chairman of the BOS will make the final decision.

Section 4. – Governing Rules Meetings of the Conjoint CAQ shall be governed by *Robert's Rules of Order, Newly Revised*, unless otherwise specified.

Section 5. – Order of Business

A. Call to Order

B. Roll Call

C. Report of Secretary-Treasurer

D. Communications

E. Report of Ad Hoc Committee(s) (optional)

F. Old Business

G. New Business

H. Adjournment

Article VII – Ad Hoc Committees

The Conjoint CAQ may create Ad Hoc Committees as necessary for their efficient and satisfactory operation and function. Each of the representing boards shall send a member of their own Appeal Committee as alternate members to form an Ad Hoc Appeal Committee to hear appeals and attempt to resolve any misunderstandings. As these members will not be involved with the construction, administration or correction of the examination, there should be no fear of bias in any way. Nevertheless, all members must adhere to all applicable conflict of interest policies. The member on the Conjoint CAQ representing his/her Specialty Certifying Board will serve as the liaison between the Conjoint CAQ and his/her respective Specialty Certifying Board. The liaison's primary duty will be to address any problems or discrepancies regarding qualification of candidates of their respective primary specialty.

Article VIII –Funding and Business Plan

In order to ensure that all new Conjoint CAQ Examinations and Conjoint CAQ re-certification Examinations will have financial stability, all participating Specialty Certifying Board members on the Conjoint CAQ, in consultation with the AOA Division of Certifying Board Services, will develop the following:

Section 1 – An Examination Development Fund An Examination Development Fund is required in order to meet the expenses incurred for developing the Conjoint CAQ Examination such as: marketing the availability of the Conjoint CAQ Examination, developing and printing the applications, determining the number of diplomates available to take the Conjoint CAQ Examination, developing and mailing the job task analysis, developing the Conjoint CAQ Examination blueprint, constructing and proofreading the Conjoint CAQ Examination, printing and securing the Conjoint CAQ Examination, staff secretarial costs, travel costs for Conjoint CAQ members, and psychometric evaluation and administration of the Conjoint CAQ Examination expenses, etc. All Specialty Certifying Boards participating in the Conjoint CAQ Examination will share the financial responsibility for the Examination Development Fund equally. If a Specialty Certifying Board decides to join the Conjoint Certification Process after the initial exam is developed, the Specialty Certifying Board will contribute 125% of the initial equal contribution of an original participating Specialty Certifying Board.

Section 2. – A Maintenance Examination Fund To ensure that a future Conjoint CAQ Examination has financial stability, a separate Maintenance Examination Fund will be developed and that fund

will be placed in a separate maintenance bank account for each Conjoint CAQ. All Specialty Certifying Boards participating in the Conjoint CAQ Examination Process will share the financial responsibility for the Examination Maintenance Fund equally.

A Maintenance Examination Fund is required of all new and existing Conjoint CAQ Examinations. All Specialty Certifying Boards participating in a Conjoint CAQ Examination will be given a three (3) year period to create and obtain their respective portion of this fund.

Section 3. – Plans for Staffing The operational agency available to provide this quality service to a Conjoint CAQ is the AOA Division of Certifying Board Services. In cases where the expenses are higher than revenue, each participating Specialty Certifying Board will be required to contribute proportionally (based upon the proportion of candidates taking the conjoint examination) to rectify the financial deficit. The Task Force understands that if this plan is approved, there would be increased financial needs for increased resources. However, this proposal has great potential to standardize and centralize the operations of all Conjoint CAQ Committees to the benefit of the osteopathic profession and all of its constituents.

Therefore, the Task Force recommends that the Bureau of Finance study and consider this proposal in order to appropriate funds to secure the necessary resources for the Division of Certifying Board Services and thus enable them to manage all Conjoint CAQ Examinations under the AOA umbrella.

Section 4. – Examination Fees All examination fees, payments and elapsed-time restrictions will be determined by each specific Conjoint CAQ in conjunction with the respective participating Specialty Certifying Boards. These funds will be utilized to resolve the expenses incurred in the development of the specific Conjoint Examination as stated in Section 1.

Article IX – Establishment of Candidate Eligibility Requirements

Section 1. – Conjoint CAQ Responsibility It is the responsibility of each Conjoint CAQ, in conjunction with the participating Specialty Certifying Boards, to determine and periodically review the requirements within the BOS guidelines for candidate eligibility and certification maintenance.

The participating members on the Conjoint CAQ, as representatives of their Specialty Certifying Boards, will serve as liaison between the Conjoint CAQ and his/her respective Specialty Certifying Board to address certification requirements and timely approval of candidates' eligibility status.

Section 2. Candidate Eligibility Requirements
At a minimum, the eligibility requirements for candidates to sit for the Conjoint CAQ Examination will be as follows:

A. AOA Membership. The candidate must be a member in good standing with the AOA at the time of the application process.
B. Primary AOA Specialty Board Certification. See Section 4, below.

C. Training Program Requirements. The candidate must have completed the AOA training requirements for the Conjoint CAQ Examination; or the practice requirements if established for a clinical pathway, or an AOA-approved training program (where applicable).

Section 3. Clinical Pathway

A. The Conjoint CAQ Examination Committee may establish a clinical pathway for those candidates that have clinical experience in the field but did not complete an AOA-approved program.
B. The criteria for this pathway are established by the Conjoint CAQ Examination Committee in conjunction with the participating Specialty Certifying Boards; such criteria must be approved by the BOS in conjunction with the AOA. The Clinical Pathway may include CME requirements, previous certifications, training approval, sufficient clinical experience, etc.
C. Clinical Pathways will close after a maximum of five (5) years, as established by the Conjoint CAQ Examination Committee. Following the clinical pathway period, candidates will not be eligible to receive the CAQ without entrance into and completion of an AOA-approved fellowship training program.

Section 4. Applicants From Non-Participating Boards

A. Active diplomates from an AOA specialty certifying board that is not a participating member of the Conjoint CAQ Examination Committee may apply for the CAQ during the established clinical pathway period.
B. When such application is received, staff will immediately notify the Conjoint CAQ Examination Committee and the non-member specialty certifying board of the application.
C. Within thirty (30) days, the non-member specialty certifying board will review the application, acknowledge the candidate's primary certification status, and forwards this information to the Conjoint CAQ Examination Committee.
D. The Conjoint CAQ Examination Committee will then review the candidate's application file and make final determination of eligibility for examination.
E. Following the candidate's successful completion of all requirements for certification, the non-member specialty certifying board will issue certification and recertification certificates, the cost for which will be reimbursed by the Conjoint CAQ Examination Committee.
F. In the event that a non-member specialty certifying board does not recommend a candidate for certification, the Board may appeal to the Conjoint CAQ Examination Oversight Committee of the BOS.
G. Actions by the Conjoint CAQ Examination Oversight Committee of the BOS may be appealed to the executive committee of the BOS.
H. Actions by the Executive Committee of the BOS may be appealed to the AOA Board of Trustees.

Article X – Published Requirements to Receive Certification

The Conjoint CAQ will publish the minimum requirements for a candidate to receive certification from the AOA. These shall include all the requirements noted under Article IX, plus the following:

a. Successful completion of the appropriate certification examination(s).

b. Any additional requirements the Conjoint CAQ chooses to establish. These requirements may include years of specialty practice, case records, scientific paper(s), published article(s), etc.

Article XI – Rules for the Conduct of Examinations

Section 1. – Examination Components Components of the examination include: when, where, how, and by whom the exam will be conducted; subjects to be covered; the definition of a passing score; average (if applicable); reexamination conditions; further study requirements; and notification to candidates. The respective Conjoint CAQ, in conjunction with the participating Specialty Certifying Boards, will determine these components, which must be in compliance with BOS requirements and regulations.

Section 2. – Item Writers The length of time that must elapse before an item writer/reviewer can sit for examination will be determined by the Conjoint CAQ in conjunction with the respective participating Specialty Certifying Boards. An item writer will receive a "pass" for taking the conjoint recertification examination if he/she is writing examination questions during his/her period of service on the Conjoint CAQ.

Section 3. – Appeal Process If a candidate feels the actions of the Conjoint CAQ, with regard to any part of the examination, constitute unequal application of the standards, regulations and requirements, unwarranted discrimination, prejudice, unfairness or improper conduct of the examination, he/she has the right to appeal to the Ad Hoc Appeal Committee, which will be composed of members from each participating Primary Specialty Board's Appeal Committee. The alternate CAQ Examination members will represent their separate Primary Boards and be knowledgeable of the entire body of material included in the testing process at the Conjoint CAQ level. Attempts will be made to resolve the misunderstanding by this knowledgeable, multidisciplinary committee. However, if the candidate is not satisfied with the results of an appeal before the Ad Hoc Appeals Committee, he/she has the right to further appeal to the BOS and the AOA Board of Trustees (BOT).

Article XII – Certificates

Section 1. – Issuance of Certificates – Participating Boards The participating Specialty Certifying Board will issue and maintain certificates, coordinating with the Conjoint CAQ. A candidate who is board certified by an AOA Specialty Certifying Board that is not a participating Specialty Certifying Board of the Conjoint CAQ may petition any of the participating Specialty Certifying Boards to issue and maintain the certificate.

Section 2. – Issuance of Certificates – Non-Member Boards For candidates approved through Article VI, Section 4. Who are awarded the CAQ, their applicable primary specialty certifying board will issue certificates of certification and recertification, to be reimbursed by the Conjoint CAQ Examination Committee.

Section 3. – Issuance of Certificates – Boards which have withdrawn. For candidates who had initiated the certification process prior to a specialty certifying board's withdrawal from a Conjoint CAQ Examination Committee, the applicable primary specialty certifying board will issue certificates of certification and recertification, to be reimbursed by the Conjoint CAQ Examination Committee

Section 4. – Revocation If a DO loses his/her Primary Specialty Board certification by revocation or expiration, his/her CAQ will also be revoked.

Section 5. – Recertification/ Osteopathic Continuous Certification Recertification/Osteopathic Continuous Certification will occur not less than five (5) years nor greater than ten (10) years of issuance of the initial CAQ. The recertification/osteopathic continuous certification guidelines will be determined by the participating Specialty Certifying Board in conjunction with the Conjoint CAQ.

Section 6. – Terminology Certificates will be issued through the participating Specialty Certifying Board with terminology that reads – Certification of Added Qualifications in Subspecialty. Recertification of Added Qualifications in Subspecialty.

Article XIII – Reentry into the Certification Process
A candidate whose CAQ eligibility status has been terminated cannot re-register for this status, but may be eligible to petition the Conjoint CAQ for reentry into the certification process as outlined within the BOS Handbook.

Article XIV – Amendments
The Conjoint CAQ may amend processes by submitting resolutions to the BOS. The BOS members must have a minimum of thirty (30) days' advance notification prior to voting. With a two-thirds (2/3) affirmative vote of the BOS members present at a meeting, the resolution for said amendments will be forwarded to the AOA Board of Trustees.

In order to clarify terminology, avoid misunderstanding and maintain uniformity, the Task Force recommends the following glossary of terms as a starting point to develop an acceptable and understandable list of definitions for the profession. Glossary (or definition) of Terms as used in this document:

American Osteopathic Association (AOA) – The AOA is the national organization for the advancement of osteopathic medicine in the United States, and the professional association for over 64,000 physicians. The AOA accredits the Colleges of Osteopathic Medicine, osteopathic internship and residency programs, and healthcare facilities.

Board Certification – A process by which an agency or association grants recognition by examination to an individual who has met certain predetermined qualifications specified by that agency or association.

Board Eligibility – Denotes those candidates who have successfully completed an approved training program and evaluation process assessing their ability to provide quality patient care in a

specific specialty. This creates eligibility status to participate in the specific certification board examination.

Bureau of Osteopathic Specialists (BOS) – The authoritative body that establishes and maintains osteopathic specialization and the pattern of training for the various specialties and fields of practices, composed of representatives from each osteopathic specialty certification board and one public member.

Certification – A voluntary process intended to assure the public that a certified medical specialist has successfully completed an approved educational program and an evaluation including an examination process to assess the knowledge, experience, and skill requisite to the provision of high-quality patient care in a specialty. Certification boards determine whether candidates have received appropriate preparation in approval residency training programs in accordance with established educational standards, evaluate candidates with comprehensive examinations, and certify those who have satisfied the board requirements.

Certification of Added Qualifications (CAQ) – A modification of a general certification. CAQ requires maintenance of valid general or special qualifications certification from which the added qualification was modified

Certification of Special Qualifications (CSQ) – A subspecialty certification conferred by a Specialty Certifying Board in a specific subspecialty area of the field certified by that Specialty Certifying Board. It requires prior attainment of general certification. Certificates read, "Certified in (subspecialty field)."

CSQ indicates the possession of knowledge, skill, training and successful examination in a subspecialty field over and above that required for general certification. CSQ designates additional abilities in limited areas of the general specialty field represented by that Specialty Certifying Board and does not require maintenance of the primary certification.

Conjoint Certification Process – When the identifiable body of knowledge for certification of added qualifications overlaps more than one specialty or subspecialty area, a conjoint examination process may be developed by the corresponding certifying Boards.

The educational component or arm of the Conjoint Certification Process will be addressed and managed by AOA Bureau of Osteopathic Education. The Council on Postdoctoral Training (COPT) approves all specialty training standards. The examination portion of the Conjoint Certification Process will be managed by the Conjoint CAQs in conjunction with their primary certifying boards. Please see diagram below.

Council on Postdoctoral Training (COPT) – The COPT recommends policies for OGME programs to the AOA Bureau of Osteopathic Education for review and recommendation to the AOA Board of Trustees for their final action.

Fellowship –Training in a subspecialty occurring subsequent to a primary residency, not to be confused with the honorary status conferred by specialty colleges and practice affiliates.

General Certification – The primary certification conferred on diplomats who meet the requirements in a specified field of medical practice under the jurisdiction of a Specialty Certifying Board. General certification represents a distinct and well defined field of osteopathic medical practice.

Program Training Review Council (PTRC) – The final approval body for new training programs, continuing approval, and individual training for individuals seeking of non-AOA approved training. IN addition, the PTRC recommends policy to COPT. Decision of the PTRC may be appealed to the BOT Appeal Committee

Res. 25-M/2009 - NEW POLICY ON DORMANT STATUS
The American Osteopathic Association has approved the following policy regarding the placement of postdoctoral training standards into dormant status:

1. If a certification examination has been placed into dormant status, the specialty colleges may also request that the basic standards in that specialty / subspecialty and/or areas of added qualifications may also be placed into dormant status;

2. If the certification examination is reactivated, the specialty college will be notified in order to request activation of the basic standard in that specialty / subspecialty and/or areas of added qualifications;

3. Prior to reactivation, the specialty college be required to review and update training standards; and

4. That "dormant status" be added to the glossary of terms in the AOA Accreditation Document for Osteopathic Postdoctoral Training Institutions and the Basic Documents for Postdoctoral Training Programs. 2009

Res. 29-M/2009 - MULTIPLE OPTI MEMBERSHIPS
Policy of the American Osteopathic Association notes that an institution belonging to more than one osteopathic postdoctoral training institution (OPTI) must designate to the AOA which OPTI for each program will serve as the "administrative" OPTI in that institution; and that the designated administrative OPTI will provide primary administrative oversight and be named on program completion certificates. 2009

Res. 37-M/2009 - FACULTY DEVELOPMENT
Category 1-B continuing medical education credit be granted to osteopathic physicians who participate in online Faculty Development modules; and that Category 1-A continuing medical education credits should not be granted for participation in online Faculty Development modules because it does not meet the criteria for Category 1-A CME. 2009

Res. 38-M/2009 - NEEDS ASSESSMENT, PRE-APPROVAL OF CME PROGRAMS FOR AOA CATEGORY 1-A OR CATEGORY 1-B CREDIT – HISTORICAL INFORMATION

Effective July 1, 2009 all AOA Category 1 CME Sponsors requesting pre approval for a formal program (Category 1A or Category 1-B credit) must provide written documentation of their needs assessment as tied to the program objectives at the time of the request for approval. 2009

Res. 41-M/2009 - JOINT VENTURE POLICY

Policy of the American Osteopathic Association regarding Joint Ventures states the following.

I. Definition.

A Joint Venture, as used in this statement, refers to a business arrangement that is structured under the terms of a contract (i.e., Joint Venture Agreement) between the AOA and one or more other taxable legal entities. Joint ventures are created for purposes of pursuing specifically identified and defined business opportunities. Joint ventures are created by contract and are not business organizations in the sense of corporations, sole proprietorships or partnerships. As such, joint ventures are not taxpaying, legal entities and, instead, function through the legal status of the participants in the joint venture.

II. Tax Status.

The AOA is incorporated as a Not for Profit Corporation in the State of Illinois. It is recognized by the Internal Revenue Service (IRS) as a tax exempt organization under Section 501(c) (3) of the Internal Revenue Code.

III. Policy.

Due to its tax-exempt status, the AOA must carefully evaluate the tax consequences of entry into and participation in joint venture arrangements or other contractual arrangements with taxable entities in order to ensure that the AOA's tax exempt status is not jeopardized. This policy shall be applicable any joint ownership or contractual arrangement with a taxable entity to undertake a specific business enterprise, investment or exempt-purpose activity regardless of whether the AOA controls the joint venture, the legal structure of the joint venture or whether the joint venture is taxed as a partnership, association or corporation.

In the event of potential adverse tax consequences, the AOA shall take appropriate steps to protect its tax exempt status, such as ensuring that the joint venture furthers the AOA's exempt purposes, requiring that the joint venture give priority to exempt purposes over returning profits to the joint venturers, committing the joint venture to not engaging in political or other activities that would jeopardize the tax exempt status and/or ensuring that all contracts entered into with the joint venture be on terms that are negotiated at arm's length or more favorable to the joint venture. 2009

Res. 6-A/2009 - MINIMUM NUMBERS FOR OPTION 2

For purposes of counting minimum resident numbers, in any Option 2 specialty, the preliminary internship may count together with the residency to meet the minimum. 2009

Explanatory Statement: Since many institutions budget a specific number of positions in each specialty program, and since the preliminary year intern in Option 2 specialties is actually pre-

committed to the residency track, counting them together will help to permit those programs to meet AOA minimum numbers and keep them in compliance to prevent program lapse.

Res. 7-A/2009 - OPTION 3 SPECIALTIES IN STATES WITHOUT TRADITIONAL ROTATING INTERNSHIP PROGRAMS

Through June 30, 2010, that Option 3 programs in institutions that do not offer OGME 1 traditional rotating internships shall fulfill this requirement through a formal written agreement with an institution that has an aoa approved family practice or AOA approved internal medicine program in order to provide DME and OGME committee oversight and supervision for AOA compliance.

Explanatory Statement

The COPT must revise this standard with approval by the BOE and BOT prior to the start of the 2010-2011 academic year.

Res. 12-A/2009 - PUBLIC COMMENT ON NEW BOS INITIATIVES

Policy of the American Osteopathic Association notes that new policies and initiatives by the Bureau of Osteopathic Specialists (BOS) be posted on the AOA Website and forwarded electronically to all specialty colleges and specialty certification boards for a sixty (60) day public comment period; and the BOS, or appropriate subcommittee thereof, review the comments received and report back to the Executive Committee of the BOS for possible further action. 2009

Explanatory Statement: The BOS should offer a period of public comment prior to making policy changes affecting said stakeholders, similar to that of other department policies

Res. 13 -A/2009 - SPECIALTY CONTINUING MEDICAL EDUCATION (CME) POLICY

Policy of the American Osteopathic Association notes that credit for specialty CME provided by CME providers other than the relevant specialty affiliate may only be awarded by the certifying board with jurisdiction; physicians may petition the specialty certifying board's CME Advisory subcommittee on a case-by-case basis for exceptions to this policy; and that each certifying board be required to establish a CME Advisory Subcommittee. It is the responsibility of each subcommittee to monitor the compliance of CME programs with the criteria, which is determined by the Subcommittee. 2009

Explanatory Statement

It is the responsibility of each specialty certifying board's CME Advisory subcommittee to monitor the compliance of CME programs based on the approved template and its defined criteria

Res. 14-A/2009 - RECOMMENDATIONS REGARDING ADMITTING MDS INTO OSTEOPATHIC GRADUATE MEDICAL EDUCATION PROGRAMS

The American Osteopathic Association accepts the white paper on MDs in DO Training Programs (attachment 1); and endorses the recommendation that through 2015 the osteopathic profession would annually review the impact of the projected 30% additional LCME MD graduates entering ACGME training programs, including an analysis of federal legislation affecting the number of graduate medical education positions, before making a final decision on whether or not to support a

new policy that would permit osteopathic graduate medical education programs to admit MDs. 2009

Explanatory Statement: There are two main reasons that the issue of admitting MD's into OGME programs has been raised:

1. The need to fill all OGME slots so they are not lost to the profession by closure or transfer to ACGME programs; and

2. The greater interest in opening new AOA-accredited residencies programs, particularly in DO-shortage areas, if there would be the possibility of such programs also being open to MD residents.

Regarding the first point, the study revealed that the increase in the number of graduates of our schools should lead to a significant increase in overall numbers of filled positions within OGME.

The study also pointed out that the second point could be addressed, while not always easily, by pursuing dual accreditation of any new AOA-accredited program.

As described in the study, a major confounding issue created by such a change in policy (for both reasons above) would be the corresponding changes required in policies for all AOA approved certifying boards, all state licensing laws and National Board of Osteopathic Medical Examiners (NBOME) licensing examination policies, not to mention a host of other unintended consequences detailed in the study.

The AOA HOD reviewed this resolution (H325-A/2009) and recommended that it be referred to the Department of Education for additional review with a report back at A/2010.

Res. 15-A/2009 - FUNDING FOR OSTEOPATHIC GRADUATE MEDICAL EDUCATION

The Bureau of Federal Health Programs will present a one-page report each year regarding GME funding.

Explanatory Statement: The report should include a brief description of the importance of the issue, discuss the current GME funding environment, and describe current activities to enhance GME funding. The report should be distributed to the AOA Board of Trustees at its mid-year meeting, to the AACOM leadership at its annual meeting, to the SOMA leadership, and COSGP leadership. This directive should sunset after five years unless reaffirmed by the AOA Board of Trustees.

Res. 16-A/2009 - MEDICAL EDUCATION RESEARCH

The American Association of Colleges of Osteopathic Medicine (AACOM) and AOA develop an annual joint research report to AACOM Board of Deans and the AOA Board of Trustees.

Res. 17-A/2009 - PROMOTION OF PATIENT CENTERED MEDICAL HOME
The AOA will develop a communication plan to include specialty colleges and members of the profession highlighting information on the patient centered medical home model development including related governmental policy changes.

Explanatory Statement: The communication plan should include a description of the importance of the patient centered medical home model, discussion of federal regulations and reimbursement issues, and a tool kit to facilitate implementation of such a model(s). The communication plan should be distributed profession wide.

Res. 21-A/2009 - CERTIFICATION ELIGIBILITY FOR ABMS-CERTIFIED DOS FOR RESOLUTION 56 PATHWAY
The eligibility requirement in Resolution 56 that osteopathic physicians must have completed training at least five (5) years prior to submitting an application be eliminated. 2009

Explanatory Statement: There have been 211 applications under Resolution 56 to date, of which 196 have been forwarded to the specialty boards as certification eligible. It has been noted that while concerns have been expressed in the past that the elimination of the requirement might have a negative impact on graduates selecting osteopathic GME programs, the Council members state that quality osteopathic programs will continue to attract residents

Res. 22-A/2009 - FACILITATING VERIFICATION OF ACGME TRAINING FOR AOA BOARD ELIGIBILITY
The American Osteopathic Association will use standardized criteria to approve ACGME training as complete; AOA staff will exclusively be responsible for the process to verify ACGME training is completed through primary source verification before ACGME-trained DOs are recognized as eligible for AOA board certification; the Program and Trainee Review Council will no longer reviews ACGME-trained DO applications; and that DOs living in states requiring a first year of AOA approved training for licensure must continue to apply for this approval through the Resolution 42 process. 2009

Explanatory Statement: These changes would follow the precedent set through Resolution 56. The revised process to verify ACGME training to be eligible for AOA board certification would not preclude an ACGME-trained DO who seeks licensure in Florida, Michigan, Oklahoma and/or Pennsylvania, from needing AOA approval of their first year of training through the Resolution 42 process. As an example, if a ACGME-trained DO practicing in Kentucky when he or she obtained AOA board certification through the expedited process outlined in this resolution, then decided to move to Pennsylvania to practice, he or she would need to apply for approval of training through the Resolution 42 pathway.

Res. 35-A/2009 - REQUESTING DIGITAL SUBSCRIPTIONS TO THE DO AND JAOA – THE JOURNAL OF THE AMERICAN OSTEOPATHIC ASSOCIATION ON BEHALF OF AOA MEMBERS

The AOA Board of Trustees request on behalf of all AOA physician and student members that they receive digital subscriptions to *The DO* and *JAOA—The Journal of the American Osteopathic Association*; and that *The DO* and the *JAOA* be authorized to deliver digital subscriptions to AOA physician and student members through electronic tables of contents and any other means BPA Worldwide recognizes. 2009

Res. 36-A/2009 - REPORT OF THE CERTIFICATION FEE TASK FORCE

The AOA Board of Trustees approves the recommendations in the attached Certification Fee Task Force report. 2009

Explanatory Statement: The Certification Fee Task Force believes that a comprehensive redesign of the postdoctoral training process is needed and is recommending such an analysis. This would include a re-evaluation of the roles, responsibilities, and authority of each participant in the training process as well as the overall goals of osteopathic postdoctoral training. The annual fees charged to the training programs should be used to cover the costs of the system. The Certification Fee Task Force recognizes that a redesign will take time and recommends a $25 increase in the annual per resident training fee now to help underwrite the costs of the specialty colleges' Education Evaluation Committees.

History

In July 2007, several osteopathic specialty colleges raised a number of concerns at the AOA House of Delegates meeting. In response, the AOA House of Delegates asked the AOA leadership to arrange a Specialty Summit to discuss the issues.

The Specialty Summit was held in the Fall of 2007. The Summit discussed issues, including revenue sharing, postdoctoral staffing and procedures, and certification issues. As a result of the meeting, the AOA Board of Trustees in February 2008 voted to approve the formation of a Certification Fee Task Force to review the purpose and structure of the certification fee mechanism as it currently exists; to examine the adequacy and equity of the current certification fee in reflecting the demands placed on the certifying boards, specialty colleges and AOA Department of Education; and to review the fee amount and distribution to determine whether it is sufficient to meet the current and future needs of the profession (Res 50, M/08).

To begin its study, the Certification Fee Task Force surveyed the specialty colleges, asking for information on the sizes of their Education and Evaluation Committees (EECs), the frequency of meetings, the topics addressed by the EECs, the length of time to address the topics, EEC costs, and suggestions on how to streamline operations and improve efficiencies. Half of the specialty colleges responded to the survey and, of these, four submitted financial information.

In October 2008, the Certification Fee Task Force informed the AOA Board of Trustees about the results of the survey and recommended approval of a second survey and a meeting with the specialty colleges to understand their concerns. The AOA Board of Trustees approved the plan. The specialty colleges were re-surveyed in January 2009 and a meeting was arranged for March 2, 2009.

March 2009 Meeting with the Specialty Colleges

The Certification Fee Task Force called a meeting of specialty college representatives to seek their input on areas in postdoctoral training for re-engineering. The meeting was well attended with specialty college representatives either in-person or on the teleconference call.

The meeting began with a review of the recent accomplishments to improve the workflow in postdoctoral training, including information on:

- CODE, an electronic portal allowing certifying boards to view member records in the AOA database, and
- FILEWORKS, an electronic mailbox allowing specialty colleges and the AOA to send secure communications over the Internet and eliminate the need to send hardcopy letters back and forth.

Following these presentations, there was a discussion of possible ideas to re-engineer the postdoctoral training system. The Chair presented the two concepts raised at the AOA Board of Trustees meeting by the Chair of the Council on Postdoctoral Training: 1) the need for improved financial support of the specialty college education and evaluating committees, and 2) the need for a new inspection process. Other re-engineering ideas presented included:

1. Studying the Accreditation Council on Graduate Medical Education system to learn its structures and processes;
2. Finding a funding stream for the Education and Evaluating Committees separate from the certification fees;
3. Place efforts on further development and integration of disparate electronic postdoctoral data systems;
4. Commit the necessary resources to the development of all subspecialties if osteopathic medicine is trying to be a complete profession.

However, there was forceful discussion that the idea of streamlining processes was no longer sufficient. Instead, it was suggested that a fundamental restructuring of the entire postdoctoral training process was needed so that the outcomes of the medical education process are clearly defined and the specialty colleges know their roles in the process. This included discussion of the need to fund the postdoctoral process through fees other than the certification fees. The specialty colleges believe the certification fees should be limited to funding certification processes only and not to fund education and evaluating committee expenses.

Discussion and Conclusion

The specialty colleges strongly articulated the need for a fundamental redesign of the postdoctoral training system – a purpose for which the Certification Fee Task Force was not designed and is not capable of addressing. Elements of the re-design include: 1) definition of the intended outcomes of the postdoctoral training process, 2) agreeing on the specialty and subspecialty areas that define a complete branch of medicine and financially supporting those areas, 3) definition of the exact roles and responsibilities of each party in the postdoctoral training process, and 4) creating an appropriate funding stream to underwrite the costs of the postdoctoral training process.

The need for a restructuring of postdoctoral training is further underscored by the complaints of unacceptable delays in the postdoctoral and certification approval processes, particularly in the nexus between postdoctoral education and certification.

The Certification Fee Task Force concluded that the real issue is much larger than the adjustment of certification fees as originally set forth in the purpose of the Task Force. The Task Force also concluded that a comprehensive review and redesign of the entire postdoctoral training process is needed. The Task Force also recognizes that it does not have the expertise needed to complete that comprehensive review. However, the Certification Fee Task Force also discussed the need to balance long-run and short-run objectives. Specifically, the specialty colleges need additional financial support now and cannot wait for the AOA to complete its redesign of the postdoctoral processes. The Certification Fee Task Force believes that the AOA should find additional monies, even if it is only incremental, to support the specialty college education and evaluation committees.

Recommendations

The Certification Fee Task Force was created to evaluate the costs of Education and Evaluating Committees and make recommendations to adjust the certification fees to accommodate some or all of the costs. The specialty colleges, however, are seeking a more fundamental redesign of the overall postdoctoral training system, which the Certification Fee Task Force supports.

The Certification Fee Task Force makes the following recommendations:

1.) The AOA should form a new Task Force on Postdoctoral Training Redesign and Funding which should include a subcommittee of the Council on Postdoctoral Training experts to perform a comprehensive review and make recommendations for the redesign of the entire osteopathic postdoctoral training process. This redesign should take into account and incorporate the recommendations, where deemed appropriate, of Michael Opipari, DO, Chair, Council on Osteopathic Postdoctoral Training as presented to the 2009 AOA Board of Trustees Midyear meeting and should work to ensure that the entire osteopathic postdoctoral training process be made more valid, reliable and efficient.

The new Task Force should study, not necessarily limited to, the following items:

(a) definition of the intended outcomes of the postdoctoral training process; (b) agreeing on the specialty and subspecialty areas that define a complete branch of medicine and financially supporting those areas; (c) definition of the exact roles and responsibilities of each party in the postdoctoral training process; and (d) creating an appropriate funding stream to underwrite the costs of the postdoctoral training process.

2.) While this new Task Force works to make recommendations to redesign the osteopathic postdoctoral training process, postdoctoral training fees charged to OGME Training Programs should be increased by $25.00 per intern/resident. This fee would be combined with the $15.00 per certified member fee that is remitted to the specialty colleges to support their education and evaluation committees. Although this increase in fees will not completely alleviate the costs of the specialty colleges that are being incurred to subsidize the funding of their education and evaluation committees, it will begin to offset those costs. It is recommended that these fees be reviewed and incrementally adjusted, annually, to meet the needs of maintaining or improving the quality of the osteopathic residency training programs within those facilities, until the review and recommendations of the new Task Force are implemented.

3.) In the long-term, as the costs of postdoctoral training approval processes decrease through the redesign and reappropriation of costs to the training programs, the Specialty Certification Fee amount being distributed to the specialty colleges should be reapportioned to the Specialty Boards, which will be incurring the costs of developing and maintaining Osteopathic Continuous Certification and incurring the costs of supporting the increasing number of conjoint examination committees.

We thank the many members of the Specialty Colleges, their Executive Directors and Staff that participated in providing guidance and input to our Task Force and appreciate the ability to serve the osteopathic profession.

Res. 37-A/2009 - AOA CATEGORY 1-A CREDIT FOR FORMAL JUDGING OF OSTEOPATHIC CASE PRESENTATIONS AND RESEARCH POSTER PRESENTATIONS CONDUCTED BY AN AOA CME SPONSOR

RESOLVED, that osteopathic physicians serving as formal judges for osteopathic clinical case presentations and/or research poster presentations be awarded AOA Category 1-A hours on an hour-for-hour basis up to a maximum of 10 hours per AOA 3 year CME cycle. 2009

Res. 40-A/2009 - INDUSTRY TRANSPARENCY STANDARDS

The American Osteopathic Association:

- acknowledges the contributions made by pharmaceuticals, biologics, and medical devices to the improved health, management of disease, and enhanced life function for millions of patients cared for by osteopathic physicians;

- acknowledges concerns regarding the perception that pharmaceutical and device companies have undue influence over physicians;
- affirms its commitment to providing all osteopathic physicians, their patients, and the public timely, accurate, and relevant information on advances in medical science, treatment of disease, prevention, wellness, and other information that advances mental and physical health;
- continues its commitment to life-long learning for all osteopathic physicians;
- supports transparency in its partnerships by creating a public Web site that discloses all partnerships entered into to advance life-long learning;
- will further advance transparency by encouraging all partners to disclose fully their relationship with the AOA and other organizations;
- directs its Council on Continuing Medical Education to adopt and implement transparency standards;
- discourages business practices that interfere with the patient-physician relationship, attempt to unduly influence the practice of medicine, or attempt to inappropriately persuade patients to seek services or products; and
- stands resolute that our commitment to advancing medical science, quality health care, the treatment of disease, and transparency in our actions, along with the ethical code by which our members serve, are the principles by which we engage Industry partners. 2009

Res. EC2-M/2010 - REVIEW OF THE UNIFORM STANDARDS
Approved Recommendations 1, 2, 4, 6-13, with the exception of the recommendations (3 and 5) that request the addition of additional members to the HFAP and BOE – Those recommendations need to provide a financial impact analysis.

Introduction

The American Osteopathic Association is actively engaged in the process of standard setting and the subsequent enforcement of standards through accreditation and certification processes. These activities take place within the context of hospital and health facilities accreditation, across the continuum of osteopathic medical education (i.e., predoctoral, postdoctoral and continuing osteopathic medical education) and in the numerous board certification programs.

There is considerable variation in the AOA's standard-setting, accreditation and certification processes. The processes used within one bureau/council/committee ("governing entity") are not followed by others. The variation is found across the full range of a governing entity's processes, from issues of appointment and composition to the process used for developing standards to the process by which accreditation and certification decisions are made and appeals conducted. This is not surprising. The processes have developed independently and within different governing entities to suit the needs, purposes and circumstances of each particular governing entity. However, the variation could also be a concern because the AOA could be challenged as to why a process used in developing or enforcing standards is not used in a different area.

At its 2006 Interim Meeting, the Board of Trustees created the Uniform Standards Review Working Group (USRWG) and gave it responsibility to study the AOA's accreditation, certification and standard setting processes. The USRWG included leadership of the governing entities involved in standard-setting, certification and accreditation programs. The goals of the USRWG were: 1) to identify the processes used to set standards and conduct accreditation and certification activities within the AOA and other organizations, and 2) to establish a set of recommended practices. It should be emphasized that the USRWG's goal is not to mandate implementation of certain processes. Rather, different governing entities work in different areas and, consequently, may use certain processes to produce the best outcome. Accordingly, the USRWG's goal is to identify processes and have each governing entity consider the recommended practices. Thereafter, where variation occurs, the AOA can identify and explain why a governing entity follows a different practice in its standard setting activities.

At its 2008 Interim Meeting, the AOA Board of Trustees received a report outlining the "Uniform Standards" for all accreditation and certification activities within the AOA. The USRWG report contained 64 standards, covering such topics as the mission statement, composition of the governing body, writing standards, evaluation of standards, scoring tools, periodic revision of standards, appeals processes, and reconsideration processes (see Attachment 1, page 10). The AOA Board approved the Uniform Standards report and asked the USRWG to compare the AOA's accreditation and certification processes to the Uniform Standards template and report back at the 2009 Interim Meeting.

At its 2009 Interim Meeting, the AOA Board of Trustees heard a presentation from Karen J. Nichols, DO, Chair, USRWG, comparing the processes of each accreditation/certification governing body to the Uniform Standards. In summary, the governing bodies were either in compliance or planned to come into compliance with almost 96% of the uniform standards. The AOA Board asked the USRWG to review the 4% not in compliance and determine: 1) if the exceptions to the Uniform Standards were appropriate; or 2) the Uniform Standards needed modification. The AOA Board asked for a report back in February 2010.

Evaluation of Exceptions

The USRWG met by conference call on December 10, 2009 to review each Item not in compliance with the Uniform Standards.

Exceptions to the Uniform Standards

Uniform Standards	
Mission of Governing Entity:	**Exception**

Uniform Standards	
The mission statement should be reviewed periodically and published on the appropriate website, as well as provided to all institutions/programs prior to inspections.	**Item (A)** COPTI - BOE document and the COPTI document conflict.

Item (A)

COPTI explained its concern regarding its mission with respect to the BOE mission, as stated in the BOE Handbook. The COPTI indicated that one section of the BOE Handbook states that the BOE is the OPTI accreditation body. Another place in the BOE Handbook states that the COPTI is the OPTI accreditation body. One statement agrees with the COPTI document and the other does not agree.

Recommendation 1: The USRWG recommends that the Bureau of Osteopathic Education reconcile the mission statement conflict between the BOE and COPTI documents and submit revisions for approval to the AOA Board of Trustees.

Appointment to the Governing Entity:	**Exception**
Criteria:	
4. The governing entity should include:	
a. Members of the regulated group	
b. Members of the applicable educating group	**Item (B)** COPTI - what is the applicable educating group?
c. Experts in the area	
d. Public Members	**Item (C)** PTRC – public members are not appropriate for this Council; public input available elsewhere. CCME – members appointed by the President of the AOA to represent various stakeholders, as per statute.
5. Stakeholder representation is to be a consideration, but as a representative democracy and not as a pure democracy.	
6. Learners in osteopathic predoctoral and	**Item (D)** PTRC - Learner members are not

postdoctoral levels should be included as appropriate.	appropriate for this Council ; input available elsewhere

Item (B)

Recommendation 2: The COPTI asked for clarification of the applicable "Educating Group." The USRWG discussed this question and agreed that the "regulated" group could also be the "educating" group for the education governing bodies. Since the "educating group" in 1.b. could be the same as the "regulated group" in 1.a., the USRWG recommends the elimination of criterion 1.b. from the Standards template.

Item (C)

There was considerable discourse on appointing Public Members to education accreditation bodies. None of the education accreditation bodies, except COCA, currently have "Public Members." The argument against having a "Public Member" on PTRC is that it is unlikely that the public member would be aware of the underlying rationale for a standard. The benefit of having a public member is that their purpose is to ensure that processes are followed and that policies instituted benefit society.

Concluding that adding public members to the education accreditation bodies might be beneficial, the USRWG agreed that immediately adding new public members to all the education accreditation governing bodies has a financial impact and may cause disruption. Therefore, the USRWG agreed that public members should be added incrementally to the education governing bodies, beginning with the Bureau of Osteopathic Education since it is over the CME accreditation, COPTI accreditation and PTRC approval processes.

Recommendation 3: As the governing body for all education processes, the Bureau of Osteopathic Education may be the appropriate venue to provide a public member. The USRWG recommends that a public member be added to the Bureau of Osteopathic Education with consideration of adding public members to the other education governing bodies at a later date.

Item (D)

This exception generated considerable discussion and the USRWG asked for additional information. Some thought it to be inappropriate to have students or residents on accreditation or approval bodies since the osteopathic profession is small. As members of a committee, students and residents may be given confidential information on their peers.

The USRWG asked for additional research on this topic. Konrad Miskowicz-Retz, PhD, Secretary to COCA, reviewed the policies of other accreditation agencies and found that two of the eight reviewed had students as members. The entities reviewed were:

- American Osteopathic Association Commission on Osteopathic College Accreditation (AOA-COCA);
- Liaison Committee on Medical Education (LCME);

- American Dental Association Commission on Dental Accreditation (CODA);
- American Optometric Association Accreditation Council on Optometric Education (ACOE);
- American Veterinary Medical Association – Council on Accreditation (AVMA-COA);
- American Council on Pharmacy Education (ACPE);
- Council on Chiropractic Education (CCE); and
- American Podiatric Medical Association – Council on Podiatric Medical Education (APMA-CPME)

The LCME includes two students as members and the CODA includes one student as a member. The other six agencies did not include students as members.

On the postdoctoral side, the Accreditation Council for Graduate Medical Education (ACGME) includes residents on their Residency Review Committees.

Joshua Prober, JD, AOA Legal Counsel, indicates that inclusion or exclusion of "learners" as members does raise legal concerns. However, those concerns can be managed through effective procedures on conflict of interest and disqualification of members, etc. Thus, legal concerns should not drive the outcome and PTRC should reconsider its underlying concerns and objectives in excluding learners.

The USRWG asked the PTRC if "learner" members are not appropriate because it is stated that way in the PTRC Handbook or because it is it not "advisable" to have "learners" on PTRC? The PTRC responded that its Handbook does not include a student or resident as members. The USRWG is making no recommendation for change in the "learner" membership of the governing bodies. The Standards template wording "as appropriate" allows flexibility for each governing body, including PTRC, to decide what is appropriate.

Appointment to the Governing Entity:	Exception
The chair should evaluate the performance of each member at regular intervals and make recommendations for possible re-appointments.	**Item (E)** The BOS chair can evaluate the BOS subcommittee chairs but not affiliate members.

Item (E)

The Bureau of Osteopathic Specialists Chair has no say over appointments to the BOS. However, the BOS Chair could institute a policy whereby subcommittee chairs evaluate their members each year. That information could then be transmitted back to the certifying board. For subcommittee members who are not functioning appropriately, the certifying board would be asked to consider naming a replacement.

Recommendation 4: The USRWG recommends that the Bureau of Osteopathic Specialists develop a process to evaluate BOS subcommittee members and submit that process to the AOA Board of Trustees for approval.

Appointment to the Governing Entity:	Exception
Public Members:	
Public members should be considered for appointment based upon their specific expertise. Public members are to assist the governing entity in fulfilling its role as "protector" of the public.	**Item (F)** BHFA – consideration of public member on hold until newly configured BHFA has formed a cohesive group and the work of several new task forces is complete.

Item (F)

The Bureau of Healthcare Facilities Accreditation is not opposed to having a public member. However, the BHFA was recently reconfigured and the BHFA Chair recommends that the current group needs time to establish its processes before bringing in a public member. The BHFA Chair also recommends that the BHFA look at 2011 as a target date for adding a public member.

Recommendation 5: The USRWG recommends that the Bureau of Healthcare Facilities Accreditation study the concept of adding a public member and make a recommendation to the AOA Board of Trustees at the appropriate time.

Scoring Tool for Compliance with Standards:	Exception
4. Standards shall be judged "met, not met, or exceeds."	**Item (G)** Some HFAP standards are scored on a yes/no or a met/not met basis. Other standards are scored on a percentage of met basis as appropriate to the individual standard.
5. The level of performance of the standards must be tied to the number of years of award.	**Item (H)** The industry standard for healthcare facilities accreditation in the United States is three years for full accreditation. In the area of clinical laboratories, two years for full accreditation. HFAP uses these criteria.

Items (G) and (H)

Regarding "met or not met," the BHFA tries to score standards as met or not met but sometimes a percentage met is the only appropriate measure.

Regarding tying the level of performance to the years awarded, the BHFA is held to industry standards that require three-year accreditations for hospitals and two-year accreditations for laboratories. The laboratory accreditation award of 2-years is set by the Centers for Medicare and Medicaid Services (CMS).

Recommendation 6: The USRWG recommends that the BHFA should be granted exceptions to these scoring standards.

Scoring Tool for Compliance with Standards:	Exception
6. Previous award determinations should affect the current award determination if the deficiencies identified are continuing from prior inspections. Additionally, this history should affect the award determination if new deficiencies are identified in such numbers that the institution has effectively exchanged new deficiencies with old one that remain in a corrective action mode.	**Item (I)** BHFA - Previous deficiencies and complaints against a facility are considered and reviewed for correction and continuous compliance during the survey process. Each facility is potentially eligible for a full three year accreditation when able to demonstrate compliance with the standards. Facilities are required to track corrective actions to assure that the corrections achieve their intent. Five percent of facilities receive a look back survey at mid-cycle (eighteen months) to spot check for continued compliance.

Item (I)

The BHFA must adhere to industry standards. It cannot reduce the award based on a look back at deficiencies. The institution is either awarded three-year accreditation or it is not; there is no reduced award in the healthcare facility accreditation industry.

Recommendation 7: The USRWG recommends that BHFA be granted an exception to this standard.

Periodic Review of Standards for Update and Revision:	Exception
1. Each governing entity should establish a regular interval for scheduled standards review and update (may vary from two to five years).	**Item (J)**
2. Every substantive update and revision should be prepared and accompanied by an explanatory rationale and anticipated cost.	**Item (K)** BHFA – CMS establishes new standards without rationales. The rationales for new CMS standards are the need to comply with Medicare to be eligible for reimbursement of care provided to Medicare and Medicaid patients. Non-Medicare standards are usually consensus standards developed by national healthcare consortiums. Anticipated costs of compliance are not considered for each standard update at present.
3. Every update/revision and rationale should be posted on the appropriate website and sent by email and hardcopy to all identified constituents for public comment prior to enactment.	**Item (L)** COPT – not sent by hardcopy to program directors and DMEs; e-mailed in COPT newsletter and posted on DO online COPTI - Hardcopies are not mailed. Should they be?
4. The comment period prior to final approval must be specified by policy as appropriate to the type of governing entity and allow for meaningful input from key stakeholders and the public at large.	**Item (M)** BHFA - Medicare updates are nonnegotiable and usually effective at time of publication. Consensus standards are given a six months advance warning for facilities to come into compliance. The BHFA always considers feedback from facilities commenting in good faith and may adjust standards in response.

5. The time segment prior to implementation must be specified by policy as appropriate to the type of governing entity.	
6. Every update/revision and rationale should be posted on the appropriate website and sent by email and hardcopy to all identified constituents prior to enactment.	**Item (N)** COPT – Too difficult to separate by specialty for each specialty's program directors.
7. All new and revised standards are to be implemented on July 1 unless there is a pressing need for a different implementation date with justification.	**Item (O)** BHFA - Updates are implemented as they are developed throughout the year. They are not tied to any calendar month or school year.

Item (J)

While the accreditation and certification governing bodies require the organizations that report to them to have periodic reviews of standards, the governing bodies themselves do not have such a requirement. It is believed that the governing bodies themselves have an obligation to undergo a period comprehensive review of their processes and standards. While there are several potential mechanisms to ensure periodic review of the governance bodies, it is suggested that, instead of creating a new hierarchy or infrastructure to accomplish this goal, the governing bodies place this requirement within their own Handbooks of Operations. Since each governing body is different, it is recommended that each decide the frequency of document reviews, not to be less often than once every five years. The governing body can decide its process to review documents, such as reviewing its documents at one specific time or reviewing segments of its documents over the specified period of time. The Bureau of Osteopathic Education should ensure that its subordinate councils periodically review their standards. At each governing body's review, the body should also consider the continuing relevance of the various provisions of the Standards template to make recommendations to the AOA Board for possible revision in light of the changing milieu of certification and accreditation.

Recommendation 8: That the BOE, BHFA, COPT, COPTI, PTRC, and CCME place the following language within their Handbooks:

It is the responsibility of this governing body to review its Handbook and standards documents. These documents will be reviewed every X years after 2009. (Review of documents may be conducted at one specific time or spread throughout the specified time period, depending on the needs of the governing body.)

Item (K)

Recommendation 9: The USRWG recommends that BHFA be granted an exception to this standard.

Item (L)

This standard generated considerable discussion. The cost, both in terms of human resources as well as postal resources, could be excessive if governing bodies are required to send a hardcopy for each revision to all identified constituents. The COPT would need to mail standards revisions to potentially hundreds of residency directors. The administrative hurdles would be enormous. It was strongly urged that the method of communication (email, hardcopy, fax, or other) be secondary to the issue of "communicating." While the governing bodies should be required to communicate with constituencies, the Chairs of the governing bodies should be given the flexibility to determine the most appropriate method for communicating an issue.

Recommendation 10: The USRWG recommends that the AOA Board approve that the standard be changed to read, "Every update/revision and rationale should be posted on the appropriate website and appropriately communicated to all identified constituents for public comment prior to enactment."

Item (M)

The BHFA allows key stakeholders six months to comment on consensus standards. Medicare standards, however, must be implemented effective at the time of publication and are non-negotiable.

Recommendation 11: The USRWG recommends that the BHFA be granted an exemption from this standard with respect to Medicare standards.

Item (N)

Same as Item (L).

Recommendation 12: The USRWG recommends that the AOA Board approve that the standard be changed to read, "Every update/revision and rationale should be posted on the appropriate website and ~~sent by email and hardcopy~~ APPROPRIATELY COMMUNICATED to all identified constituents for public comment prior to enactment."

Item (O)

As a non-educational accreditation body, the BHFA wanted to make sure that others were in agreement that BHFA standards should not be implemented only on July 1. The USRWG agrees with BHFA and concludes that BHFA is not in conflict with the standard.

Additional Considerations

The USRWG discussed issues beyond those in the Uniform Standards template. To wit, the group also discussed: (1) potential conflicts in the OPTI approval process, and (2) congruence in the education governing body mission statements.

Recommendation 13: The USRWG recommends that the Education Policy and Procedure Review Committee address two issues:

(1) The BOE serves as both the accrediting body for OPTI action and the appeal body for OPTI actions. Does this place the OPTIs in a possible "double jeopardy" situation?
(2) It is difficult for individual education governing bodies to construct congruent mission statements. This activity will likely need some oversight or coordination.

Conclusion

The USRWG considered the exceptions to the Uniform Standards, as requested by the AOA Board of Trustees. The USRWG recommends:

That the AOA Board of Trustees accept this report by the Uniform Standards Review Working Group; and

That the AOA Board of Trustees approve the recommendations contained within this report and direct the Bureau of Osteopathic Education, the Bureau of Osteopathic Specialists, the Council on Osteopathic Postdoctoral Training, the Council on Continuing Medical Education, the Council on Osteopathic Postdoctoral Training Institutions, and the Program and Trainee Review Council to implement the recommended changes.

Uniform Standards Template

In October 2008, the American Osteopathic Association (AOA) Board of Trustees approved the Uniform Standards for Accreditation (Resolution 9, C/08). The Board expects all AOA accreditation activities to comply with the approved Uniform Standards.

Mission of Governing Entity:
Every governing entity should have a mission statement approved by the AOA Board of Trustees which codifies the over-arching focus and philosophy of that entity.
The mission statement should be reviewed periodically and published on the appropriate website, as well as provided to all institutions/programs prior to inspections.
The accreditation/certification process should be consistent with the governing entity's mission.

Premise of Evaluations:
Evaluations of institutions/programs should be summative to ensure that they meet threshold standards for approval of the institution/program.
The governing entity must have processes in place to give formative recommendations to institutions/programs to move them in the direction of achieving quality improvement.
As part of the evaluation process, the institution/program should be evaluating its own processes continuously and be able to offer its rationale, goals and approach to implement the improvements to achieve excellence.
Appointment to the Governing Entity:
Criteria:
7. The governing entity should include:
a. Members of the regulated group
b. Members of the applicable educating group
c. Experts in the area
d. Public Members (see below)
8. Stakeholder representation is to be a consideration, but as a representative democracy and not as a pure democracy.
9. Learners in osteopathic predoctoral and postdoctoral levels should be included as appropriate.
Term Length:
Long enough to learn the workings of the governing entity and short enough to bring in new perspectives. More frequent, shorter terms are advisable.
Term Limits:
It is recommended that the governing entity consider term limits, keeping in mind the balance between the benefits of steady hands/institutional wisdom with the importance of bringing new ideas and perspectives into the mix through turnover.
The chair should evaluate the performance of each member at regular intervals and make recommendations for possible re-appointments.

Number of Governing Entity Members:
Large enough for diversity and small enough to be functional, which is generally considered to be between 9 and 15.
Public Members:
Public members should be considered for appointment based upon their specific expertise. Public members are to assist the governing entity in fulfilling its role as "protector" of the public.
Orientation for New Governing Entity Members:
An orientation shall be conducted by staff for all new governing entity members following a protocol approved by the existing governing entity members.
Standards:
Premise of Standards:
Standards should be written at a threshold level that reflects excellence in education and healthcare delivery, while encouraging quality improvement.
Development and Structure:
10. Standards should be clear, measurable, beneficial and achievable.
11. Each standard should articulate an independent aspect that can be evaluated.
12. Standards should state what must be accomplished and the purpose for the standard should be clear.
13. A standard should be a positive declarative sentence in the third person.
14. Standards are rules, not guidelines.
15. Standards provide an objective measurement of performance.
16. A crosswalk should be maintained to provide examples for governing entities, evaluators/inspectors and those being inspected.
17. For tracking purposes, all standards must be named and referenced by name in preference to numbers.
18. Proper terminology for standards (requirements) is "must" or "shall."
Rubric for Meeting Standards:
The content structure of the rubric should include the following:
5. What will be measured;
6. How it will be measured;
7. Defined process to obtain/record the information/results; and
8. Rubrics can be applied in the evaluation process as well as the summary of findings and recommendations for an institution/program.

Scoring Tool for Compliance with Standards:
7. Standards shall be judged "met, not met, or exceeds."
8. The level of performance of the standards must be tied to the number of years of award.
9. Previous award determinations should affect the current award determination if the deficiencies identified are continuing from prior inspections. Additionally, this history should affect the award determination if new deficiencies are identified in such numbers that the institution has effectively exchanged new deficiencies with old one that remain in a corrective action mode.
Periodic Review of Standards for Update and Revision:
10. Each governing entity should establish a regular interval for scheduled standards review and update (may vary from 2 to 5 years).
11. Every substantive update and revision should be prepared and accompanied by an explanatory rationale and anticipated cost.
12. Every update/revision and rationale should be posted on the appropriate website and sent by email and hardcopy to all identified constituents for public comment prior to enactment.
13. The comment period prior to final approval must be specified by policy as appropriate to the type of governing entity and allow for meaningful input from key stakeholders and the public at large.
14. The time segment prior to implementation must be specified by policy as appropriate to the type of governing entity.
15. Every update/revision and rationale should be posted on the appropriate website and sent by email and hardcopy to all identified constituents prior to enactment.
16. All new and revised standards are to be implemented on July 1 unless there is a pressing need for a different implementation date with justification.
17. All entities are encouraged to evaluate and research their processes to add to the body of literature in accreditation.
18. The implementation date must be clearly marked on the title page of the document.
Appeals Process:
The accreditation and certification process must include access to an appeal process. The appeal process must include access to review first, within the AOA Board of Trustees' departmental structure in which the decision was made and, second, if necessary, a subsequent appeal through the AOA Board of Trustees' appeal process.
The initial accreditation or certification decision of a governing body should provide affected institutions, programs or individuals with a written document containing all specific details on the basis for a decision, including any standards that are not met so that the individual, program or institution is provided with notice of the alleged deficiency or deficiencies that led to a decision.

Appeals are not for a "de novo" review of the issue. The purpose of the appeal is to correct factual and/or procedural errors and is not to second-guess the judgment of the governing entity.
The appeal committee of the governing entity must consider appeals made on the basis of:
4. A substantive factual error(s) that led to the challenged decision; or
5. Failure to follow established process and procedures (e.g., conflict of interest, no quorum, inspectors did not have requisite expertise, etc.) that affected the challenged decision; or
6. An outcome from the governing entity that is not consistent with prior decisions using the same standards.
Appeals must be supported by documentation of the factual and/or procedural error. Appeals may not be based on new information or documentation. Information/ documentation must have been available and provided during the initial review decision.
Requests for appeal should be reviewed by the chair of the appeal committee in consultation with the Secretary of the bureau, council or committee that made the challenged decision to determine if it meets the requirements for appeal, as outlined above.
A decision to not allow appeal can be reviewed through the AOA Board of Trustees appeal procedure.
An appeal committee of a governing entity should be comprised of individuals who are familiar with the standards at issue, but dispassionate in the appeal.
Bureau/council/ committee members who voted on or otherwise participated in the decision in question must **not** serve on the appeal committee.
The appeal should proceed soon after the challenged decision. Each governing entity should set a time in which the appeal must be brought and should balance the need to provide the affected individual/program/institution with sufficient time to prepare an appeal with the need to implement accreditation/certification decisions. The appeal procedures should allow an appellant no more than 180 days from receipt of a decision or discovery of an appealable error to request an appeal. The appeal committee shall reply within 21 days of receiving an appeal and provide the appellant with an outline of the plan for hearing in revealing the appeal or advising the appellant that the appeal petition does not meet the criteria for appeal.
The appeal process should be structured so that the governing entity's appeal committee would conduct a hearing and reach a decision within 180 days after the appeal is approved by the Chair to go forward.
Possible decisions on an appeal include: affirmation of the governing entity's decision; or overturning the governing entity's decision.

If an appeal committee votes to overturn the decision of the governing entity, it may be appropriate for it to also refer the matter back to the governing entity for further consideration.
It is the obligation of the parties to the appeal to provide information that will allow the appeal committee to resolve the issue before it. However, in rare circumstances, it may also be appropriate for the appeal committee to defer decision and request additional information.
Reconsideration Process:
Appeals are limited to the circumstances set out above. Governing entities may also provide a reconsideration procedure that allows for consideration of new information.
Requests for reconsideration are to be reviewed by the same governing entity responsible for the initial decision and can be based on new information.
An appellant has the option of entering the appeal process if the reconsideration fails.
Where a reconsideration process is provided, an appeal committee may direct that an appeal petition based on new information or documentation back to the governing entity, which will have the option of accepting the reconsideration which may include the presentation of new information.

Res. 7-M/2010 - APPLICATION OF RESOLUTION 56 TO CERTIFICATION OF ADDED QUALIFICATION (CAQ)

Policy of the American Osteopathic Association notes that osteopathic physicians who enter the AOA certification process for a Certification of Added Qualifications (CAQ) through Resolution 56 will be accepted to enter the examination process, provided that the candidate holds a corresponding AOA primary or subspecialty certification to which the CAQ is dependent, regardless of the pathway for the ABMS Certificate of Added Qualification. 2010

Res. 9-M/2010 - GRANTING OF CERTIFICATION OF ADDED QUALIFICATIONS (CAQ) FOR ITEM WRITERS OF INITIAL CERTIFICATION EXAMINATIONS

Policy of the American Osteopathic Association notes that (1) item writing content experts for initial examinations for Certification of Added Qualifications (CAQ) in new specialties be granted a time-limited CAQ in that specialty for a five (5) year period; (2)to qualify, each item writing content expert must meet all of the requirements for certification, with the exception of taking and passing the certification examination; (3) to qualify, each item writing content expert must have written at least the number of items prescribed by the examination committee; (4) to qualify, each item writing content expert must also be currently certified by the appropriate American Board of Medical Specialties (ABMS) certification board, if applicable; (5) boards with unique circumstances may request a waiver of the ABMS board certification requirements; and (6) all item writing content

experts are precluded from taking any certification examination for a period of two (2) years from the last date of service as an item writing content expert. 2010

Res. 13-M/2010 - BUREAU ON INTERNATIONAL OSTEOPATHIC MEDICAL EDUCATION AND AFFAIRS – WHITE PAPER III UPDATE [See Res. 37-A/2008]

The American Osteopathic Association (AOA) recognizes that it and many of its members, component societies, and institutions desire or need to interact with various governmental and regulatory bodies, scientists, educational institutions, and health care practitioners within the international community. It also appreciates that different languages, cultures, customs, and health practices make communication more difficult and increase the potential for miscommunication. The AOA therefore desires, in all interactions and communications, that information gathering, education, collaboration, and cooperative ventures be conducted in a professional and ethical manner that accurately represents osteopathic medicine as practiced in the United States.

To this end, the AOA has developed this White Paper and stresses the responsibility of integrating ethics and respect for the known history, authority, and relationships currently governing international health and medical policy when communicating information concerning the AOA and the osteopathic profession in the United States to individuals or organizations unfamiliar with same outside the US border.

HISTORY & PURPOSE

The AOA has sought input and recommendations from its Bureau on International Osteopathic Medical Education and Affairs (BIOMEA) since its formation as a Council in 1996. Furthermore, the BIOMEA interacts directly with the AOA Board of Trustees to formulate and issue pertinent "White Papers" as informational pieces to describe the scope, direction, and activity of the AOA in the international arena.

In 2000, BIOMEA's initial recommendations were approved and an International White Paper was issued. The initial White Paper focused upon ethical interactions between components of the AOA and those international healthcare practitioners and organizations having significant relevance to the osteopathic profession worldwide. Topics included:

1. AOA Official Interactions
2. Interactions with International Governmental Officials and/or Health/Medical Regulatory Bodies
3. Interactions with International Colleges of Medicine or Osteopathy or Their Graduates
4. American Osteopathic Rights in International Settings
5. International "Osteopathic" Rights in the United States
6. International Membership in the AOA

The second White Paper (2005) reaffirmed conclusions reached in the first White Paper (2000) while providing additional background, insight, and direction for expanding and building upon other

international interactions. In particular, the second White Paper focused on the following topics related to international directions by the AOA and its members:

1. Communication
2. Identity
3. Politics & Diplomacy
4. Research & Education
5. Service
6. Resources

The second White Paper also initiated an addendum of *Potentially Significant International Organizations & Groups,* in an attempt to identify organizations and groups within and outside the United States with which the AOA may have contact or correspondence in discussing international osteopathic curricula, accreditation, certification, and/or licensure.

The purpose of this third International White Paper (2007) is to review and update previous White Papers and to describe the current and anticipated scope and activity of the American Osteopathic Association in the international arena. It is also intended as an informational document to provide relevant background and perspective for the AOA and its members for responsible decision-making relative to international education, research, practice and health policy. While not all inclusive, the perspective and principles delineated in this third International White Paper should serve as guidelines for most international interactions.

PREAMBLE

For those in the United States of America, involvement in global health has grown beyond the moral, humanitarian motives made by individual practitioners and institutions wishing to contribute to the healthcare needs of populations in underserved nations. Now, for a variety of personal and practical reasons, U.S. physicians and physicians-in-training are also looking at educational and practice opportunities outside the United States. Osteopathic (DO) and Allopathic (MD) medical students increasingly seek safe and meaningful international educational opportunities; many desire assurance that their earned degrees will prepare them for the future implications of globalization.

Great challenges and tremendous opportunities in the field of healthcare have also been created by globalization. We are experiencing an increased permeability of our borders to travel-related illnesses and to diseases thought to have been eradicated in the United States of America and we fear that our public health infrastructure may be ill-prepared for intentional or unintentional introduction of biologic agents capable of creating epidemic illness. Conversely, international colleagues' experiences, approaches, and knowledge have never been more readily accessible.

As borders between countries, information, and economies lose their traditional relevance, the need to understand and interact with international healthcare colleagues and policy makers grows. In an accelerating fashion, health policy decisions and evidence-based experience in medical, surgical, manual, and other healthcare fields outside our national borders directly impact our own internal

patient populations and the practices of our osteopathic medical graduates. The impact on healthcare providers, educators, researchers, and policy makers brought about by such globalization necessitates coordinated decisions based upon a clear understanding of the global picture.

The need to think and act globally to assure the quality of healthcare practitioners – both osteopathic and allopathic – crossing borders (e.g., between Canada and the United States or within the European Union) must embrace responsible health policy considerations as it impacts access, safety, and portability. To this end, the AOA expanded its involvement with international groups and organizations and has encouraged ambassadors from the AOA or its practice affiliates to interact with global healthcare entities such as the World Health Organization, the World Osteopathic Health Organization, the Fédération Internationale de Médecine Manuelle, the Global Health Council and the Osteopathic International Alliance. These interactions have resulted in numerous processes to evaluate international curricula and educational standards and prompted efforts to define and develop uniform educational and/or licensure standards relative to osteopathic medicine. Such involvement has greatly expanded the perspective and understanding of numerous health policy makers around the globe and within the AOA membership itself concerning the osteopathic profession. In particular, these efforts have raised awareness of the global role of the AOA in health care policies and principles and its commitment to distinctive contributions to high quality medical care (health systems change, access, reliability, and patient protections).

Globalization is affecting the osteopathic profession, but it is not solely an economic or trade phenomenon; it is a convergence of cultures. It leads inevitably to continuous cultural evolution and an increase in quality standards. The processes of which should be undertaken with humility and an understanding of the national and professional cultures involved.

INTRODUCTION

The osteopathic medical profession originated in rural America in 1892. Almost immediately graduates emigrated to other countries. Historically, national boundaries and practice rights served to create cultural divergence within the osteopathic profession. As a consequence, the osteopathic philosophy, science, and art have evolved differently over time on numerous continents with varying impact on healthcare delivery in each country. In some countries, the philosophy, science and art of osteopathy needed to operate in a limited spectrum-of-practice setting, linked or not to parallel standards of medical diagnosis and treatment. In some countries, selected elements of the osteopathic culture were transferred in post-graduate or specialty training settings to full spectrum-of-practice physicians simply as "manual medicine" skills. In yet other countries, these full-spectrum manual medicine physicians seek to expand their understanding of the osteopathic philosophy, science and art. As a consequence of divergence, the recognition of what it means to practice "osteopathically" has become blurred and confusion abounds in both public and professional settings. This confusion complicates efforts by the profession to convey the contribution of knowledge and service they are committed to make in promoting health and fighting disease.

Cultural divergence in healthcare arenas is now being replaced by convergence. This is a direct consequence of increasing transportation, communication, and information exchange and is seen in the proliferation of national organizations committed to establishing global vision statements and strategic plans that include their international role. Such collaboration is also seen from stakeholders within the osteopathic arena. A number of international organizations, including the Osteopathic International Alliance, the European Register of Osteopathic Physicians, and the World Osteopathic Health Organization, have recently been constituted to address similar issues.

The role that responsible US healthcare organizations can and should play in this convergence of cultures is no longer speculative. The Institute of Medicine's *America's Vital Interest in Global Health* (IOM, 1997) makes a strong case for the importance of global health and the USA's ability and responsibility to foster it. To this end, the Association of Academic Health Centers established a Division of Global Health in 1998 and, in its published *Global Dimensions of Domestic Health Issues (2000),* makes commitments to seek strategic collaborations with other organizations to improve health and health policy internationally. Likewise in 1996, traditionally national organizations such as the American Osteopathic Association constituted the Bureau on International Osteopathic Medical Education & Affairs (BIOMEA).

BIOMEA is currently charged with reporting to the AOA Board of Trustees. Its current mission is stated as follows:

The mission of the Bureau on International Osteopathic Medical Education and Affairs (BIOMEA) is to provide organizational leadership that promotes the highest standards of osteopathic medical education and practice throughout the world and facilitates positive interactions between the AOA, AOA affiliates, and international healthcare organizations. The purpose is to ensure the continued contribution of the American model of osteopathic medicine in the United States (U.S.) and internationally.

BIOMEA seeks to facilitate those public and professional interactions, which increase the understanding and advancement of osteopathic medicine as a complete system of medical care. BIOMEA will promote the osteopathic philosophy that combines the needs of the patient with the current practice of medicine, surgery, and obstetrics, emphasizes the interrelationships between structure, function, and provides an appreciation of the body's ability to heal itself.

This third White Paper combines and updates the first two White Papers, and represents the dramatic and rapid changes that have occurred as a consequence of globalization, outreach by the AOA and its members, and international events. The structure and function of the third International White Paper focus on the following topics related to international interactions and directions by the AOA and its members:

1. AOA Official Interactions
2. Interactions with International Governmental Officials and/or Health/Medical Regulatory Bodies
3. Communication
4. Identity

5. Politics & Diplomacy
6. Research & Education
7. Interactions with International Colleges of Medicine or Osteopathy or Their Graduates
8. American Osteopathic Rights in International Settings
9. International "Osteopathic" Rights in the United States
10. International Membership in the AOA
11. Service
12. Resources

The periodically updated addendum, *Potentially Significant International Organizations & Groups,* identifies organizations and groups within and outside the United States with which the AOA and its members may have contact or correspondence in discussing international osteopathic curricula, accreditation, certification, and/or licensure.

1. AOA OFFICIAL INTERACTIONS

The AOA itself shall be directly represented only by those it has authorized to do so. No interactions by an unauthorized individual, college, specialty organization, or institution should imply a specific AOA status or endorsement, nor be allowed to be represented as such.

The AOA Bureau on International Osteopathic Medical Education and Affairs (BIOMEA) is charged with informing and educating AOA leadership and representatives; gathering, investigating, and recommending policy relative to international osteopathic medical education and affairs; maintaining information used in training international ambassadors and representatives; and serving as a repository for information related to the aforementioned activities. AOA members and affiliates are encouraged to contact BIOMEA and its members and staff with information, recommendations, international contacts, and potential directions for the AOA in meeting its international agenda.

2. INTERACTIONS WITH GOVERNMENTAL OFFICIALS AND/OR HEALTH/ MEDICAL REGULATORY BODIES

Interactions carried on by individuals, colleges, specialty organizations or other U.S. osteopathic institutions to discuss osteopathic medicine should be accomplished in a careful, professional, and ethical manner, accurately representing the American model of osteopathic medicine. Information detailing the international contact name, preferably including telephone, fax, and e-mail information, title and synopsis of discussion, may be sent to the AOA Division of State Government & International Affairs, 142 East Ontario, Chicago, Illinois 60611, Phone (312) 202-8000. While it is not always possible to do so, an advanced call to the AOA may be beneficial and is encouraged.

In dealing with international governmental officials, or health and medical regulatory bodies, the following points may be conveyed:

1. The AOA seeks to better understand the status of international medical communities in the areas of education, research, and health care delivery.

2. The AOA seeks to encourage international recognition, understanding, and acceptance of the American DO degree.
3. The AOA seeks to advance international recognition and value for osteopathic philosophy, as well as its practice and educational standards.
4. The AOA will actively offer assistance and guidance, upon request, to nations or official organizations wishing to provide for the licensure/registration and practice rights of osteopathic physicians educated in colleges of osteopathic medicine accredited by the AOA Commission on Osteopathic College Accreditation (COCA).
5. BIOMEA will, upon request, assist COCA regarding the legitimate authorities or programs from other countries in the development of colleges of osteopathic medicine or osteopathic graduate medical education programs when such entities clearly demonstrate the capacity to be accredited by COCA.

3. COMMUNICATION

The AOA recognizes the need for accurate and ethical communication in relation to international issues, particularly in light of differences in language and culture.

Information into and out of the United States is capable of both supporting a rapidly growing evidence-base for wise healthcare decisions and of confounding appropriate decisions with misinformation. The AOA is dedicated to providing accurate information related to the contributions of its members and the osteopathic approach. To this end, the following elements have been agreed upon:

1. The AOA will act as a clearinghouse for information concerning international applications of the philosophy, science, and art of osteopathy and osteopathic medicine.
2. The AOA will also contribute information to the Osteopathic International Alliance (OIA) clearinghouse so that it may also serve as a credible, reliable international source of information, and contribute to the *Glossary of Osteopathic Terminology* as well as interested governmental, regulatory, and Non-Governmental Organization (NGO) bodies.
3. The Bureau on International Osteopathic Medical Education & Affairs (BIOMEA) will identify persons available to translate Bureau materials into various languages, starting with French, German, and Spanish and eventually all official UN languages.
4. The AOA recognizes the efforts of the American Association of Colleges of Osteopathic Medicine (AACOM) and the Educational Council on Osteopathic Principles (ECOP) to maintain a peer-reviewed *Glossary of Osteopathic Terminology* and encourages an accurate translation into other languages that it might serve as a universal language reference for osteopathic and manual medicine education, research, and clinical discussions.
5. Members of the AOA will refrain from representing the AOA or its official position without the express permission of the AOA.
6. Members of the AOA are encouraged to educate the public as well as healthcare colleagues about the manner in which the philosophy, science, and art of osteopathic medicine are practiced in the United States of America.
7. The AOA charges BIOMEA to continue to plan and provide an international seminar and forum for the profession at the annual meetings to update AOA members on international issues, the activities of their colleagues, and the AOA's progress abroad on their behalf.

4. IDENTITY

The AOA recognizes the need to identify and educate international organizations, governmental authorities, and leaders concerning the benefits of osteopathic philosophy, science, and art in promoting/maximizing health while limiting disease and dysfunction.

To this end, the following directions are supported:

1. The AOA will actively seek to provide communication and/or representation to key international bodies with the expressed intention of communicating the scope of osteopathic philosophy and practice and the potential for the osteopathic profession to contribute to health and preventive medicine throughout the world.
2. The AOA will work specifically with the Pan-American Health Organization (PAHO) and the World Health Organization (WHO) in demonstrating the ability of the osteopathic profession to contribute to health and wellness in the Americas.
3. Wherever possible, the AOA will interact with and educate key international leaders and international bodies about the osteopathic profession with the expressed intention of expanding opportunities whereby graduates of AOA-accredited schools (or the American osteopathic profession as a whole) could make positive contributions.
4. The AOA will specifically interface with the International Association of Medical Regulatory Authorities (IAMRA), International Federation of Manual Medicine (FIMM), the Osteopathic International Alliance (OIA), the Pan-American Health Association (PAHO), the World Osteopathic Health Organization (WOHO) and others who seek to identify and contribute to areas of overlapping missions.
5. The Bureau on International Osteopathic Medical Education and Affairs (BIOMEA) and its representatives will aspire to collaborate with international colleagues and organizations to obtain unlimited medical and surgical practice rights internationally for osteopathic physicians.
6. BIOMEA will develop a Network Database (accessible to AOA members) of individual DOs and affiliates around the world, who are willing to assist other DO expatriates.

5. POLITICS & DIPLOMACY

The AOA embraces its unique position as representing American trained osteopathic physicians and surgeons, the largest group of osteopathic practitioners in the world and its historic link to the birthplace of the entire osteopathic profession. However, the AOA also recognizes the sovereignty of healthcare licensure and delivery systems in other nations as well as the evolutionary differences in osteopathic education and scope of practice that occurred when osteopathy emigrated to other countries. Above all, the AOA acknowledges the need to be geographically and culturally sensitive in interacting within the international healthcare arena.

To this end:

1. The American Osteopathic Association's *"Statement of Healthcare Policies and Principles"* notes that as an organization it is dedicated to placing patients first and protecting the

patient/physician relationship. This position of the AOA extends beyond U.S. borders and will serve as a template for policy relating to political and health policy considerations internationally.

2. The AOA accepts its role and ability to provide organizational leadership unifying osteopathic medical education & practice throughout the world. It maintains the AOA Bureau on International Osteopathic Medical Education & Affairs (BIOMEA) to recommend liaison and policy to this end.
3. The AOA supports the growth of the Osteopathic International Alliance (OIA) as an umbrella organization of internationally governmentally recognized organizations made up of osteopaths, osteopathic physicians and surgeons, and/or manual medicine physicians who value and promote the osteopathic approach.
4. The AOA will continue to contribute to the development of qualified AOA International Ambassadors to serve as knowledgeable and effective liaisons for the osteopathic medical profession in international affairs and policy.
5. The AOA will maintain & enhance contacts with international organizations including, but not limited to the Canadian Osteopathic Association (COA), European Union (EU), Fédération Internationale de Médecine Manuelle (FIMM), Global Health Council (GHC), International Association of Medical Regulatory Authorities (IAMRA) Pan American Health Organization (PAHO), U.S. Agency for International Development (USAID), World Bank (WB), World Health Organization (WHO), and World Osteopathic Health Organization (WOHO).
6. The AOA will work with the Federation of Medical Regulatory Authorities of Canada [FMRAC], Federation of State Medical Boards [FSMB], and International Association of Medical Regulating Authorities [IAMRA] so as to reach as many ministries of health as possible.
7. The AOA will develop and maintain affiliates outside the U.S.A. who qualify for appropriate representation in the AOA House of Delegates.

6. RESEARCH & EDUCATION

The AOA is committed to contributing to the expansion, dissemination, application, and integration of the evidence-base for healthcare practices generally, including the field of manual/neuromusculoskeletal medicine that constitutes one of the distinctive cornerstones of the osteopathic profession.

To this end, the following directions are supported:

1. Wherever possible, the AOA will encourage collaboration and/or wide international dissemination of the findings of research related to the promotion of health including palpatory diagnosis and manual medicine approaches; the relevance of somatic dysfunction and its reduction in affecting health promotion and disease prevention; and outcomes research documenting patient satisfaction and the clinical safety, cost-effectiveness, and efficacy of osteopathic clinical approaches (or manual-medicine integrative approaches).
2. The AOA will delineate pathways by which members of the AOA and representatives of the AOA Council on Research, Bureau of Osteopathic Clinical Education and Research (BOCER), and/or AACOM may effectively interact with international medical and osteopathic institutions and organizations, through the OIA, to plan, foster, and/or

participate in collaborative research advancing osteopathic and/or neuromusculoskeletal medicine.

3. The AOA will seek to identify and collaborate with institutions having the potential and desire to develop osteopathic medical education that would, at a minimum, parallel the educational standards adopted by the AOA. Furthermore, it will charge BIOMEA to encourage, promote & offer assistance to the AOA Commission on Osteopathic College Accreditation (COCA) in anyway necessary.
4. The AOA will delineate the pathway or pathways by which representatives of the AOA, AOA specialty colleges, BOE, and/or COCA may (upon request) effectively and responsibly consult with/for international medical and osteopathic institutions and organizations to evaluate, improve, and/or coordinate educational standards and evaluation between countries and/or educational bodies.
5. The AOA is a resource to AACOM, Educational Council on Osteopathic Principles (ECOP), and other organizations for information on international research and education.
6. The AOA will delineate the pathway or pathways by which an international educational institution might apply for and attain appropriate accreditation in order to graduate osteopathic physicians completely versed in the osteopathic philosophy, science, and art. Unless otherwise assigned, BIOMEA might be charged to evaluate applications with respect to the international implications, risks, and benefits of each application relative to the AOA's international strategic plan.
7. The AOA will encourage specialty colleges and colleges of osteopathic medicine to develop member training opportunities outside the U.S.A., including but not limited to undergraduate/post-graduate fellowships, CME programs, and international exchanges.
8. Professional seminars, lectures, workshops and other educational meetings concerning osteopathic medicine or surgery should promote understanding of healthcare content generally within the scope of practice or education of those attending the course as should osteopathic graduate medical education (OGME).
9. To ensure that the highest quality of osteopathic medical care is made available to all Americans, the AOA acknowledges the value of international contributions made to the field, either individually, by groups, or by organizations and will record these findings in a Network Database. This Database will have available the current international research, activities, and contributions of osteopathic and manual medicine groups to healthcare. This Network Database will, where possible, maintain a record of cost-efficacy analyses and outcomes of these approaches.
10. Communications and written materials should clearly state that education about the philosophy, science, and/or art of osteopathy or osteopathic medicine does not alone create an osteopathic practitioner or entitle an attendee to claim such.

7. INTERACTIONS WITH INTERNATIONAL COLLEGES OF MEDICINE OR OSTEOPATHY OR THEIR GRADUATES

Interactions by individuals, colleges of osteopathic medicine, osteopathic specialty organizations or other U.S. osteopathic institutions to advance the understanding of the science, art, and practice of osteopathic medicine in the United States, are encouraged at international colleges of medicine or osteopathy, as well as with their students and graduates.

To this end:

1. Such interactions should always be accomplished in a careful, professional, and ethical manner, accurately representing the American model of osteopathic medicine. Lectures, discussions, and/or demonstrations are typically appropriate for international audiences and should be used responsibly to advance understanding. Members of the AOA, its affiliates, and AOA accredited institutions and programs, should refrain from the hands-on teaching of osteopathic manipulation treatment, injection, diagnostic or therapeutic surgical and/or diagnostic or therapeutic invasive procedures to individuals who do not, or will not upon graduation, have the complete foundation to responsibly master or possess the legitimate scope of practice to apply said skills or procedures.
2. With regard to continuing medical education (CME) at, or organized by, international colleges of medicine or osteopathy, it should be made clear that the AOA recognizes continuing medical education programs in other countries only when such programs meet the continuing medical education requirements of the AOA. Only the AOA shall determine when a CME program qualifies for AOA recognition.
3. Programs, including CME and Continuing Professional Development (CPD) programs, organized by U.S. osteopathic organizations to advance the understanding of the science, art, and/or practice of osteopathic medicine which might include students or graduates of international colleges of medicine or osteopathy, must clearly indicate to these individuals that they may not falsely advertise their participation in said program. International osteopathic ethics limit claims, written or verbal, regarding participation in such programs, to statements of attendance at a specific educational or scientific meeting. U.S. osteopathic physicians who teach in such programs shall make this clear to both the organizers and participants.

8. AMERICAN OSTEOPATHIC RIGHTS IN INTERNATIONAL SETTINGS

The AOA Commission on Osteopathic College Accreditation (COCA) is recognized in the United States by the Federal government and its Department of Education, Department of Health and Human Services, and related governmental entities, as the official accrediting agency for all U.S. colleges of osteopathic medicine. The AOA is the body that recognizes and approves osteopathic graduate medical education and continuing medical education. The AOA, through its Bureau for Osteopathic Specialists, is the body responsible for the specialty certification of osteopathic physicians.

To this end:

1. The degree, Doctor of Osteopathy (D.O.), or Doctor of Osteopathic Medicine (D.O.), when granted by an AOA accredited college of osteopathic medicine, is considered in all 50 states, the District of Columbia, and territories, to be eligible for full medical licensure, equal in all rights, privileges, and responsibilities as those physicians holding the degree Doctor of Medicine (M.D.).
2. In the United States, physicians with an AOA recognized D.O. degree may serve as physicians in all capacities and are fully reimbursed at the same level and for the same

services as those with the M.D. degree. They may practice in state, private and governmental hospitals as well as in out-patient settings.

3. American osteopathic physicians, by virtue of their education and AOA certification(s), have valuable skills to offer patients wherever they may be accorded the right and privilege to practice their healing arts.
4. The AOA has no jurisdiction internationally, but is willing and anxious to assist members of the AOA in representing their credentials to government agencies, departments of health, or other professional institutions.
5. COCA has the ability to accredit outside of the U.S., but "will only consider the accreditation of complete osteopathic medical education as known and accredited in the U.S. and utilizing similar standards" as approved by COCA in the December 14, 2008, Interim Policy Statement on International Accreditation of Colleges of Osteopathic Medicine.
6. As officers in the Medical Corps of the U.S. Uniformed Services, osteopathic physicians have for many years served on military bases around the world. Several osteopathic physicians hold, or have held, high-ranking positions, such as the Surgeon General of the United States Army and the Assistant Secretary of Defense for Health Affairs.
7. American osteopathic physicians and colleges are active in international humanitarian and missionary work in numerous countries. DOCARE International is an AOA affiliated osteopathic organization that coordinates and delivers humanitarian work. Osteopathic clinicians are also providing international humanitarian and missionary care through their churches, communities, specialty colleges, service and other organizations.

9. INTERNATIONAL "OSTEOPATHIC" RIGHTS IN THE UNITED STATES

It is the unwavering position of the AOA that the only type of licensure for D.O.s in the United States is one reflecting a full scope of medical practice. For all licensure as a D.O. in every state in the United States, the D.O. must be a graduate of an AOA accredited college of osteopathic medicine. No state issues a "limited license" to any practitioner, either an American citizen or an international citizen, wishing to practice osteopathy or osteopathic medicine in the United States.

To that end:

1. Where state laws permit, internationally-trained manual therapeutic practitioners, or "non-physician osteopaths," may observe or even work in a physician's office. Such individuals may only interact with patients, however, to the extent allowed by the statutes of that state; while under the supervision of an attending physician, or his/her staff. In no case may the international practitioner attempt to represent his or her degree as equal to an American D.O. degree. Likewise, the interaction with a client may never be represented as, or implied to be, an osteopathic examination or treatment.
2. "Non-physician osteopaths," or those practicing manual therapy may, within specific guidelines, participate in U.S. osteopathic educational or research activities organized by AOA members, colleges, specialty colleges, institution, or other affiliates. AOA guidelines are specific to the situation. For example, the "non-physician osteopath", or manual therapist, may be employed under the supervision of an American D.O. to assist in teaching osteopathic manipulative treatment (OMT) techniques at an osteopathic college or in a CME program. In such cases, however, it must be clearly stated to

students or attendees that said individual is not a physician. Neither may an internationally trained "non-physician osteopath", or manual therapist, be counted amongst those osteopathic medical faculty members required for AOA-approved CME credit.

3. International Doctors of Medicine (M.D.) who have earned a "diploma or specialty in manual medicine (osteopathic)" or its equivalent in their medical pre-doctoral or post--doctoral training, may not represent themselves in the United States as osteopathic practitioners.
4. Those international M.D./D.O. physicians whose D.O. was granted by a non-AOA accredited international osteopathic college may not represent themselves as osteopathic practitioners in the United States, nor may they use their internationally obtained D.O. diploma or degree in the United States in any professional capacity. To advertise to the public that they are D.O.s is a violation of the state medical licensing laws, rules and regulations in the United States, as well as a violation of the AOA Code of Ethics.
5. International M.D. or M.D./D.O. practitioners may or may not be eligible to sit for allopathic licensure in the United States. Such a decision is outside the purview of the AOA. These physicians may not however represent themselves as an osteopathic physician, D.O., in the United States as there is no provision for sitting for an American osteopathic test, or obtaining an osteopathic medical license except by graduation with a "D.O." degree from an AOA-accredited college of osteopathic medicine.
6. International institutions, organizations, or programs seeking AOA accreditation or recognition must meet all AOA guidelines for the appropriate and pertinent osteopathic medical programs.

10. INTERNATIONAL MEMBERSHIP IN THE AOA

American educated and trained D.O.s living and/or practicing abroad may join the American Osteopathic Association under the same guidelines as those osteopathic physicians living and/or practicing in the United States. Costs of AOA membership are specified in annual publications of the AOA and may reflect an additional cost for processing and mailing internationally. International M.D. and M.D./D.O. practitioners living and/or practicing abroad or those who have moved to the United States from abroad are eligible for "AOA International Physician Membership" status.

To this end:

1. Membership requires completion and acceptance of the "International Physician Application" of the AOA, along with a letter of recommendation from a member of the AOA who can attest to the ethical character and professional qualifications of the applicant. This category is only open to those international physicians with a license for full-scope medical practice as a physician in their country of citizenship.
2. The membership category "International Physician Membership" is a non-voting category designed to identify individuals wishing to receive educational, research, and similar pertinent information from the AOA. Such members may not hold office in the AOA or any of its affiliate organizations. Membership in this category may not be publicized or claimed to represent any level of professional qualification; nor may such membership be used to imply additional skills, knowledge, or other status beyond that for which they qualify.

11. SERVICE

The AOA represents over 61,000 fully licensed osteopathic physicians in the United States who are dedicated to promoting health and treating disease. Osteopathic physicians' contributions in primary care and the distinctive osteopathic philosophy are widely recognized by health policy makers in the United States and by leaders in rural and underserved areas. The AOA believes that these attributes could contribute to the betterment of health and healthcare internationally.

To this end:

1. The AOA will continue aiding American DOs in humanitarian and mission work by facilitating international governmental permission to bring in medical teams and supplies and to provide osteopathic medical and surgical care.
2. The AOA will encourage international recognition of AOA-accredited DOs by developing a systematic method of contacting the various ministries of health (MOH) to apprise them of the unique education, high standards and full practice rights of physicians of osteopathic medicine thus accredited.
3. The BIOMEA will continue collaborating with the OIA and other international organizations to facilitate humanitarian and mission work.
4. The AOA will delineate pathways through which members of the AOA and representatives of AACOM, DOCARE International, SOMA, and other international osteopathic outreach groups may effectively collaborate with national and international medical, osteopathic, and humanitarian institutions and organizations to promote health and provide/facilitate access to quality care in underserved international sites.

12. RESOURCES

The AOA has committed resources to address the many acute national issues of its members in the United States, Canada and throughout the world. The AOA acknowledges that its members function in a global society and that our next generation of osteopathic physicians demonstrates significant interest in making international commitments on behalf of the profession.

To this end:

1. The AOA will conduct periodic assessments of AOA member needs and desires regarding internationally-oriented member services; and prioritize input from its student and post-graduate representatives.
2. The AOA will prioritize contacts and develop criteria for deciding what countries & organizations should be the focus of AOA activity.
3. The AOA will charge BIOMEA to recommend policies and procedures on international osteopathic medicine to the Bureau of Osteopathic Education & the AOA Board of Trustees.
4. The AOA will enhance and maintain electronic and Internet capabilities to allow for easy access of international network database information.

ADDENDUM: Selected U.S. and International Organizations & Groups

This addendum lists selected organizations and groups which the AOA either maintains active interactions with or are/may be potentially significant partners in conducting the functions and achieving the missions of the AOA, particularly as related to international issues. This list is not complete but will continue to be expanded as other organizations and groups are identified. See also the AOA document: entitled *AOA-Involved International Organizations* located at: http://www.osteopathic.org/files/lcl_intlorglist.pdf

Note that the Chart below is arranged by the abbreviation most commonly used to identify the group or organization. When known, websites as well as the group's scope of influence are listed.

Following the chart are descriptions or mission statements of certain organizations or groups with which the AOA or its members are most likely to come into contact.

Res. 22-M/2010 - REPORTING COMLEX USA-3 PASSING SCORES

All programs will provide a written report to their OPTI Administration indicating the names of all OGME-2 trainees who have not successfully passed COMLEX USA-3 either through failure or nonparticipation by May 1 each year; OPTI Administration will report the list of the names reported to the OPTI to the AOA Manager of Trainee Services by May 31 each year for review by the COPT; all OGME-3 contracts issued to OGME 2 trainees thirty days prior to June 1 the start date of the OGME 3 contract year contain the language "contingent on successfully passing COMLEX USA-3;" and institutions must not allow trainees to enter their third year of training until there is documentation on file of successful passage of COMLEX USA-3 and indicate in TIVRA the extension of the anticipated completion date for this reason. 2010

Res. 25-M/2010 - FACULTY DEVELOPMENT / CORE COMPETENCY CATEGORY 1-A CME CREDIT

The osteopathic profession support CME programs on professionalism, a core competency, through approval of faculty development programs that will train and encourage more osteopathic physicians to become involved in teaching students and residents and CME policy permits the awarding of a maximum of 15 hours of Category 1-A CME credit per three-year cycle to osteopathic physicians who attend Faculty Development workshops, incorporating any or all of the core competencies, offered by AOA Category 1 CME Sponsors. 2010

Explanatory Statement: The Council recognized the ongoing quest for excellence in teaching, research, outreach, and leadership. To accomplish this goal the Council has recommended that faculty development hours be increased from 10 hours to 15 hours per CME cycle

Res. 26-M/2010 - ONSITE MONITORING FOR CONTINUING MEDICAL EDUCATION PROGRAMS – ELECTRONIC SIGNATURE VS. SIGNED SIGNATURE

The term "signed" attestation of attendance and participation at AOA-approved Category 1 Sponsored CME Programs include the use of an electronic method of signature as long as there is evidence the physician attended the educational programs and events. 2010

Explanatory Statement: The Council asked that MEMO B-July/03-37 be amended by adding the above "resolved" to allow the use of an electronic signature as an acceptable method for on-site monitoring for CME program

Res. 28-M/2010 - CHANGE DEFINITION OF AN EMERGING STATE SOCIETY
The definition of an emerging state society is a societies that has 300 or fewer dues paying osteopathic physician members of that state as reported annually in the AOA Healthy and Viable Affiliate Organizations Program. 2010

Explanatory Statement: As of May 31, 2009, the AOA identified twenty-six (26) states within the current definition. With the proposed change, seven (7) additional societies would be able to participate in the Emerging States' Program. Reviewing the historical data and comparing the number of AOA physician members in a state to the number of physician members in that state results in the elimination of states with very limited resources. This contributes to the number of states seeking to continue to receive benefits as "distressed" due to the loss of emerging status as well as potentially excluding the state from participating in the AOA House of Delegates. The HVAOP has been in effect for four years. State affiliates are required to provide the number and classes of membership annually. The Bureau believes the number of physician members within the state is a more accurate representation of resources available to states. The Bureau also believes this change will have a positive impact on the number of states currently considered to be "distressed" who continue to receive the benefits of the emerging state status. Using the current definition (300 or fewer AOA physician members), the potential cost is $13,000 per year to support the participation of emerging states in the House of Delegates Reimbursement Program (based on a $500 maximum reimbursement per airline ticket) if every society participated. Using the proposed definition (300 or fewer divisional affiliate physician members), the potential cost could be $16,500 per year (based on a $500 maximum reimbursement per airline ticket) if every society participated, or an increase of $3,500 over the current definition

Res. 38-M/2010 – AOA BUREAUS, COUNCILS AND COMMITTEES
A strategic review of the AOA's Bureaus, Councils and Committees be completed every three years to make certain that the AOA has the appropriate committee infrastructure in place to advance the strategic plan. 2010

The Board of Trustees charged the Committee on AOA Organizational Structure and the Committee on Strategic Planning with responsibility for review of the current organizational structure. The Committees met separately in New Orleans during OMED and discussed the Board's instruction. Based on the discussion and in the interest of completing the process in time to present recommendations at the February 2010 Board of Trustees meeting, the AOA President designated a special joint subcommittee to discuss the bureaus, councils and committees and also designated AOA Past President George Thomas, DO as a special consultant to work with the subcommittee. The subcommittee met by telephone conference in November to review benchmark information and consider specific proposals. This report was then drafted based on the

subcommittee's recommendations and circulated to the two Committees for their review and approval.

Benchmark Information. The Committees received and discussed information concerning the bureau-council-committee structure and operations of comparable professional associations, including the American Bar Association (ABA), American Dental Association (ADA), American Dietetics Association, American Medical Association (AMA), American Nurses Association (ANA) and the American Veterinary Medical Association (AVMA), each of which has a larger membership base than AOA, ranging from the 70,000 members of the Dietetics Association to the more than 400,000 members of the ABA.

That information did not indicate any particular rule of thumb in terms of the appropriate number of bureaus, councils or committees for an organization. The ABA, for example, has many more committees. However, much of its committee structure included groups dedicated to subject matter content (e.g., Health Law, Tort and Insurance Practice, Corporate Law, etc.) and parallel young lawyers committees designed to foster involvement by younger attorneys at an early stage in their careers. At the opposite end, the AMA (American Medical Association) had far fewer committees, but the AMA is not directly involved in educational accreditation and certification activities, which are administered through separate corporate entities, i.e., the Liaison Committee on Medical Education, the Accreditation Council for Graduate Medical Education, the American Board of Medical Specialists, the Accreditation Council for Continuing Medical Education, the Joint Commission on Accreditation of Healthcare Organizations. Other activities are administered through corporate subsidiaries, such as the AMA Insurance Agencies. Thus, the AMA's activities may not require as extensive a network of bureaus, councils and committees.

Finally, the benchmark information may also reflect different organizational preferences in terms of governance. A larger committee structure and with greater authority given to committees may reflect an organizational preference for allowing greater grass-roots member involvement to provide assurance that decisions are not staff-driven or controlled by a small number of powerful members.

In sum, the benchmarking information indicates that the complexity of committee structure in membership associations varies. There is no clearly correct or improper number of committees. Rather, the extent of the bureau-council-committee network reflects the culture and activities of an organization. The fact that the ABA has a far larger network of committees and councils does not indicate that the AOA's structure is too small. Similarly, the fact that the AMA's committee structure does not indicate that the AOA's structure is too large. Instead, what is necessary is a comprehensive review of the organizational structure to determine which activities are necessary to drive the AOA's strategic plan forward.

Recommended Changes. The Committee met by telephone conference in November to review the existing bureau-council-committee structure. The premise at the outset was to recognize that all of the bureaus, councils and committees have been useful, constructive and added value to the AOA's function and operations. Instead, the question that the Committee sought to answer was

what activities (and Bureaus, councils and committees to oversee such activities) were needed to advance the Strategic Plan. As a secondary consideration, the Committee also sought to determine whether there were opportunities for consolidation of activities currently handled by multiple entities that could be handled by a single entity.

The charge to the Committees exempted the Education pathway from consideration. Because the AOA's educational operations are the subject of review and recommendation in the EPPRC III process, the Committees did not make any recommendations for changes to the infrastructure that oversees the educational activities.

Analysis Phase I:

The first question the Committee reviewed was what activities does the AOA need to advance the strategic paths. Considering the 6 GREAT Family strategic paths, the Committees identified the following key activities:

PATH 1 – GOVERNANCE:

Finance

Budget, Investments, Oversight of Financial Reporting

Governance

Audit, Strategic Planning, Review of AOA Policy, Personnel

AOA Non Dues Business Operations (Conventions, HFAP, 142 E Ontario Building))

Conventions, HFAP, Building

PATH 2 – RESEARCH

Research

Research grants, CAP program, Scientific Affairs and Public Health issues, JAOA

PATH 3 – EDUCATION

Predoctoral Education Accreditation and Policy

Postdoctoral Education Accreditation and Policy

Board Certification and Policy

Continuing Medical Education Accreditation and Policy

PATH 4 – ADVOCACY

Governmental Advocacy- International, Federal and State levels

Advocacy to Hospitals and Third Party Payors

Advocacy to Public

PATH 5 – TEAMWORK

Affiliated Organizations – Divisional and Specialty, including regulatory oversight and enhancing collaborative activities

PATH 6 – FAMILY

Membership, including students, interns/residents and new physicians

Awards and Recognition

ACTIVITIES OUTSIDE THE STRATEGIC PATHS

AOA Presidential appointments/nominations to related organizations within and outside of AOA, including AOIA, AOF, OFRF, AT Still Foundation

Analysis Phase II

Based on the key activities noted above, the Committees identified which of the existing bureaus-councils-committees are responsible for these functions, with the following conclusions:

STRATEGIC PATH 1 – GOVERNANCE

Finance

Budget – Finance Committee and Budget Adjustment Committee

Investments – Investment Committee

Oversight of Financial Reporting – Finance Committee

Governance

General – Committee on AOA Governance & Organizational Structure

Regulatory – Committee on Constitution & Bylaws

Audit – Audit Committee

Strategic Planning – Committee on Strategic Planning

Review of AOA Policy – Council on AOA Policy

Personnel – Committee on Administrative Personnel

AOA Non Dues Business Operations

Conventions – Bureau of Conventions

HFAP – HFAP Advisory Committee, Bureau of Healthcare Facilities and BHFA Appeal Committee

142 E Ontario Building – Council on Building

STRATEGIC PATH 2 – RESEARCH

Research

Research grants – Council on Research

CAP program –Bureau of Osteopathic Clinical Education and Research

Scientific Affairs and Public Health issues – Bureau of Scientific Affairs & Public Health

JAOA – Committee on Professional Publications; JAOA Editorial Board

STRATEGIC PATH 3 – EDUCATION

Predoctoral Education Accreditation and Policy

Commission on Osteopathic College Accreditation

Postdoctoral Education Accreditation and Policy

Bureau of Osteopathic Education

Council on Postdoctoral Training

Program and Trainee Review Council

Council on Osteopathic Postdoctoral Training Institutions

Board Certification and Policy

Bureau of Osteopathic Specialists

Continuing Medical Education Accreditation and Policy

Bureau of Osteopathic Education

Council on Continuing Medical Education

STRATEGIC PATH 4 – ADVOCACY

Governmental Advocacy- International, Federal and State levels

International – Bureau of International Osteopathic Medical Education and Affairs

Federal – Bureau of Federal Health Programs

State – Bureau of State Government Affairs

Advocacy to Hospitals and Third Party Payors

Bureau of Socioeconomic Affairs

Joint Committee on Quality & Reimbursement

Advocacy to Public

Bureau of Communications

STRATEGIC PATH 5 – TEAMWORK

Affiliated Organizations – Divisional and Specialty, including regulatory oversight and enhancing collaborative activities

All Affiliates – Regulatory – Committee on Basic Documents and Operations of Affiliated Organizations

Divisional Affiliates – Non Regulatory – Bureau of Emerging States Concerns

Specialty Affiliates – Non Regulatory – Bureau of Osteopathic Specialty Societies

STRATEGIC PATH 6 – FAMILY

Membership, including students, interns/residents and new physicians

Bureau of Membership

Interns/Residents – Council on Interns and Residents

Bureau of Ethics

Bureau of Insurance

Litigation Fund Committee

New Physicians – Council on New Physicians in Practice

Students – Bureau of Student Affairs

Awards and Recognition

Committee on Awards

Bureau of Osteopathic History & Identity

ACTIVITIES OUTSIDE THE STRATEGIC PATHS

Presidential Appointments to Related Activities

AOIA appointments

AT Still Research Institute appointments

Dale Dodson Fund appointments

AOF Appointments

OFRF Appointments

Bureau of Hospitals

Analysis Phase III

With this analysis in mind, the Committees are forwarding the following nine (9) recommendations to the Board of Trustees:

2000 Under the Governance Strategic Path:

Finance

- The Investment Committee should be made a subcommittee of the Finance Committee

Governance

- Governance directly relates to the AOA's Constitution and Bylaws. Constitution & Bylaws should be made into a subcommittee of Governance & Organizational Structure.

2001 Under the Research Strategic Path:

- No changes suggested

2002 Under the Teamwork Strategic Path:

- Change the Bureau of Emerging States Concerns to a Bureau of State Affiliate Concerns, which will be a counterpart of the BOSS for Divisional Associations.

2003 Under the Family Strategic Path:

- The Bureau of Ethics should become a subcommittee of the Bureau of Membership
- The Bureau of Insurance should become a subcommittee of the Bureau of Membership

- The Litigation Fund Committee is no longer budgeted. It should not be a formal committee, but its defined composition should be the structure used when requests for funding are submitted to the Board of Trustees.
- The Mentor of the Year Selection Committee should become a part of the Committee on Awards.

2004 Procedural Review

- There should be a strategic review of the Bureaus, Councils and Committees completed every three years to make certain that the AOA has the appropriate committee infrastructure in place to advance the strategic plan.

Res. 5-A/2010 - INTEGRATED CORE COMPETENCIES

Policy of the American Osteopathic Association notes that the required core competencies shall include: (1) Osteopathic philosophy and osteopathic manipulative medicine; (2) Medical knowledge; (3) Patient care; (4) Interpersonal and communication skills; (5) Professionalism; (6) Practice-based learning and improvement; and (7) Systems-based practice; and that the first competency OPP/OMT shall be integrated into each of the other six (6) competencies, as indicated in the attached document; and that the Basic Document for Postdoctoral Training Programs be revised to reflect the seven osteopathic core competencies**.**

Explanatory Statement: The bureau recommends Osteopathic Principles and Practice (OPP) and Osteopathic Manipulative Medicine (OMM) continue as the first of seven core competencies in the osteopathic profession and that OPP/OMT be integrated into all the core competencies.

Res. 15-A/2010 - CME CREDITS VS CME HOURS

RESOLVED, that the term "CME credits" be used instead of "CME hours" in all policy relating to CME and specialty CME credits to be consistent with the other two accrediting CME systems in the United States.

Explanatory Statement: The Council asked that we amend all documents now and in the future to reflect "CME credit(s)" to be consistent with the terminology that the American Medical Association and the American Academy of Family Physicians use to define their CME credits system.

Res. 27-A/2010 - REVIEW OF INACTIVE PROGRAMS

All American Osteopathic Association-approved programs that cease to have trainees for 18 months be reviewed by their OPTI for academic viability and potential assistance to be noted in the annual report. 2010

Explanatory Statement: Non-functional programs are either in a state of flux administratively or may be academically non-viable. If approved this policy must be included in the *OPTI Basic Documents* as a required standard. This resolution is intended to create awareness by the OPTI OGME Committee of non-active programs and to provide assistance if possible, to each program. No reporting to AOA is required by OPTI's.

Res. 28-A/2010 - RESIDENT TRAINING APPROVAL FOLLOWING ADMINISTRATIVE PROGRAM CLOSURE

If a dually accredited residency program voluntarily or administratively withdraws from AOA approval while continuing approval status is in effect, the existing DO residents shall maintain AOA approval status until completion of existing residents' training. Any new DO residents will not have AOA recognition. 2010

Explanatory Statement: Some programs consider withdrawal due to OPTI and AOA program fees. Residents receiving AOA approval should be protected for AOA certification eligibility till completion of training. This standard shall be included as V.A.5.3f in the *AOA Basic Documents for Postdoctoral Training*.

BY MAIL B-1 – 2011 - TEACHING HEALTH CENTERS SPONSORSHIP

The American Osteopathic Association has approved the development of a pilot program of AOA primary care residency program sponsorship utilizing accredited OPTIs. 2011

Res. 5-M/2011 - RESPIRATORY SYNCYTIAL VIRUS (RSV)

The American Osteopathic Association supports efforts to have 33-35 week gestation neonates receive anti-RSV (respiratory syncytial virus) antibody injections during RSV season. 2011

Res. 6-M/2011 - BORDETELLA PERTUSSIS – INFANT ACCELERATED VACCINATION

The American Osteopathic Association supports the use of the accelerated pediatric immunization schedule for pertussis prevention in areas experiencing increased Pertussis prevalence. 2011

Res. 7-M/2011 - BORDETELLA PERTUSSIS – ADULT VACCINATION

The American Osteopathic Association supports recommendations to vaccinate all adults, and especially those who care for infants and children with the tetanus toxoid, reduced diphtheria toxoid and acellular pertussis (Tdap) vaccine. 2011

Res. 11-M/2011 - RESIDENCY POSITIONS FOR OSTEOPATHIC MEDICAL STUDENTS

The American Osteopathic Association and its medical specialty affiliates will strive to advance innovative methods to develop osteopathic graduate medical education (GME) positions in current under-developed and undeveloped hospitals, clinics and institutions as well as work with the US Congress and appropriate private, state and federal governmental and regulatory bodies, boards and agencies to remove any and all barriers to the development of new osteopathic GME position, secure their recognition and funding; and, that the goal of the osteopathic profession, its affiliates and colleges of osteopathic medicine (COMs), is to develop sufficient numbers of GME positions to provide an osteopathic graduate medical education position for every graduate of an osteopathic college by the year 2017, working within the framework of the osteopathic profession's Osteopathic Postdoctoral Training Institute (OPTI) structure. 2011

Res. 45-M/2011 - REQUIRED CORE COMPETENCY PROFICIENCY FORMS

Osteopathic Specialty Colleges desiring to substitute its own Program Director Annual Report and Final Resident Assessment, rather than the American Osteopathic Association's (AOA) required forms, must integrate the AOA Core Competency and related elements with associated questions into their forms. The substituted sample forms must include program director and resident signature and be forwarded to COPT for approval to utilize. Those not approved must use AOA forms as published on the AOA website; and that copies of the Final Resident Assessment (Program Complete), hard copy or electronic, must be maintained in the resident's file and forwarded at program completion to the OPTI. 2011

ES5-A/2011 - SPECIALTY STANDARDS APPROVAL

The American Osteopathic Association has appointed a Specialty Standards Review Committee that will: (1) review Specialty Standards after the initial COPT review; (2) review comments received from stakeholders during the 45 day public comment posting; (3) submit recommendations to the COPT to be considered in final approval decisions; (4) the Committee has the authority to forward specific Specialty Standards to the full Board of Trustees for review and recommendation; and that nothing within this resolution be construed as waiving final authority of the BOT to approve or disapprove specialty standards in whole or in part. 2011

Res. 8-A/2011 - WHITE PAPER ON GUIDELINES FOR INTERNATIONAL ELECTIVES AND CULTURAL COMPETENCIES FOR OSTEOPATHIC PHYSICIANS-IN-TRAINING – APPROVAL OF

The American Osteopathic Association approves this White Paper as a resource for osteopathic physicians-in-training and osteopathic training institutions and to encourage educational standardization of key component elements for international and cultural enrichment programs completed by those institutions, in order to foster safety, maximize educational outcomes and positively impact outcomes for osteopathic physicians-in-training.

The American Osteopathic Association (AOA) recognizes the significant impact of culturally diverse perspectives, values, beliefs, traditions, and customs upon health care choices, health policy, and actual delivery of health care. It also appreciates that osteopathic physicians-in-training often gain valuable insights by participating in required or elective rotations in international or culturally-focused U.S. sites. Therefore, the AOA recommends development and implementation of a core "cultural competency" curriculum which would serve to meet the challenges of cross-cultural issues and osteopathic care for culturally-diverse groups in the United States. Furthermore, it recommends standardization of certain expectations for international clinical and/or research electives involving osteopathic physicians-in-training (students, interns and residents).

To facilitate safe, appropriate and meaningful expectations for such a curriculum and for international rotations, it is important that information gathering, collaboration and cooperative ventures by osteopathic institutions and representative bodies (including the American Association of Colleges of Osteopathic Medicine [AACOM] and individual colleges of osteopathic medicine [COM]) be conducted in a manner compatible with the AOA's educational and ethical standards. Furthermore, partnerships with collaborating institutions, when possible, should be based upon

fostering mutual respect and mutual benefit, sharing information and resources, and minimizing the burden on host institutions -- especially while working in Least Developed Countries (LDC).

To these ends, the AOA has developed this White Paper. Its suggestions and guidelines will hopefully enable osteopathic medical students, as well as interns and residents, to experience quality clinical clerkships both outside and across the United States while developing competencies in delivering care for patients of diverse cultural, ethnic and religious backgrounds. Equally important, the AOA desires that osteopathic physicians-in-training engaging in clinical electives in international or culturally-sensitive sites may informally yet appropriately serve as the ambassadors of the "profession" and propagate a better understanding of the American model of osteopathic education and care.

HISTORY & PURPOSE

In dealing with various international issues, the AOA has sought and continues to seek input and recommendations from its Bureau on International Osteopathic Medical Education and Affairs (BIOMEA) since formed as a Council in 1998. Furthermore, BIOMEA interacts directly with the AOA Board of Trustees to formulate and issue pertinent "White Papers" as informational pieces to describe the scope, direction, and activity of the AOA in the international arena. Topical "White Papers" also serve AOA leadership by providing pertinent background material for focused, informed discussions leading to future decisions or policy.

In 2009, BIOMEA recommended the development of and approval of a White Paper on Guidelines for Standardization of International Clinical Clerkship and Cultural Competency for COM Students. Recognizing the applicability to interns and residents as well, this White Paper focuses on pertinent educational and logistical issues of preparing osteopathic physicians-in-training for the challenges of their clinical electives (in international and culturally-sensitive sites). It also emphasizes the ethical interactions between components of U.S. COMs, international partners, and culturally-diverse communities in delivering such quality clinical clerkships consistent with the AACOM and AOA educational standards. Topics included:

1. Development of effective guidelines for clinical clerkship curricula in international and culturally-diverse sites
2. Student, preceptor, and curricular evaluation of electives in international and culturally diverse sites
3. Pre- and post- international departure orientation concerns and needs
4. Immunizations and prophylaxis
5. Travel documents and insurance
6. Travel advisory alert and risk issues
7. Language issues in international and culturally-diverse sites
8. Ethical issues related to clinical and research electives
9. Representation of the U.S. osteopathic profession
10. Recommended core "cultural competency" curricular components towards understanding culture and customs of host countries and culturally-diverse sites

PREAMBLE

International health experiences (or those obtained in certain enclaves within the United States) can broaden a person's perspective and provide a better understanding of the effect of health and illness on individuals and their culture. Such experiences have been shown to increase interest in global public health and primary care medicine for medical students and residents. For osteopathic physicians-in-training these experiences provide an opportunity not only to choose a career in international health and provide care to the underserved, but also to educate the global health community about the philosophy and practice of U.S. osteopathic medicine. Participation in an international rotation may also help osteopathic physicians-in-training to better understand opportunities and limitations related to the practice of osteopathic medicine generally and of manual treatment specifically in a given country or patient population.

Regardless of such interests, osteopathic physicians-in-training and the institutions in which they train must increasingly seek educational opportunities that are both meaningful and safe. Ideally, such "quality" educational health rotations will add to one or more of the following: knowledge of osteopathic medicine and philosophy, insights into indigenous or tropical medicine, broadening of general clinical skills, opportunity to witness or apply hands-on manual medicine practices, and acquire on-site cultural or language competency in order to prepare for the many challenges of 21st century health care delivery in diverse populations.

The benefits for each COM in the United States in developing international elective and cultural competency programs are becoming increasingly obvious, based particularly upon the growing interest of their students in engaging in international clinical rotations or humanitarian aid activities, interacting with culturally diverse populations, serving U.S. communities with large ethnic populations and witnessing the impact of certain health policies, especially in impoverished regions of the world (including parts of the United States). To this end, the AOA, as an internationally-linked and culturally-sensitive organization for osteopathic medical practice, seeks to broaden its involvement with the issues of international clinical electives for COM students. It also strongly encourages each COM to consider and address the aforementioned issues to facilitate and streamline educational and logistical issues pertaining to students' travel and hands-on clinical experience in a host country or culturally-centered U.S. community.

INTRODUCTION

The elements described in this document will be of value for participating osteopathic physicians and physicians-in-training at all stages of the continuum of osteopathic medical education, from predoctoral education through practice and continuing education. If students are participating in international or culturally-based experiences as part of their education, i.e. "for credit", then these experiences would also need to satisfy any requirements of the respective AOA-recognized accrediting agency or approving committee.

Research indicates that international health experiences have positive educational outcomes, including increasing the likelihood of choosing a primary care career and interest in serving

underserved populations in the United States and abroad. The offering of such experiences can be attractive to applicants and can provide a wide range of clinical and cultural experiences for students and residents. In a survey conducted by BIOMEA in February 2011, 16 (76%) out of 21 responding COMs reported providing international health involvement opportunities. 16 COMs reported that osteopathic medical students are allowed to serve clinical rotations, 10 COMs reported that they have established international clinical rotations, and 14 COMs reported having international clubs or interest groups focused on international health issues.

Many believe that osteopathic education will benefit from interactions between educational leaders that foster the development of consensus on global health competencies and that help establish learning objectives linked to corresponding educational approaches. Furthermore, with increased global mobility and the accompanying threats of emerging, re-emerging, and communicable diseases, the AOA and many COMs feel that future osteopathic physicians should be familiar with a wider range of illnesses and considerations for prevention and care. Therefore, despite associated costs and risks, some U.S. COMs are developing and refining educational experiences for medical students and residents in international sites (and culturally-distinctive enclaves in the United States). International health experience opportunities have been shown to preserve medical students' idealism in developing a professional commitment and appreciation for cultural diversity and in dealing with global health concerns. Increasingly, international opportunities have become powerful recruiting tools for both undergraduate and graduate osteopathic medical school programs.

The AOA therefore encourages educational standardization of key component elements for such international and cultural enrichment programs. In order to foster safety, maximize educational outcomes and positively impact outcomes for osteopathic physicians-in-training, the AOA asked BIOMEA to identify key issues and resources.

The following ten (10) topics and two Appendices were summarized by BIOMEA; they make up the bulk of this White Paper, which also recommends guidelines on safe, effective, respectful and relevant international osteopathic health opportunities, in order to provide a blueprint for development of standards that consider curricular, cultural competency, and other logistical issues. This information should make osteopathic physicians and physicians-in-training more informed and better equipped to care for patients in this increasingly diverse and globalized world.

To meet this charge relative to international electives or planned rotations by an osteopathic physicians-in-training, the AOA recommends:

1. **Development of effective guidelines for international clinical clerkship curricula and its implementation**

   The AOA wishes to convey the benefits of this recommended outline for international/culturally-sensitive curricular components intended for COM students and OPTI residents who wish to have foreign clinical exposure. The following outline (as recommended by BIOMEA) is intended to assist individual COMs and OPTIs to uniformly address the issue of international educational interactions:

1.1. The AOA requires professionalism abroad by its members and representatives. Osteopathic institutions, faculty, and physicians-in-training are therefore expected to demonstrate *respect*, *compassion* and *integrity*; as well as a commitment to ethical principles, and sensitivity to patients' age, gender, religion, culture, disabilities, and impairments.

1.2. The AOA encourages certain logistical steps in advance of undertaking international or culturally-related clerkships. A COM or OPTI, for example, may require a CV from the designated international site clinical preceptors to be available for both the curriculum committee and the physicians-in-training, in order to provide understanding of the preceptor's background, affiliation, clinical teaching interests, cultural orientation or requirements, research interests, and professional affiliations.

1.3. The AOA encourages osteopathic physicians-in-training to be adequately oriented prior to departure. The "Know Triple A" (KAAA) mnemonic for example, would encourage osteopathic physicians-in-training engaging in clinical rotations abroad to **Know** and:

- **Appreciate** types of medical practice and delivery systems differing from U.S. health care delivery, including methods of controlling health care costs and allocating resources;
- **Advocate** for quality patient care, patient safety, and health promotion; and
- **Act** as an informal global ambassador for the AOA, his/her respective COM or OPTI, and, when appropriate, for osteopathic medical care.

Finally, osteopathic students should appreciate cultural diversity being observed in the host country.

1.4. The AOA strives for maximal interpersonal and communication skills. Osteopathic physicians-in-training are encouraged to demonstrate communication skills that result in effective information exchange. They are expected to create and sustain a therapeutic and ethically sound relationship with their patients (both in an international or in a culturally-sensitive community), use effective listening skills while working in the affiliated health care facility, and work effectively with others as a member or leader of a health care team. While being clinically-competent in a site or community, non-English language ability is not a requirement at all sites, this issue should be part of any discussion related to such a rotation.

1.5. The AOA encourages better understanding of the fundamentals of clinical competencies in COM-affiliated international and culturally-sensitive site(s). Physicians-in-training gaining added medical knowledge, expanded physical and history taking skills, interpersonal skills, language and communication skills, professionalism, cultural competency, and alternative health policy implications as well as practice-based learning are all examples of fundamentals meriting inclusion in such curricula.

1.6. The AOA encourages better understanding of the fundamentals of distinctively osteopathic clinical competencies, recognizing that osteopathic educators and researchers have identified a number of overseas clinics and institutions where the study or application of the osteopathic philosophical approach and/or integration of manual medicine or osteopathic techniques would provide new perspectives or opportunities

for students to experience these within the context of different and sometimes unique patient populations. Ongoing interactions between members of the Osteopathic International Alliance (OIA) and formal exchanges of information between teachers and researchers representing their countries in the International Federation of Manual / Musculoskeletal Medicine (FIMM) have led to appreciation of such quality educational opportunities internationally.

1.7. The AOA encourages that all approved internationally- and culturally-based educational opportunities continue to also provide practice-based learning. Osteopathic physicians-in-training should be able to investigate and evaluate their patient care practices with the aid of their local preceptors, appraise and assimilate both scientific evidence and evidence-based osteopathic application to patient care whenever possible, understand indigenous infectious conditions, appreciate cultural definitions of health and illness, be able to demonstrate the ability to conduct a directed, full history and physical given language limitations, and to improve their patient care practices while engaging in such clinical electives.

1.8. With regard to assessment tools related to cultural competencies, a physician-in-training portfolio generated during the clinical electives period is strongly encouraged. Standard preceptor evaluations related to key cultural competencies could be an integral part of the portfolio. A report from the host institution's medical director (or equivalent) to delineate physician-in-training behavior, cultural competencies, knowledge of medicine, degree of clinical skills, and spirit of team work approach (individually or as a group) may also be beneficial.

2. Student, preceptor, and curricular evaluation of international electives

The AOA recommends an official agreement pertaining to the expectations and responsibilities of both the clinical preceptor and osteopathic physician-in-training. Rather than a shadowing experience, the physician-in-training should be encouraged and allowed to provide hands-on clinical activities, based on their experience level and abilities, in order to develop confidence in that specific clinical setting. A template is illustrated in Appendix 1.

3. Pre- and post-departure orientation concerns and needs

Osteopathic training institutions and centers are encouraged to organize pre-departure orientation curricula, developed at each COM or OPTI and directed by at least one faculty member. Students interested in global health may also play a role in implementing the pre-departure orientation.

The following topics may be addressed:

3.1. Basic Health Precautions: Osteopathic physicians-in-training should understand basic precautions including water and food safety, injury prevention (transportation), and vector-borne illness prevention.

3.2. Insurance: Osteopathic physicians-in-training will most likely be required to acquire travel health insurance either through their institution or commercially, and present proof of their insurance to their institution.

3.3. Post-Exposure Prophylaxis (PEP): Osteopathic physicians-in-training should understand appropriate PEP for HIV/AIDS, hepatitis, malaria, and tuberculosis and the steps to take following exposure, as addressed in the immunizations/prophylaxis section.

3.4. Medical Care: Osteopathic physicians-in-training should most likely be advised to prepare a small kit of personal medications before departing, including inhalers, antibiotics (as appropriate), etc., and to identify in-country or regional health clinics and/or hospitals where they can receive care if necessary.

3.5. Regional or Country-Specific Cultural Sensitivity Summary & References: It is highly recommended that osteopathic physicians-in-training have access to a regional or country-specific summary identifying key issues and differences related to health care delivery; local understanding/status of osteopathic practitioners; culturally or medically vulnerable groups; gender or caste biases; and any political/domestic issues of concern. This summary could be linked to bibliographical and/or internet sites selected to expand upon key issues.

4. Immunizations and prophylaxis

The AOA recognizes the need for travel immunizations in a timely manner. An estimated 15% to 45% of short-term international travelers, including young adults, experience a health problem associated with their trip; albeit the majority being self-limiting viral infections. Virtually any place in the world can be reached within 36 hours, less than the incubation period for most infectious diseases. The ease with which people see the world has dramatically increased the number of international travelers. Respiratory infections, such as influenza and colds, develop in 10% and 25% of travelers. Women traveling to the tropics are at higher risk for urinary tract infections. As problematic, physicians in Western countries are now seeing infectious diseases

never before encountered. Travelers are at risk both from infections transmitted from person to person and by insects (vector-borne diseases). Malaria, which is transmitted by mosquitoes, is the most widespread and infects between 300 and 500 million people world wide annually. Between 10,000 and 30,000 of these cases occur in travelers. Anyone traveling to high-risk countries should be advised or required to take precautions.

To this end, the AOA wishes all travelers to comply with CDC recommendation for immunizations and prophylaxis. With CDC requirements changing from time to time and location to location, consult http://wwwnc.cdc.gov/travel/content/vaccinations.aspx for the most up to date information.

5. Travel documents and insurance

Osteopathic training institutions and centers may facilitate sessions on various aspects of international travel for osteopathic physicians-in-training who need to obtain certain documents long before departing for an international clinical elective or other training. In many cases, osteopathic physicians-in-training will be naïve to the amount of time needed for some bureaucratic issues and should make sure of both timeline and processes for obtaining these documents as early as possible prior to a scheduled departure.

Documents that may require a significant amount of advance notice include:

5.1. Appropriately classified entry visa
5.2. Passport
5.3. Institutional Review Board (IRB) approval from COM/OPTI and/or international site if there are plans to participate in any research activity (regardless of who has initiated the protocol)
5.4. International certificate of vaccinations

The main medicine-related documents that should be carried at all times are:

5.5. Copy of undergraduate diploma (if requested or required)
5.6. Certificates of BLS (Basic Life Support/CPR) & ACLS (Advanced Cardiac Life Support Course)
5.7. Additional certificates of education (RN degree, etc.)
5.8. Letter from Dean or residency program director indicating their current medical school or post-graduate training status

Finally, certain optional travel documents may be recommended:

5.9. International Student Identity Card (ISIC)
5.10. International Driving Permit
5.11. Copies of prescriptions for any required medications

Passports

Passports are issued by the U.S. Department of State and are valid for 10 years. It is the most

important document a traveler will carry abroad. A student/resident must complete the application, which can be done online; however, if this is the traveler's first passport, the application should be made in person. The U.S. Department of State has a website that will help one to find the nearest location to apply.

When applying for a passport, the traveler must show proof of citizenship and proof of identity. Proof of citizenship can be given in the form of a birth certificate, but if the traveler does not have a birth certificate, a combination of the following documents can be used in its place:

- Letter of no birth record
- Baptismal certificate
- Hospital birth certificate
- Census record
- Early school record
- Family bible record
- Doctor record of postnatal care.

Permanent U.S. residents should contact their representative embassy regarding applying for a valid passport and specific requirements, which vary from country to country. Before departing, it is recommended to verify the validity requirements of the destination country. From the U.S. State Department website, "If possible … renew your passport approximately nine (9) months before it expires. Some countries require that your passport be valid at least six (6) months beyond the dates of your trip. Some airlines will not allow you to board if this requirement is not met."

U.S. passport applicants will need two identical photographs, measuring 2" by 2". Many pharmacies, stores, and travel agencies provide passport photo services. Please visit the U.S. Department of State website: http://travel.state.gov/passport/, for up to date passport fee structures.

Visa

Whether or not the traveler needs a visa (and which type of visa is needed) in order to pursue clinical elective training abroad depends on the country in which s/he plans on completing their rotation or clinical activity and how long s/he will be abroad. A visa can either be in the form of a separate document or a simple stamp on a passport and gives the traveler permission to enter a country and, in essence, live there for a period of time. The State Department website can tell the traveler if a visa is necessary for a specific destination. All U.S. permanent residents must contact the representative embassy of the country they plan to enter. Entry visa requirements vary from country to country depending on diplomatic relations. For more information, see: http://travel.state.gov/visa/.

International Certificate of Vaccinations

Travelers are advised to obtain an international certificate of vaccinations before their departure (see immunization/prophylaxis section). This document can be found at the local Department of Health, a travel agency, doctor's office or passport office. Travelers should make sure they

have all necessary vaccinations. For up to date information on vaccinations and other health concerns, check the CDC website: http://wwwnc.cdc.gov/travel/content/vaccinations.aspx.

International Student Identity Card
Although not a requirement, The Council on International Education Exchange provides the International Student Identity Card (ISIC), which offers medical students discounts worldwide on things like travel fares, restaurants, shops, theaters, and hotels. It also carries medical benefits, worldwide assistance, and bankruptcy protection.

The ISIC offers basic medical benefits, covering medical expenses and emergency evacuation fees, up to a certain monetary amount. Students will also get worldwide assistance in the form of a toll-free 24/7 emergency number to call for help with lost passports and legal issues; operators speak 24 languages. The card also offers bankruptcy protection if a student's airline goes bankrupt. As a special bonus, students also receive an ISE Global phone card with free talk time. For specific details on ISIC benefits and costs, visit http://www.isic.org/.

International Driving Permit
Many countries do not accept the U.S. driver's license, but most do accept the International Driving Permit (IDP). There are two organization authorized by the State Department to provide IDPs: the American Automobile Association (AAA – http://www.aaa.com), and the National Auto Club (http://www.thenac.com). To obtain an IDP, the applicant must be 18+ years old and present two passport-size photo, as well as a valid U.S. driver's license. The fee is less than $20.00. Visit http://travel.state.gov/travel/tips/safety/safety_1179.html, for more information.

The traveler will feel more prepared for the international elective experience once these documents are all in order.

6. Travel advisory alert and risk issues
Osteopathic training institutions and centers are encouraged to facilitate sessions discussing international travel advisory alerts and post-9/11 risks associated with certain regions of the world that are unfriendly toward the U.S. Measures should be taken to ensure that osteopathic physicians-in-training are adequately prepared for safe and responsible travel practices. When traveling abroad, the odds favor a safe and incident-free trip, however, travelers are sometimes the victims of crime and violence, or experience unexpected difficulties. No one is better able to explain this than the U.S. consular officers who work in the more than 250 U.S. embassies and consulates around the globe. Every day of the year, U.S. embassies and consulates receive calls from American citizens in distress. Happily, most problems can be solved over the telephone or by a visit to the Consular Section of the nearest U.S. embassy or consulate. There are other occasions, however, when consular officers are called upon to help U.S. citizens who are in foreign hospitals or prisons, or to assist the families of citizens who have passed away overseas. Therefore, the following travel tips will help travelers avoid serious difficulties during overseas travel.

Prior to Departure

What to Take

Safety begins when the traveler packs. To help avoid becoming a target, do not dress so as to appear to be an affluent tourist. Expensive-looking jewelry, for instance, can draw the wrong attention. Travelers are encouraged to travel light, primarily due to mobility issues.

Travelers are advised to carry the minimum number of valuables, and plan places to conceal them. Passports, driver's licenses, cash and credit cards are most secure when locked in a hotel safe. When the traveler has to carry them on person, s/he may wish to put them in various places rather than all in one wallet or pouch. Avoid handbags, fanny packs and outside pockets that are easy targets for thieves. Inside pockets and a sturdy shoulder bag with the strap worn across your chest are somewhat safer. One of the safest places to carry valuables is in a pouch or money belt worn under clothing. Travelers are advised to copy their passport, driver's license, and credit card(s) and leave the copies at home. In case any of these items are lost, copies can be used to help facilitate contact with the proper representative agencies that would re-issue the stolen item(s).

To avoid problems when passing through customs, keep medicines in their original, labeled containers. Bring copies of prescriptions and the generic names for the drugs. If a medication is unusual or contains narcotics, carry a letter from a doctor that attests to the traveler's need to take the drug. If there is any doubt about the legality of carrying a certain drug into a country, consult the embassy or consulate of that country before traveling. Bring travelers checks and one or two major credit cards instead of a huge amount of cash.

Travelers are advised to put their name, address and telephone numbers inside and outside of each piece of luggage. The use of covered luggage tags will help avoid casual observation of a traveler's identity or nationality; if possible, luggage should be locked.

Travelers should consider purchasing a telephone calling card, a convenient way of keeping in touch. However, verify that it can be used in the elective location(s). Access numbers to U.S. operators are published in many international newspapers. Find out the access number before leaving the U.S.

What to Leave Behind

Do not bring anything that would be unacceptable to lose. Leave at home:

- Valuable or expensive-looking jewelry
- Irreplaceable family objects
- All unnecessary credit cards
- Social Security card, library card, and similar items that may routinely be carried in a wallet.

Leave a copy of the travel itinerary with family or friends at home in case contact is necessary, in an emergency or otherwise. Make two photocopies of passport identification pages, airline

tickets, driver's licenses and the credit cards that will be carried on the elective. Leave one photocopy of this data with family or friends at home; pack the other in a place separate from the originals. Also, leave a copy of the serial numbers of any traveler's checks with a friend or relative at home. Carry a copy in a separate place and cross them off the list as they are cashed.

What to Learn About Before Departing

Security

The Department of State's Country Specific Information is available for every country in the world. They describe entry requirements, currency regulations, unusual health conditions, the crime and security situation, political disturbances, areas of instability, and special information about driving and road conditions. They also provide addresses and emergency telephone numbers for U.S. embassies and consulates. In general, Country Specific Information does not give advice, but instead describes conditions so travelers can make informed decisions about their trips.

For some countries, however, the Department of State issues a Travel Warning in addition to Country Specific Information. The Travel Warning may recommend that Americans defer travel to that country because of a dangerous situation there.

Travel Alerts

Travel alerts are a means to disseminate information about relatively short-term conditions posing significant risk to the security of American travelers. They are issued when there is a perceived threat, even if it does not involve Americans as a particular target group. In the past, Travel Alerts have been issued to deal with coups, pre-election disturbances, and violence by terrorists and anniversary dates of specific terrorist events. Travelers can access Country Specific Information, Travel Warnings, and Travel Alerts 24-hours a day in several ways:

The Internet

The most convenient source of information about travel and consular services is the Consular Affairs home page. The website address is http://travel.state.gov.

Telephone

Overseas Citizens Services (OCS), at 1-888-407-4747, can answer general inquiries on safety and security overseas. This number is available from 8 a.m. to 8 p.m. Eastern Time, Monday through Friday (except U.S. federal holidays). Callers who are unable to use toll-free numbers, such as those calling from overseas, can obtain information and assistance from the OCS during these hours by calling +1-202-501-4444.

Local Laws and Customs

When leaving the U.S. travelers are subject to the laws of the country that is being visited. Therefore, before leaving, a traveler should learn as much as possible about the local laws and customs of the destination country. Good resources are libraries, travel agents, and embassies,

consulates, or tourist bureaus of the countries to be visited. In addition, keep track of what is being reported in the media about recent developments in those countries.

7. Language issues

Osteopathic training institutions and centers are highly encouraged to either establish informal courses in languages such as Spanish and French (or any other international common languages), or establish an elective foreign language course with emphasis on medical terminology and basic aspects of patient history taking and patient communication. As verbal communication is the basis of any clinical interaction, it may be expected or even required that an osteopathic physician-in-training may have basic language proficiency when pursuing an international clinical elective in a language other than English. The following recommendations may help ensure abilities to elective supervisors and build specific medical communication skills to facilitate their learning and effectiveness.

7.1. Language Basics: Osteopathic physicians-in-training should identify languages and language dialects spoken by patients in the area they will be working in advance of their elective. They should be aware that the local language used may be different from the official language of the host country or the language spoken by other health professionals. Osteopathic physicians-in-training should attempt to have a basic ability to communicate in the local language when feasible – especially at a site where a translator/interpreter is not available. This may include, for example, language training programs for weeks to months prior to departure or a similar program on-site.

7.2. Host Language Expectations: Osteopathic physicians-in-training should understand and comply with host expectations of language competency.

7.3. Interpreters: Osteopathic physicians-in-training should know whether they will be practicing with the assistance of an interpreter while on their elective. They should understand the role of interpreters in the medical interview and the constraints associated with use of family members and other health professionals as interpreters.

8. Ethical issues related to clinical and research electives

Osteopathic training institutions and centers are encouraged to conduct, sponsor or facilitate sessions to discuss possible ethical issues that travelers may encounter in the host country. Osteopathic physicians-in-training should be aware of the clinical and research ethical dimensions of studying and working abroad (especially in low-resource environments) and follow recognized standards of professional and ethical behavior.

8.1. Expectations of the Elective: It is recommended that osteopathic physicians-in-training should develop clear and appropriate goals and expectations – especially for electives in low-resource countries.

8.2. Understanding of Ethical Framework: Osteopathic physicians-in-training would benefit from being exposed to an array of potential ethical dilemmas prior to their departure that they may face while on international electives, and be provided with a framework to approach such problems.

8.3. Code of Conduct: The AOA strongly recommends that osteopathic training institutions and centers offer clear guidelines on professional behavior expectations for osteopathic physicians-in-training (especially on electives in low-resource settings), and

should ensure that they are aware of these guidelines prior to departure. Ethical guidelines for international representatives are also covered in BIOMEA's 2010 White Paper III. Furthermore, osteopathic physicians-in-training should be reminded of the imperative to "do no harm" while on electives.

8.4. International Research Activities: Osteopathic physicians-in-training and institutions must comply with ethical guidelines and all government regulations (here and abroad) pertaining to participation in any proposed research. To this end, they should therefore communicate closely with their own Institutional Review Board (IRB) prior to committing to any form of international research activity. Furthermore, researchers need to appreciate the impact of relevant cultural issues in modifying the interpretation of certain core bioethical precepts governing research in the U.S. or by U.S. citizens abroad. Key international research guidelines, consensus documents dealing with international research ethics, and country-specific research ethical standard informational sources can be found in Appendix 2.

8.5. Appropriate Licensing: The AOA recommends that a clear chain of responsibility (COM/OPTI/student) be detailed to make sure that osteopathic physicians-in-training have the appropriate licenses/privileges and malpractice insurance required by the hosting institution. Furthermore, it is advised that both the COM and the osteopathic physicians-in-training ensure that their on-site supervisor has a clear understanding of the level of clinical skills/abilities/privileges in the United States.

8.6. Identified Contact Person: COMs and OPTIs with intermittent programs should consider ensuring that there is a faculty member or other specific contact identified with whom they may consult concerning ethical issues or other questions that arise while on site at an international placement. (Ideally this would be an individual specifically linked to the physician-in-training's home institution.)

8.7. Supervision: COMs and OPTIs typically retain the responsibility for understanding the type and amount of supervision that will be available for their osteopathic physicians-in-training who are participating in an off-site elective. This supervision should be appropriate for the level of training the osteopathic physicians-in-training are undertaking.

9. Representation of the U.S. osteopathic profession

BIOMEA has previously held ambassador training sessions and developed some basic guidelines for physicians-in-training to remember when traveling internationally.

9.1. Dos and don'ts of international work

a. Do:

- Conduct yourself in a professional manner at all times
- Research the country and culture to be aware of differences that may be of importance
- Be aware of personal cultural biases
- Remember that because the U.S. osteopathic profession is not that well known outside our borders, the physician-in-training is a de facto representative of the entire profession
- Make sure every team includes someone familiar with the country and culture
- Slow down, be patient
- Listen carefully – utilize both eyes and ears to this end

- Words are secondary – 10% verbal – 90% non-verbal: body language can be incredibly powerful
- "Break bread together;" meet, greet and eat; there are different ways of doing things
- Be flexible
- Recognize that public criticism can be a "big no-no" in certain cultures; likewise, public praise can also be objectionable in certain cultures
- Know/learn the culture of that country to try not to offend
- Know your strengths and use them

b. Don't…

- Be a browbeater
- Be coercive
- Be the "Ugly American" who sometimes doesn't even know when he or she is being overbearing
- Act manipulative
- Be arrogant
- Make assumptions
- Push too hard or too much

9.2. Policy Statements: If an osteopathic physician-in-training or a representative of a COM or OPTI seeking to set up an international rotation attends a meeting where an issue comes up for which they do not know what the AOA policy is, refrain from making any statements that could be attributed as AOA policy. When requested, the AOA and BIOMEA will provide osteopathic physicians-in-training with materials needed to provide a unified and consistent message regarding the U.S. osteopathic profession.

9.3. Clearinghouse: When possible, COMs or OPTIs will interview DOs or health officials from other countries to gather information about those countries and should report back to the AOA or BIOMEA representatives for use in the AOA's international clearinghouse.

10. Recommended core "cultural competency" curricular components

BIOMEA encourages COMs and OPTIs to develop "cultural and linguistic" curricular components that reflect a set of congruent behaviors, knowledge, attitude, and policies that together strengthen osteopathic physicians'-in-training readiness to experience an international clinical elective in regions or communities where understanding of culture and basic linguistic background would be significant help to that individual. In doing so, the COMs/OPTIs may emphasize that:

10.1. Cultural competence in health care combines the tenets of patient/family-centered care with an understanding of the social and cultural influences that affect the quality of medical services and treatment.

10.2. With the ever-increasing diversity of the U.S. population and evidence of racial and ethnic disparities in health care, it is important that future health care professionals are educated specifically to address issues of culture in an effective manner.

10.3. Both faculty members and osteopathic physicians-in-training may demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illnesses and respond to various symptoms, disease, and treatments.

10.4. Osteopathic medical students and residents are encouraged to learn to recognize and appropriately address gender and cultural biases in health care delivery, while first considering the health needs of the patients.

10.5. Cultural Competence Curriculum

- a. The aim of a cultural competence curriculum is to enhance the patient-health care provider interaction and to assure that osteopathic physicians-in-training have the knowledge, skills, and attitude that allow them to work effectively with patients and their families, as well as with other members of the health care community.
- b. Health care professionals are encouraged to be educated to avoid stereotyping, but to also be aware of normative cultural values that can affect informed consent and can have serious consequences.
- c. For a cultural competence curriculum to be effective, certain institutional requirements should be considered:
    - i. Successful curricula have the support of the academic dean, faculty, director of medical education and physicians-in-training.
    - ii. Institutional, community, and international resources (with special consideration to non-monetary resources) are typically combined into successful curricula.
    - iii. Community/religious leaders may participate in the design of the curriculum and provide the necessary feedback, as may international medical and/or osteopathic collaborators.
    - iv. Where possible, institutional commitment from faculty to design such a curriculum is best.
    - v. In the most successful programs, the evaluation process is clearly defined.

10.6. Assessment of Osteopathic Physicians-in-Training in Cross-Cultural Education. Such an evaluation may include both qualitative and quantitative strategies required to appropriately assess the "impact" of cross-cultural curricula. The education approach may focus on:

- a. ATTITUDES
    - i. Examples
        1. Has the osteopathic physician-in-training learned the particular importance of curiosity, empathy, and respect in cross-cultural encounters?
        2. Does the osteopathic physician-in-training demonstrate these attitudes, as corroborated by evaluation?
    - ii. Evaluation Strategy
        1. Standard surveying
        2. Structural interviewing
        3. Self-awareness assessment
        4. Presentation of clinical cases
        5. Objective structural clinical exam
        6. Videotaped/audio-taped clinical encounter

b. KNOWLEDGE
    i. Examples
        1. Has the osteopathic physician-in-training learned the key core cross-cultural issues, such as the styles of communication, mistrust, prejudice, autonomy vs. family decision-making, customs relevant to health care and sexual/gender issues?
        2. Does the osteopathic physician-in-training make an assessment of the key core cross-cultural issues, as corroborated by evaluation?
    ii. Evaluation Strategy
        1. Tests (multiple choice, true-false, oral examination)
        2. Unknown clinical cases
        3. Presentation of clinical cases
        4. Objective structural clinical exam
c. SKILLS
    i. Examples
        1. Has the osteopathic physician-in-training learned how to explore core cross-cultural issues and the explanatory model?
        2. Has the osteopathic physician-in-training learned how to effectively negotiate with a patient?
        3. Does the osteopathic physician-in-training explore the explanatory model and negotiate with a patient, as corroborated by evaluation?
    ii. Evaluation Strategy
        1. Presentation of clinical cases
        2. Objective structural exam
        3. Videotaped/audio-taped clinical encounter

APPENDIX 1 EXEMPLAR: Template for osteopathic physician-in-training evaluation of the international or culturally-relevant site program and clinical preceptor of the osteopathic medical physician-in-training.

1. Clinical experience
    i. Complete a thorough SOAP process or note
    ii. Complete examination of common chronic disorders (e.g., diabetic)
    iii. Practice history and physical exam skills
    iv. Develop communication skills with patients, nurses, and the attending
    v. Develop documentation skills
    vi. Develop professionalism in dress and behavior
    vii. Gain exposure to developing differential and treatment options
    viii. To fully understand and appreciate endemic diseases and their evidence-based clinical management
    ix. To be able to explain the concept of American model of osteopathic practice to the hospital staff including director of medical education
2. Hints for a positive experience for both the preceptor and student:
    i. Be aware of the osteopathic physician-in-training's stage of professional knowledge and experience

ii. International clinical preceptors should not assume the osteopathic physician-in-training has all of the facts, but rather expect them to be able to find the correct information with the best reliable and clinically-relevant answers

3. Osteopathic physician-in-training performance evaluation: the evaluation form should include the osteopathic physician-in-training's name, international preceptor's name and his/her specialty, and the elective date. The evaluation form could be categorized as following:
    i. Can't judge/Never observed
    ii. Poor – unacceptable performance for this level of training
    iii. Needs improvement – for this level of training
    iv. Good – performance as expected with this level of training
    v. Very good – above average performance for this level of training
    vi. Outstanding
4. Consistently, osteopathic physician-in-training performance evaluation forms could include competencies such as:
    i. Medical and/or osteopathic medical knowledge
    ii. History taking
    iii. Physical exam
    iv. Problem solving/clinical judgment
    v. Progress notes
    vi. Informal patient presentation to the international clinical preceptor
    vii. Learning habits
    viii. Interpersonal relationships with patients
    ix. Reliability, initiative, and dependency
    x. Relationship with preceptor and staff
    xi. Language (and other communication) with patients
    xii. Cultural understanding and sensitivity
    xiii. General comments by international clinical preceptor

APPENDIX 2: Internet links to key guidelines and consensus documents dealing with international research ethics, plus a link to country-specific research ethical standard informational sources.

In planning international research or interfacing with global research partners, the following resources are either specifically designed to enhance an ethical approach to research or to assist in understanding cultural or regional issues (e.g., Islamic or Confucian ethics) that are currently being interpreted, discussed, or debated.

A training module resource entitled "International Study" created by the Collaborative Institutional Training Initiative (CITI): https://www.citiprogram.org/irbpage.asp?language=english

Council for International Organizations of Medical Sciences (CIOMS) International Ethical Guidelines for Biomedical Research Involving Human Subjects: http://cioms.ch/publications/layout_guide2002.pdf

Nuffield Council on Bioethics: http://www.nuffieldbioethics.org/research-developing-countries

International Guidelines for Ethical Review of Epidemiological Studies:
http://www.ufrgs.br/bioetica/cioms2008.pdf

Or order the latest version of the document from CIOMS:
http://www.cioms.ch/frame_ethical_guidelines_2009.htm

World Health Organization's Good Clinical Practice Guideline (WHO GCP):
http://apps.who.int/medicinedocs/pdf/whozip13e/whozip13e.pdf

Operational Guidelines for Ethics Committees that Review Biomedical Research:
http://www.who.int/tdr/publications/publications/pdf/ethics.pdf

Report and Recommendations of the U.S. National Bioethics Advisory Commission, April 2001:
http://bioethics.georgetown.edu/nbac/pubs.html

Global Health Competencies and Approaches in Medical Education: a literature review (existing curricular examples of what is currently in the literature):
http://www.biomedcentral.com/content/pdf/1472-6920-10-94.pdf

Follow this link for a table of country-specific internet addresses (ministries of health and other websites) with information to start researching a given country's ethical review requirements:
https://www.citiprogram.org/members/learnersII/References.asp?intReferenceID=25856

Res. 9-A/2011 - CONTINUING MEDICAL EDUCATION FOR PRACTICE IMPROVEMENT PROJECT OF OSTEOPATHIC CONTINUOUS CERTIFICATION PROGRAM

AOA policy notes that physicians completing a practice improvement project for osteopathic continuous certification be awarded Category 1-B AOA CME by the AOA as determined by the physician's specialty certifying board; and that this CME award should be limited to once per CME cycle. 2011

Res. 11-A/2011 – AOA / STATE AFFILIATION AGREEMENT

I. Purpose

The purpose of affiliation between the American Osteopathic Association (AOA) and the named osteopathic specialty organizations is to ensure the health and viability of the osteopathic medical profession. The AOA and affiliated specialty organizations expect and desire that each shall support, assist and/or participate with the other with respect to all matters of common interest which further the fundamental and primary purposes of each.

This agreement to affiliate is made in order to:

a. Enhance the image of osteopathic physicians by fostering the profession's intersociety relationships;

b. Have an effective national and affiliate network of trained volunteers who vigorously represent the osteopathic medical profession;
c. Promote and develop future affiliate and national leaders;
d. Support both the AOA and specialty affiliates in their activities and programs to benefit members and the osteopathic medical profession; and
e. Share information that helps to preserve and advance the livelihood of osteopathic physicians and the osteopathic medical profession.

II. Privileges of Affiliated Status

A. Representation: Affiliated specialty organizations have the privilege to representation at the annual meeting of the AOA House of Delegates, as defined by AOA Constitution and Bylaws, the Bureau of Osteopathic Specialty Societies, and such other bureaus, councils and committees as defined by AOA policy.

B. Advocacy: Affiliated specialty organizations have the privilege to participate in grassroots advocacy efforts which include, but may not be limited to, signing on to letters of position or statements sent to the federal, state, local and international governments, and participation in targeted legislative outreach.

C. Educational Programs: Affiliated specialty organizations are entitled to participate in cooperative educational programs including, but not limited to, the AOA Osteopathic Medical Education (OMED) program; Regional Osteopathic Medical Education (ROME) programs; and Advocacy for Health Partnerships (AHP) Programs.

D. Data Sharing: Affiliated specialty organizations and the AOA shall participate in a data sharing arrangement relative to the specialty. This data will include but not be limited to information regarding residency training, certification, CME, and any other information mutually agreed upon by parties.

E. Promotional Materials and Use of Logo: Specialty organizations recognized as AOA affiliates may identify themselves as such on circulars, brochures and other such promotional materials related to continuing education programs, unified and joint educational programs, or such other programs and materials according to logo use as defined within the AOA Brand Guideline documents.

F. Benefits and Services: Specialty organizations are entitled to participate in programs as noted in the AOA Benefits and Services Guide which is updated on an annual basis.

III. Affiliate Standards

A. Definition of a Specialty Affiliate: The name by which a specialty affiliate is known within the AOA must clearly reflect both the character and purpose of that organization, and provide a description of that organization's composition.

1. The terms "Academy" and "College" are used in the names of specialty organizations that are directly involved in academics, postdoctoral residency training and/or the granting of a degree. These terms are considered synonymous when used in the name of an AOA specialty affiliate.

2. The terms "Association" and Society" are used in the names of specialty organizations that have common goals or interests, or are subgroups within a larger entity that are not necessarily involved in educational issues. These terms are considered synonymous.

B. Jurisdiction: The AOA will not recognize as a specialty affiliate any organization that duplicates the function or prerogatives of any presently affiliated specialty organization.

C. Incorporation: A specialty organization shall be incorporated in an appropriate state, territory or the District of Columbia. The specialty understands and agrees that it is the sole responsibility of the specialty to examine and comply with laws relating to: incorporated associations in the state where the specialty is located, the filing requirements of non-profit corporations, and the nature of activities to be undertaken by the specialty to maintain its corporate status in good standing as required by state laws.

D. Annual Reporting of Specialty Activities: The specialty shall prepare and report to the AOA annually through the Healthy and Viable Affiliate Organizations Program (HVAOP).

E. Membership: The AOA and specialty organizations recognize the value of membership in each other's association. AOA shall encourage osteopathic physicians to join the specialty affiliate and the specialty affiliate shall encourage specialists to join the AOA. In cases where a joint membership recruitment campaign is conducted, such a campaign will be based on mutually agreeable marketing expenses, if necessary.

IV. Responsibilities

A. Separate Corporate Entities: The AOA and specialty organizations expressly acknowledge and agree that each are, and intend to maintain, separate corporate entities and, as such, shall not incur any liability, obligations or expense on behalf of each other. The specialty affiliate and the AOA and its members are prohibited from acting as agents or representatives of the other without express prior written authority. The specialty affiliate agrees to indemnify and holds harmless the AOA and its officers, directors and employees from and against any suit, claim, obligations, cost and expense which may arise by any such misrepresentation of authority by specialty, its officers, directors or employees. Similarly, the AOA agrees to indemnify and hold harmless the specialty affiliate and its officers, directors and employees from and against any suit, claim, obligations, cost and expense which may arise by reason of a misrepresentation of authority by the AOA, its officers, directors, or employees.

B. Self Governance: The AOA understands and agrees that a specialty is a self-governed and independent legal entity which observes all AOA affiliated status obligations.

Term and Termination

A. The term of this affiliation agreement shall commence on the date this governing Resolution is approved and shall continue until revoked by the AOA or the affiliated organization upon sixty (60) day notice, or surrendered by the affiliate pursuant to the terms under Item VI. Probation, Suspension and Revocation of Affiliate Status.

V. Probation, Suspension and Revocation of Affiliated Status

A. Authority and Events: The AOA shall have the authority to place on probation, suspend or revoke the affiliated status granted to the specialty if the Board of Trustees determines the conduct of the specialty to be in violation of the affiliation agreement.

VI. Procedure to Resolve Disputes Relative to Affiliates and Affiliation Status

A. Inquiry: Upon receipt of a signed, written request from a complainant, (i.e., member physician, other affiliated organization, or the public), the AOA Board of Trustees may request an investigation of an affiliate by a duly appointed investigating body for the purpose of determining whether there is reasonable basis to believe that a specialty's affiliate status should be placed on probation, suspended or revoked.

B. Panel: The AOA Board of Trustees will appoint a panel of experts to conduct an investigation of an affiliate's status. Such a panel will be made of two members of the Committee on Basic Documents and Operations of Affiliated Organizations, two executive directors of AOA approved affiliated organizations, two physicians selected at large from the AOA members and AOA legal counsel.

C. Investigation: The investigating body shall:

1. Review the initial complaint to determine if it contains sufficient evidence that an inquiry be conducted. Validity of complaints will be determined by the presentation of sufficient documented evidence to constitute grounds for probation, suspension, or revocation. Evidence shall be defined as allegations of misconduct, malfeasance or other behaviors by an officer, board member or executive director that would impact on the conduct of business and the reputation of the specialty affiliate or the AOA.

   Following the outcome of its deliberations, the panel shall notify the AOA Board of Trustees, which will notify both the originator of the request and the specialty affiliate.

2. If the panel determines that the complaint contains sufficient evidence to conduct an investigation, a meeting will be convened with the complainant and specialty affiliate representatives at which time evidence will be reviewed with both parties based on facts and information submitted.

3. On the basis of the material and testimony presented, the panel shall determine whether there is or is not sufficient evidence to support the complaint and make a recommendation to the AOA Board of Trustees

C. Notification: Within thirty (30) days after the determination of the panel, the President of the AOA shall send notification of the purported violation by Certified Mail, Return Receipt Requested to the appropriate representatives of the specialty and the originator of the request. This notification shall inform the specialty affiliate of the results of the panel and provide the specialty affiliate and complainant the opportunity to appeal the panel's finding to the AOA Executive Committee and provide the parties with a designated time in which to respond.

In the event that no appeal to the determination is received, the AOA will notify the specialty affiliate and complainant of this outcome and, if required, provide the specialty affiliate with a set time in which remediation of the complaint will be conducted.

D. Determination: The AOA Board of Trustees shall review the findings of the investigating body and evidence and arguments offered by the specialty affiliate; it shall consider the gravity of the offense; and, it shall take any action which it deems appropriate, which may include placing the specialty on probation, suspending or revoking the specialty's affiliated status. The determination of the AOA Board of Trustees shall be an affirmative vote of two-thirds of the Board of Trustees present and voting at the duly called meeting at which a quorum is present. The action of the AOA Board of Trustees shall immediately be communicated to the appropriate representatives of the specialty by Certified Mail, Return Receipt Requested.

1. Probation. The AOA Board of Trustees may place a specialty on probation for a period not to exceed six months.
2. Suspension. The AOA Board of Trustees may suspend a specialty's affiliated status for a period of twelve months, which shall result in the loss of all privileges.
3. Revocation. The AOA Board of Trustees may also revoke a specialty's affiliated status. In the event that a specialty's affiliated status is revoked, the specialty affiliate will cease to have the right to represent itself as an affiliated specialty of the AOA and will lose all benefits and privileges provided therein.
4. Reapplication. Any specialty whose affiliation status has been revoked may reapply for affiliate status 12 months after the date of revocation.

VII. Miscellaneous Provisions

A. Confidentiality: The AOA will hold and will cause its officers, directors and employees to hold in strict confidence, unless compelled to disclose by judicial or administrative process or, in the opinion of its counsel, by other requirements of law or as necessary, all documents and information provided to the AOA as required by this agreement.

B. Severability: In the event any part of this agreement is found to be illegal, in violation of public policy, or otherwise unenforceable in laws, such finding shall not invalidate any other part(s) of this agreement.

C. Choice of Law: The parties acknowledge this agreement shall be governed by and construed under the laws of the State of Illinois.

Res. 15-A/2011 - MAINTAINING QUALITY RESIDENCY INSPECTIONS THROUGH INDEPENDENT PHYSICIAN REVIEWERS

All independent inspectors must be experienced medical educators who hold either a DO degree or advanced level degree in education/medical education (Masters or PhD level); all reviews of Section V of the residency standards (Program Requirements and Curriculum) must be performed by an AOA board certified" DO or education specialist as defined above at the discretion of the specialty college [osteopathic physician expert that is trained to complete the audit and expert assessment according to objective measures]; a three-year pro forma income/loss statement and the document proposing the revised structure of the inspection review process will be circulated for comment to the specialty colleges in advance; and that hospitals will be notified a year in advance of the approved fee changes for the new inspection program scheduled to start fiscal year 2013 and the approved formula for budgets. 2011

Res. 18-A/2011 - OSTEOPATHIC CONTINUOUS CERTIFICATION REQUIREMENT FOR PRIMARY CARE PHYSICIANS IN NON-TRADITIONAL PRACTICES

The American Osteopathic Association (AOA), in conjunction with its Bureau of Osteopathic Specialists (BOS), will develop criteria to define primary care physicians in non-traditional practices and develop a policy and process to allow their participation in osteopathic continuous certification (OCC) with component 4 chart extraction tailored to the physician's type of practice, upon recommendation of the specialty certifying board and approved by the BOS; and that primary care physicians in non-traditional practice still must participate in the required educational components as part of the osteopathic continuous certification (OCC) process. 2011

Res. 46-A/2011 - NON COMPLIANT SPECIALTY COLLEGE STANDARDS SUBMISSION

Policy of the American Osteopathic Association states, that any specialty affiliate non compliant with any mandated requirement of the AOA Department of Education or any AOA Education bureau or council, after a reasonable notification of at least six (6) months' time, shall be reported to the AOA Board of Trustees for consideration of sanctions.

Explanatory Statement: The requirements for the new standards were sent to all specialties almost 2.5 years before their due date for submission. In addition, at least 8 separate memos were sent by AOA COPT to all specialty affiliates between December 2008 and March 20011, serving as reminders and with additional information to assist in the preparation of those new standards. Verbal reports regarding this requirement were given by, Dr. Opipari at multiple meetings and in all COPT Newsletters. It is felt that there is no excuse for any non-compliance for this mandate from BOT. No specialty has ever requested additional time for any reason.

Res. 49-A/2011 - REPEAL OF RES. NO. B-29-A/2010 – APPROVAL OF ACGME RESIDENCY

Resolution B-29 (A-2010) is repealed. A moratorium has been placed on existing approvals of ACGME training via Resolution B-29; all osteopathic physicians seeking AOA approval of ACGME training as an OGME-1 year must in the future apply through the existing "Resolution 42" process; the Bureau of Osteopathic Medical Educators (BOME) has been charged with producing a white paper evaluating the AOA approval of ACGME residency training to be presented at the 2012 mid-year meeting of the AOA Board of Trustees. This white paper must address: the current state of the AOA Department of Education's approval process of ACGME residencies, the historical data regarding this process including the number of applications and the percent of approvals by specialty, make recommendations on the future of the approval process; and that this paper recommend a process for trainees that would not be eligible under Resolution 42. 2011

Res. 63-A/2011 – POLICY GOVERNING COMMERCIAL USE OF ASSOCIATION NAME, LOGO AND OTHER INTELLECTUAL PROPERTY

Introduction

The following policy and procedure govern the commercial use of the American Osteopathic Association (AOA) name, logo and other intellectual property. [The AOA receives frequent requests for support of non commercial products, such as clinical guidelines or best practices in treatment, and governmental policy positions. This policy and procedure are not intended to change the process through which such proposals are evaluated and approved]

Purpose of Policy and Procedure

The AOA seeks to be the professional home for all osteopathic physicians. Its mission is to advance the distinctive philosophy and practice of osteopathic medicine. To realize this vision and achieve its mission, the AOA must protect its name and reputation. Safeguarding the AOA name and reputation requires vigilance not only with respect to the AOA's own actions, but also to the individuals and entities with which the AOA does business.

The AOA periodically is offered the opportunities to partner with individuals and corporations that are interested in building a relationship with osteopathic physicians and the osteopathic community. Some individuals and corporations may be interested in securing the AOA's endorsement, approval or other favorable statement concerning the merits of a product or service. Others are interested in licensing the AOA's name, logo and intellectual property for use in marketing their products. This Policy statement is intended to set out a clear process through which the AOA can identify acceptable uses of its name, logos and other intellectual property in order to best protect its reputation.

It is expressly noted that this Policy is not applicable to individual physicians who have membership in or board certification from the AOA. Members are encouraged to promote their membership and/ or certification status. Similarly, the policy is not applicable to members of the osteopathic family of organizations who may promote their affiliation with the AOA.

General Rule

The American Osteopathic Association (AOA) may enter into endorsement and licensing arrangements where the agreement is consistent with the AOA's policy and in the best interests of the AOA and its members. The AOA's name and intellectual property associated with its name shall not be used commercially by individuals, corporations and/or organizations without the prior written approval and, if appropriate, written licensing agreement with the AOA.

Procedure

Products and services will not be endorsed or the AOA's name and intellectual property licensed until a vendor has been reviewed and approved by the AOA's Finance Department using

appropriate resources and the product has been reviewed by the Bureau(s), Council(s) or Committee(s) with expertise and jurisdiction in the area (e.g., insurance products should be reviewed by the Bureau of Membership's subcommittee on insurance; scientific products should be reviewed by the Bureau of Scientific Affairs, electronic medical records and other technology products should be reviewed by the Information Technology Advisory Bureau). Questions regarding whether a particular form of agreement or the nature of an agreement appropriate will be referred to the Bureau of Membership's Subcommittee on Ethics. The Executive Director shall be advised of all requests for endorsement or licensure agreements. The Executive Director, in consultation with the AOA President, shall determine the appropriate bureau, council or committee and staff persons to be involved in the review process.

Types of Relationships

1. Endorsements. Endorsement will be perceived as a direct approval of the endorsee and its product by the AOA. It creates a close relationship that could result in allegations of liability against the AOA if an endorsed product or service is defective or the endorsee acts improperly. To be a credible voice for osteopathic medicine, the AOA must be viewed as truly independent from improper influence of the pharmaceutical and healthcare industry, corporations, other medical associations and organizations, other commercial organizations, and governmental authorities. Endorsement of products, particularly when tied to an agreement for monetary compensation, may be perceived as creating a conflict of interest that hinders the AOA's ability to evaluate objectively the quality of products and services of competitors. Endorsements should only be given in circumstances where the value of a product and the credibility of the endorsee are beyond reproach. Additionally, the evaluation and approval process that leads to an endorsement must be transparent and accountable. Finally, the AOA's endorsement will only be given with the direct approval of the Board of Trustees after careful evaluation and recommendation by an appropriate bureau, council or committee with relevant expertise.

2. Licensing. Licensing refers to a relationship that allows other parties to use the AOA's name, logo and other intellectual property to promote a product or service. While the relationship may not include an explicit endorsement of the product or service, but the use of the AOA's name or logo in promotional materials may create that appearance. Since the "American Osteopathic Association" name, logo and other intellectual property associated with the AOA name are among the most valuable assets of the AOA, the AOA must not only protect the integrity of the intellectual property, it must also prevent their misuse or misapplication. Therefore, in addition to the concerns arising out of endorsement relationships, the AOA must act to control the manner in which its name and intellectual properties are used. No business or person shall adopt or use the AOA name or intellectual property in connection with its products or services, whether offered for sale to AOA members or to the public as a whole, without the express prior written permission and license of the AOA. Additionally, the AOA's guidelines for use of its intellectual property shall indicate that the name and logo and other property are not to be used in promotional materials in a way that could be construed as an endorsement of the product unless that product has been endorsed.

3. Sponsored Events/Advertising. Corporations and other organizations may offer to sponsor AOA events or services at AOA meetings or events or purchase floor space at which it can install a booth to promote products or services at AOA scientific exhibition. Various organizations may purchase space for advertisements in the AOA publications. Acceptance of sponsorship or advertisement does not indicate or imply an AOA endorsement. Accordingly, the Executive Director and Editor in Chief shall have discretionary authority to evaluate and accept sponsorship and advertisement proposals, provided that such programs are consistent with applicable regulations.

Considerations

The Board of Trustees shall analyze the information collected by the Bureaus-Councils-Committees and their staff and assess whether the benefits of a proposed endorsement or licensing arrangement exceed the risk of potential damage to the AOA's name and reputation.

The AOA may consider entering into a licensing arrangement for products or services that are beneficial and useful for a significant number of members, either by offering a unique service or product or that provide a competitive advantage for members that allow the AOA to offer "value-added" or otherwise unique incentives to retain old members and attract new members.

To assist in the evaluation process, AOA staff shall be responsible for the following:

1. Having a general understanding of similar products or services offered in the marketplace

2. Objectively and independently researching the proposed licensee/endorsee and their products or services and finding information from third-parties;

3. Researching the market and determining if other entities offer similar products and consulting with the Chair to evaluate whether the AOA should see if the other entities are interested in extending a competing proposal; and

4. Communicating with the AOA Finance Department to make certain that it reviews the individual/ entity and has been able to secure the necessary information and records to assess stability and viability.

Additionally, in evaluating proposals, Bureaus, Councils and Committees and AOA staff asked to review requests for endorsements or licensure arrangements may wish to consider the following factors:

- Is it advisable and desirable to have an endorsement or licensing arrangement for the product or service in question?
- Is the product reviewed and approved (or not reviewed and approved) by regulatory agencies, such as the Food and Drug Administration, or by other sources of objective product reviews and evaluation?
- Does the product comply with applicable laws and regulatory requirements?

- Is there sufficient data and/or other evidence to support the safety, efficacy, promotional/ advertising claims regarding the product?
- Will the marketing plan of any product to AOA members provide assurances that the privacy of AOA members will be respected and that solicitation and promotion will not be conducted in such a way that it would be considered harassing

Agreements
The Agreement reached regarding licensure of the AOA's name and intellectual property must preserve the ability of the AOA to withdraw its approval and cancel the agreement at any time at the sole discretion of the AOA.

Res. 64-A/2011 – GUIDE FOR ADMINISTRATIVE PROCEDURE FOR BUREAU OF MEMBERSHIP – SUBCOMMITTEE ON ETHICS

This is the Guide for Administrative Procedure of the Bureau of Membership's Subcommittee on Ethics. It is created pursuant to the Board of Trustees' authority under the Bylaws (Article VII [Board of Trustees], Section 1 [Duties)], part h), which specifies that the Board may adopt and amend "a Guide for Administrative Procedure regulating the procedure applicable to matters involving violations of the Code of Ethics."

1. Background.

The American Osteopathic Association (AOA) is required by its Bylaws (Article IV) to maintain a Code of Ethics, with which all AOA members are expected to comply. The Code of Ethics is expected to address the duties of physicians to patients to other physicians and to the profession at large, as well as the responsibilities of physicians to the public. The Code's provisions may not be "in conflict with the Constitution or Bylaws of the Association."

The Bylaws (Article VII [Board of Trustees], Section 1 [Duties]) also specify that the Board of Trustees is responsible for enforcing the Code of Ethics and has the authority to "Decide finally all questions of an ethical or judicial character." The Bylaws further explain that a Committee on Ethics is responsible for investigating "all charges or complaints of violation of the Constitution, Bylaws, or of grossly unprofessional conduct of any member." [As part of an administrative reorganization completed in July 2010, the Committee on Ethics became a subcommittee of the Bureau of Membership]

The Bureau of Membership's Subcommittee on Ethics ("Subcommittee") serves to assure the Association's membership and the osteopathic profession that members of the Association comply with a Code of Ethical and professional conduct. The Subcommittee's complaint review process is a confidential, peer review procedure consistent with the requirements of the Illinois Medical Studies Act.

2. Composition of Subcommittee.

The Subcommittee on Ethics consists of five members, who are appointed by the AOA President to serve staggered four-year terms. The Subcommittee's membership is comprised of two members of the Board of Trustees (one of whom is designated by the President to serve as Chair) and three members-at-large. The Committee Secretary shall be the General Counsel for the AOA.

Because it is a Subcommittee of the Bureau of Membership, the Chair of the Bureau of Membership is also a member of the Subcommittee. At the discretion of the AOA President, the Bureau Chair may either be appointed to serve as one of the five voting members or hold a non-voting ex officio position.

3. Nature of Review.

(A) Complaint Driven Process. The Subcommittee conducts a complaint-driven review process. It does not initiate its own reviews based on news stories or other information. Rather, the review process is initiated by a complaint that alleges unethical or other professional misconduct on the part of an osteopathic physician who is a member of the AOA.

1. Complaints may be submitted by another physician, a patient, an individual member of the public or by an organization (hospital, nursing home, insurer, an affiliate or the AOA itself, etc.)
2. All complaints must be signed by the individual alleging misconduct or an authorized representative of the organization submitting the complaint. The Subcommittee will not consider anonymous complaints because anonymous complaints may prevent a physician from providing a complete response to the allegations.
3. The Subcommittee can only review complaints against AOA members. Allegations against non-members will be kept on file. Physicians applying for AOA membership will be expected to respond to the ethics complaint and the complaint will be reviewed before membership is awarded.

(B) Review of Affiliate Actions. If an AOA member has been suspended or expelled from a divisional society or affiliated organization based on a breach of the AOA's Code of Ethics, the AOA Board of Trustees can request that the Subcommittee review the record of that decision and determine if the AOA should take a similar action. If the Subcommittee (and Board of Trustees) concurs with the action of the divisional society or affiliated organization, then the member shall be suspended for the same period of time or expelled from this Association upon the same basis as in the decision of the divisional society or affiliated organization. (AOA Bylaws, Article VII, Section 1, part h, ¶2.)

(C) Decisions That Do Not Require Subcommittee Review. Complaints that are submitted related to alleged criminal offenses or the action of a state licensing board are not reviewed by the Subcommittee. Instead, the AOA Bylaws provide that on the final conviction of any member of an offense amounting to a felony under the law applicable thereto, or the final revocation of, or suspension of, a license to practice in a state based on a finding of a

violation of a disciplinary provision of the state's licensing law by a state licensing agency, or the voluntary surrender of a license while under investigation of charges of having violated the licensing law, the member is automatically deemed expelled from membership. (AOA Bylaws, Article VII, Section 1, part h, ¶1.) [The Bureau of Membership has authority to restore to membership a doctor whose license was revoked, and later retroactively reinstated by his licensing board]

(D) Role of the Subcommittee. The Subcommittee reviews complaints and documentation of alleged wrongdoing and the physician's response to the allegations and assesses whether there is evidence of a violation of the AOA's Code of Ethics. Based on the information available to it, the Subcommittee may recommend that the AOA Board of Trustees take action against the physician's membership, determine that no action is appropriate based on the information received or request additional information.

4. Process. The following summarizes the procedure to be followed by the Subcommittee in reviewing complaints:

Step 1: Receipt of Complaint. The Subcommittee receives the complaint. Staff sends a letter to the complainant to acknowledge receipt of the complaint. Staff determines if the physician is a member of the Association and if the complaint raises an issue that can be reviewed.

Step 2: Request for Response.

(a) If the physician is a member of the AOA, then a letter is sent to the physician that requests response to the allegations within 60 days.

1. Statements and Information. Physicians under investigation by the Subcommittee may submit formal statements and documentation in support of their position. It is recognized that complaints to the Subcommittee on Ethics may be duplicative of complaints filed as part of civil litigation and/or complaints filed with state medical licensing boards. The Subcommittee will accept copies of responses filed to civil litigation or state medical boards in lieu of a separate response.
2. No Discovery. Statements and documentation should be based on information in the physician's possession. There is no discovery phase or process that allows for discovery from the person or entity that submitted the complaint or from the AOA or other persons.
3. Representation by Counsel. Physicians may choose to be represented by legal counsel.

(b) If the physician is not a member, a copy of the letter is kept on file so that the complaint can be reviewed if the physician subsequently applies for membership. The complainant is advised that the complaint cannot be reviewed.

Step 3: Receipt of Response. After the Subcommittee has a complete file, including a complaint and response, the complaint will be reviewed at the Subcommittee's next meeting.

[The Subcommittee meets on an as-needed basis to review complaints. Meetings are typically held four times per year.]

Step 4: Deliberation. After a complaint and response are received, the Subcommittee reviews complaint and response and any documentation or other evidence submitted regarding the complaint. The quorum for a meeting is three voting members. In general, there will not be a formal hearing at which the physician or complainant testifies. Physicians or complainants who want to provide testimony should do so by affidavits. However, the Subcommittee has authority to request a hearing if it believes the hearing will assist the Subcommittee's review process.

Step 5: Decision/Recommendation. The Subcommittee has the option of: (a) finding that there is evidence that a violation of the Code of Ethics has occurred, (b) finding that there is no evidence that a violation of the Code of Ethics has occurred, or (c) finding that additional information is required to review the complaint. If additional information is required, the Subcommittee will instruct staff to locate the necessary information or request it from an appropriate source (e.g., the physician, the complainant).

Step 6: Reporting of Decision/Recommendation.

(a) Recommended Action. If the Subcommittee finds that there is evidence that a violation of the Code of Ethics has occurred, it will issue a report and recommendation for review by the Board of Trustees in Executive Session. The report may recommend action against a physician's membership, including censure, probation or suspension for up to a three-year period, or expulsion, as the findings warrant. [The four different levels of sanctions are understood to have the following meanings: (1) Expulsion - the most severe penalty - the individual's membership is revoked immediately. (2) Suspension – the individual's membership is revoked for a temporary period (AOA Bylaws specify up to 3-years). (3) Probation – no immediate action against membership, but the individual is given a warning that further ethical misconduct will result in suspension or expulsion. Probation is for a limited time period (AOA Bylaws allow for up to 3-years). Conditions may attach to the probation (such as specific CME course) as specific requirements for reinstatement to membership in good standing; and (4) Censure – an official expression that the misconduct is significant and inappropriate. In other words, an official reprimand, but without specific consequences in membership status. The Subcommittee may also recommend that the Board of Trustees accept a physician's signed agreement to complete continuing education or perform community service or other remediation in lieu of action against membership status. The Board has the discretion to accept the Subcommitte's recommendation or request that the Subcommittee review other information.

(b) Dismissal. If there is no evidence that a violation of the Code of Ethics has occurred, the Subcommittee will issue a letter to dismiss the complaint.

(c) Reporting to Complainant. The Subcommittee's review is a confidential, peer review process. The Subcommittee will report to a complainant that an investigation has been concluded, but information regarding its findings and recommendations will remain confidential.

Step 7: Appeal. Physicians shall be advised that they have a right to appeal decisions. Appeals will be considered by the Appeal Committee of the Board of Trustees consistent with the standards and procedures of the Appeal Committee. The Appeal is not a *de novo* review. The Appeal Committee may recommend that a decision be overturned if it determines the Board/Ethics Subcommittee decision is a "clear error"; flawed due to procedural errors; or an abuse of direction. Where appropriate, the Board of Trustees may remand the matter back to the Subcommittee on Ethics so that the appellant and/or AOA staff can provide additional information for review by the Subcommittee.

5. Confidentiality. The complaint review process is for the benefit of the Association and the osteopathic profession. It is not intended to serve as evidence in civil litigation or another organization's review of the incident. The process is structured so that deliberations and information regarding the outcome will be protected from discovery under the Illinois Medical Studies Act. Complainants will not be advised of the Subcommittee's deliberations or decision except as set out in this document. Specific findings and recommendations will remain confidential and will not be reported to third parties or agencies except as may be required by law.

Res. 14-M/2012 - WHITE PAPER ON AVENUES FOR APPROVAL OF ACGME TRAINING

1. A new resolution that simplifies and streamlines the review of all graduate medical education training for osteopathic medical school graduates to achieve AOA-approval of ACGME training should be prepared by the AOA Department of Education and circulated to all stakeholders.

2. A Task Force should be appointed and charged with the responsibility of creating a White Paper that examines the impact of requiring AOA-approval of ACGME training for osteopathic medical licensure in Florida, Michigan, Oklahoma, and Pennsylvania.

3. Pending the outcomes of Recommendations 1 and 2, and the creation of more credible and less cumbersome processes to accomplish the intent of Resolution 42 without undue negative consequences on the osteopathic profession and graduates from colleges of osteopathic medicine that chose to train in ACGME programs, that Resolution 42 should be withdrawn.

4. The AOA, its leaders and its members should immediately cease referring to any doctor of osteopathic medicine (DO) who completed a portion or all of their residency training in ACGME-accredited programs as "having left the profession."

Executive Summary

Currently, osteopathic medical students have the option to apply for graduate medical education (GME) training programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) through the National Residency Match Program (NRMP), the Military Match, or osteopathic graduate medical education (OGME) programs accredited by the American Osteopathic

Association (AOA) through the National Match Service (NMS). At this time, more osteopathic medical students are choosing to apply to residency programs that are ACGME-accredited than the number entering AOA-accredited programs.

Based on months of investigation and a series of meetings reviewing a robust array of current articles, reports, editorials and data related to Resolution 42; an assessment of current physician training models (both predoctoral and postdoctoral) in the rapidly changing environment of healthcare; and discussions with colleagues and policymakers, this white paper summarizes the facts and concerns connected to the past, present and forecasted scenarios impacting and affecting OGME.

This white paper endeavors to accomplish the following:

1) review the history of resolution 42,

2) summarize the breadth of literature (facts) related to Resolution 42,

3) consider the dynamic landscape of GME (concerns),

4) maintain objectivity in the reporting of findings, and

5) be bold and proactive in offering recommendations.

Resolution 42: History

From 1968 to 1978, the number of colleges of osteopathic medicine (COM's) increased from 5 to 14. Due to this rapid expansion in the number of COM's by the early 1980's, the availability of an adequate number of osteopathic postgraduate training positions for first-year graduates (PGY-1 positions) was becoming a concern. By 2010, the number of COM's (including branch campuses) had increased to 32 and the concern for a possible shortage of PGY-1 training sites had been replaced by a real deficit of over 1600 positions.

During the past 25 years, the AOA responded to these training needs through a series of processes and resolutions. The first response (1986 - 1990) to the predicament was a "pilot project that granted COM graduates AOA approval of the first year of ACGME-accredited training".[6] From 1990 - 1995, Resolution 65 allowed for graduates with "special circumstances" to request AOA approval of ACGME PGY-1 training; from 1996 - 1998, Resolution 22 added the stipulation that in addition to special circumstances, the PGY-1 year also needed to meet the rotational requirements of an AOA internship; from 1998 - 2000, Resolution 19 removed those specific curricular requirements; and since 2000, Resolution 42 has allowed both current and past COM graduates that trained in ACGME programs to request AOA approval of their PGY-1 year.

Resolution 42 has 4 requirements that must be met before approval is granted for ACGME training. First, the applicant must be a AOA member in good standing. Second, the applicant must complete a (one-page) application. Third, the ACGME residency program must submit a letter verifying

training (including training dates and rotations completed). Fourth, the applicant must provide proof that an osteopathic training activity was completed (this may include, but is not limited to attending an AOA-sponsored conference that provided the equivalent of 8 hours of 1-A CME, presenting an osteopathic clinical presentation to their ACGME program, or attending an osteopathic training module offered by a regional Osteopathic Postdoctoral Training Institution [OPTI]).

Since January 1, 2002, the AOA has processed 2181 requests for AOA Approval of PGY1 training through Resolution 42. Of 2181 requests, 2170 were approved and 11 were denied (i.e., the overall approval rate for requests processed through Resolution 42 stands at over 99% through December 31, 2010).

The Practice of Osteopathic Medicine

Osteopathic medicine is distinctive. Osteopathic medical students graduate from colleges accredited by the Commission on Osteopathic College Accreditation (COCA). Osteopathic physicians demonstrate their competencies for the practice of osteopathic medicine by completion of a uniquely osteopathic examination series (COMLEX-USA), partly during their distinctive curriculum at a college of osteopathic medicine (i.e., COMLEX-USA Level 1, Level 2-CE, and Level 2-PE) and partly during their AOA-accredited or ACGME-accredited residency training (i.e., COMLEX-USA Level 3).

Osteopathic physicians in residency and for their entire career in practice should continue their lifelong learning and development of physician competencies, including the use of osteopathic principles and practice and osteopathic manipulative treatment (OMT).

What are the facts?

- ✓ The purpose of the AOA is articulated through its core values:

  Vision Statement

  To be the professional home for all osteopathic physicians

  Mission Statement

  To advance the distinctive philosophy and practice of osteopathic medicine

- ✓ The number of osteopathic medical school graduates is greater than the number of funded osteopathic PGY1 positions and the deficit grows larger each year.
  - o 2006 COM grads = 2814; Funded PGY1 OGME = 2206; *Deficit = 608*
  - o 2011 COM grads = 4228; Funded PGY1 OGME = 2553; *Deficit = 1675*
  - o 2016 COM grads = 5975; Funded PGY1 OGME = 3050; *Deficit = 2925 (projected)*
- ✓ In the face of increasing numbers of COM graduates, the fill-rate for AOA PGY-1 positions offered through the NMS match has remained stable. The *after-scramble* data provides information about capacity but not "choice".
  - o 2000 NMS AOA PGY-1 positions filled *before scramble = 1450*
  - o 2005 NMS AOA PGY-1 positions filled *before scramble = 1485*
  - o 2009 NMS AOA PGY-1 positions filled *before scramble = 1433*
- ✓ The number of active applicants for ACGME funded PGY1 positions is increasing.
  - o 2007 NRMP active *applicants = 27,994*
  - o 2011 NRMP active *applicants = 30,589*
- ✓ The Commission on Osteopathic College Accreditation (COCA) has standards that COM's must adhere to regarding osteopathic medical student education:

  "The AOA Commission on Osteopathic College Accreditation (COCA) serves the public by establishing, maintaining, and applying accreditation standards and procedures to ensure that academic quality and continuous quality improvement delivered by the colleges of osteopathic medicine (COMs) reflect the evolving practice of osteopathic medicine. The scope of the COCA encompasses the accreditation of the COMs."
- ✓ The National Board of Osteopathic Medical Examiners (NBOME) provides the means to protect the public by assessing the competencies of osteopathic physicians.

  "The mission of the National Board of Osteopathic Medical Examiners is to protect the public by providing the means to assess competencies for osteopathic medicine and related health care professions."

What are the concerns?

- ✓ Geographically, 83% of all AOA-approved residency positions are located within 10 states. The top reason cited by fourth-year students to choose residency locations is geographic.

- ✓ There are four states (FL, MI, OK, and PA) that require AOA-approval of PGY1 training as a requirement for state licensure. These four states offer 44.9% of all AOA-approved and funded PGY-1 residency positions (FL = 220; MI = 452; OK = 68; PA = 407; Total = 2553).
- ✓ AOA board certification is required to hold certain administrative positions in osteopathic medical schools and AOA-accredited postdoctoral programs, and to serve as an osteopathic Director of Medical Education or an OPTI Academic Officer,
- ✓ The federal government is considering cuts to the budget that support both direct graduate medical education (DGME) and indirect medical education (IME) funding. The Simpson Bowles Commission has recommended a $60 billion dollar reduction in graduate medical education (GME) funding over the next 10 years.
- ✓ Currently there are ACGME Proposals (Common Program Requirements) that are being discussed that could negatively impact the ability of osteopathic medical school graduates to gain entry into ACGME residencies and fellowships after 2014.
- ✓ The Federation of Medical Licensing Boards and a number of specialty colleges are discussing Maintenance of Licensure (MOL) and Maintenance of Certification (MOC). The impact of these issues and their associated effect on physicians and their practice patterns will need to be monitored closely.
- ✓ The number of international medical school graduates (IMG) seeking ACGME training positions is increasing. The addition of more IMG and osteopathic applicants to the NRMP will further stress the capacity of PGY-1 training positions and result in more competition.
- ✓ From 2007-2011, the NRMP offered an additional 1576 PGY-1 positions while the number of active USMD seniors increased by 1353 and osteopathic graduates seeking positions increased by 1408; prevailing patterns of growth in medical schools (osteopathic and allopathic) will continue to widen the deficit in PGY-1 positions in the NRMP.[1,19]
- ✓ Medical students (76%) report that residents, faculty and other medical students bash or badmouth their career and specialty interests. These students report that this negativity influences their ultimate specialty choices.
- ✓ There are several anecdotal reports of osteopathic physicians that train in ACGME-programs that feel disenfranchised. Many of these DO's opt not to join the AOA, do not attend or participate in osteopathic national or state medical society activities, and do not seek AOA board certification.

Discussion

During the past 25 years, the backdrop surrounding the profession of medicine has changed.

During that same time period, osteopathic medicine as a profession has changed. The changes are accelerating in both magnitude and complexity.

Based on the facts and concerns noted above, it is more probable than possible that a perfect storm is developing on the horizon for the osteopathic profession, OGME and osteopathic medical school graduates. It is imperative that all stakeholders firmly grasp the "banner of osteopathy" initially set in motion by Andrew Taylor Still in 1874 and exert a more proactive role advancing the profession using well-developed and precise forecasting models based on as much objective evidence as possible; minimizing visceral, reflexive responses.

Res. 57-A/2011 - DEFINITION OF A SMALL SPECIALTY AFFILIATE

A small specialty affiliate shall be defined as a specialty affiliate organization with 300 or fewer dues-paying osteopathic physician members of that specialty as reported annually in the AOA Healthy and Viable Affiliate Organizations Program; and the AOA will offer the benefits as outlined below to these identified small specialty societies pending a financial impact analysis

Explanatory Statement: The Bureau of Osteopathic Specialty Societies recognizes that small specialty affiliates have unique needs and limited resources. Discussion on how best to meet the needs of small specialty affiliates has occurred within several AOA Bureaus, Councils and / or Committees as well as the EPPRC III Task Force. The AOA Division of Affiliate Affairs, applying the requested definition, identifies eight specialty affiliates meeting this criterion.

Res. 65-A/2011 – BOT RESOLUTION POSTING - RESOLUTION B-4-A/2010, AMENDMENT OF

The American Osteopathic Association has established a BOT Resolution Publication deadline at which time submitted finalized resolutions would, where possible, appear on the AOA website and which would be at least 10 days in advance of the start date of the next regularly scheduled BOT meeting when such resolutions would be considered by the BOT; any Resolution which is received after the established Resolution Submission Deadline will become a "Late Resolution" and may go forward to the BOT for discussion and action; following action by the Board of Trustees on any late resolution, any divisional or specialty affiliate may designate a late resolution for discussion at the next regularly scheduled meeting of the Board of Trustees; the AOA website format will allow the entry of public comments which will be associated with each proposed Resolution; the public comments received through such process will be made available in a timely manner to the applicable AOA organizational element and any Affiliate organization responsible for or associated with the submission of the pertinent Resolution; the time limit established and published for such public comment which will allow sufficient time for the proposing organization(s) to have sufficient time to review these comments prior to the start date of the applicable BOT meeting; and that the effective date of implementation of this Resolution Publication Deadline will be for the next AOA BOT meeting which occurs a minimum of 6-months following passage of this Resolution.

Explanatory Statement: The AOA Board of Trustees embraces the values of transparency and good governance reflected in Resolution B-4, but implementation of Resolution B-4 has presented unforeseen consequences. There are limited occasions at which the Board of Trustees meets and such meetings require expenditure of the AOA's financial resources and the limited time of its trustees and officers. The cumbersome procedural requirements under Resolution B-4 do not add value to the deliberative process and may present a barrier to the Board of Trustees ability to do the AOA's business.

The amendments set forth in this Resolution are intended to reconcile the goals of the original resolution without harming the AOA. The amendment makes the following changes: (1) The 30-day advance publication is reduced to 10 days because the deadline is unrealistic and presents a significant barrier to the AOA's ability to do business during the limited time available for regular

meetings of the Board of Trustees, while 10 days advance notice should be ample time for affiliated organizations to review and prepare responses to resolutions; and (2) if Resolutions are not published 10 days in advance, they are designated "Late Resolutions" and Affiliates are given an opportunity to schedule them for full discussion at the next Board of Trustees meeting

Res. EC-4-M/2012 - CME DEFICIENT MEMBERS, INCENTIVES AND DETERRENTS

The Board of Trustees should be given discretionary authority to evaluate members' efforts to comply with the CME requirements for membership and determine if waivers of the requirement are appropriate; for DOs who are CME deficient at the end of the 2010-2012 CME cycle the current policy on CME requirements for membership will remain in existence and if the Board of Trustees determines that a waiver of the requirement should be used, waivers should not be available for DOs who are CME deficient unless they have obtained 10 credits in Category 1-A or obtained an overall total of 120 credits of AOA-approved CME; if the Board of Trustees determines that a waiver of the requirement should be granted for DOs who are CME deficient for the future CME cycles (i.e., beginning with the 2013-2015 CME cycle), waivers will only be granted for DOs who have completed a minimum of 10 credits of AOA Category 1-A credit and an overall total of 120 AOA-approved CME credits; and except in exigent circumstances beyond a physician's control (e.g., severe illness, military deployment, etc.) the Board of Trustees should not grant waivers of the CME requirement applicable to board certified DOs because the public accountability associated with board certification. 2012

Res. 4-M/2012 - OSTEOPATHIC TEACHING / PRECEPTORING OSTEOPATHIC INTERNS AND RESIDENTS AT ALLOPATHIC INSTITUTIONS – AOA CATEGORY 1-B CREDITS

AOA Category 1-B credit be awarded to any DO that teaches osteopathic residents regardless of the institution residency affiliation and the Program Director or DME must send a signed evaluation to the Division of CME verifying the teaching activity.

Explanatory Statement: The Council continues to uphold its current AOA policy. Only preceptoring of osteopathic residents will qualify under this policy. No credit is awarded for preceptoring physician assistants, nurse practitioners or allopathic residents.

Res. 5-M/2012 - COLLEGES OF OSTEOPATHIC MEDICINE / BRANCH CAMPUSES AS AOA CATEGORY 1 CME SPONSORS – SPONSORSHIP

All Branch Campuses must independently apply to be recognized as an AOA Category 1 CME Sponsor and that the policy will go into effect January 1, 2013.

Explanatory Statement: The CCME reviewed the *Accreditation Manual of Colleges of Osteopathic Medicine* defining COM Accreditation Standards and Procedures defining the terms Additional Location and Branch Campus to determine how sponsorship by COMs would apply as CME Sponsors. Below are the terms COCA uses to define an additional location, branch campus, and how the COMs are structured.

Branch Campus – COMs that have their institutional accreditation status from the COCA.

A branch campus is any location of an institution other than the main campus which is permanent in nature, offers courses in educational programs leading to the doctor of osteopathy or doctor of osteopathic medicine degree, has its own faculty and administrative or supervisory organization, has its own budgetary and hiring authority, and may have affiliated clinical sites. These will be considered a Branch Campus and must follow the procedures outlined under Chapter VI: USDE Requirements.

Additional Locations – A location that is geographically apart from the main campus at which the institution offers at least 50 percent of an educational program. An additional location is geographically apart from the main campus, and offers at least 50 percent of an educational program. The additional location will not have separate administration, faculty, or budgetary independence, all of which are required for a branch campus or for a new COM. Students may be admitted directly to the additional location as their primary place of enrollment. Students from the entire program can take classes at the additional location

1. Sponsorship is obtained from the parent campus.
2. Branch campuses maintain separate budgets, have their own dean and make independent decisions from parent campus.
3. The Additional locations do not have separate addresses, deans and do not make independent decisions. They are not listed in iMIS.

Res. 11-M/2012 - INDEPENDENT PHYSICIAN REVIEWERS – BOARD CERTIFICATION STATUS

The AOA and ABMS Board Certified osteopathic physician medical educators will both be eligible to be selected as AOA physician independent reviewers and eligible to review implementation of all Sections of the AOA Basic Document for Postdoctoral Training to include Section 5 (Program Requirements and Curriculum).

Explanatory Statement: A request from a specialty college representative to the 2011 Annual BOT meeting resulted in an amendment to an amendment to the Substitute B-15 Resolution (A/2011) which has a potentially significant negative impact on many osteopathic physician medical educators in our profession. The amendment involved the credentials of DO physicians that would be acceptable to the AOA as future independent residency/fellowship program site visitors. This change, the requirement of only "AOA" Board certification, would exclude those osteopathic physician educators who are only "ABMS" Board certified from the potential independent inspector pool.

After many years in which ABMS certified osteopathic physician educators have successfully participated and contributed to the residency inspection/site visit process, the BOT's action appears as a discriminatory and regressive action. At the 2011 Annual BOT meeting, there was no evidence submitted as to why this group of medical educators would suddenly be not acceptable as program

site reviewers of the quality of OGME programs and their compliance to specialty college standards for accreditation.

Res. 13-M/2012 - COUNCIL OF MEDICAL SPECIALTY SOCIETIES' CODE FOR INTERACTIONS WITH COMPANIES, AOA SUPPORT FOR

The American Osteopathic Association confirms its support for the principles set forth in the Code of Interactions with Companies and has referred the Code to the BOE to revise and/or develop appropriate policies consistent with the principles of the Code and the needs of the osteopathic profession. 2012

Res. 21-M/2012 - RESOLUTIONS TO AOA BOARD OF TRUSTEES

The Board of Trustees, in its intention to allow for greater participation in discussions from affiliated organizations as part of "good governance" values of transparency and openness agrees to the following:

- Resolutions being brought before the Board should have an advance publication requirement of at least 14-days prior to the start of the Board's meeting; and
- If resolutions are not published in advance, affiliates will be given an opportunity to request full discussion at the next meeting of the Board of Trustees. 2012

Explanatory Statement: The 30-day advance publication is unrealistic and presents a significant barrier to compliance with Resolution B-4. 14 days should be ample time for affiliated organizations to review and prepare responses to resolutions.

Additional Explanatory Statement: The Committee heard comments from specialty affiliates that the 10 day time frame significantly limits the ability to analyze resolutions and prepare thoughtful and considerate response. The Committee determined that 14 days should allow for affiliates to participate in the policy process while permitting the AOA Bureau/Council/Committee structure to meet the time frame as well. The Committee recognizes that affiliated organizations retain the ability to request reconsideration of any resolution for discussion and debate at the next scheduled meeting of the AOA Board of Trustees.

Concerns were raised regarding the ability of affiliated organizations to bring resolutions directly to the AOA Board of Trustees. The Committee feels the current structure allows for multiple opportunities for affiliated organizations to bring forward issues of concern, such as the existing Bureau / Council / Committee structure, or seeking support of a member of the Board of Trustees to introduce the resolution.

Res. B-31-M/2012 - ACGME PROPOSED COMMON PROGRAM REQUIREMENTS

The American Osteopathic Association unequivocally and inalterably opposes the Accreditation Council on Graduate Medical Education (ACGME) proposed Common Program Requirements which limit osteopathic physicians' ability to move from osteopathic postdoctoral training to allopathic postdoctoral training; and will strongly encourage the withdrawal and/or amendment of the proposed Common Program Requirements to allow ACGME programs to continue to select

and train osteopathic physicians who choose to enter ACGME-accredited residency training programs after completing osteopathic postdoctoral internship or residency training. 2012