Mr. Speaker, the Committee on Rules & Order of Business met on July 20, 2017, to consider late resolutions.

The Committee recommends that the House of Delegates APPROVE the following late resolution for consideration and action at the 2017 AOA House of Delegates.

H-347 RANSOMWARE AND CYBERSECURITY

And I so move. **APPROVED**

The Committee also recommends that the House of Delegates APPROVE the following late resolution for consideration and action at the 2017 AOA House of Delegates.

H-348 PROTECTION OF LICENSURE FOR OSTEOPATHIC MEDICAL STUDENTS, RESIDENTS AND PRACTICING PHYSICIANS SUFFERING FROM DEPRESSION

And I so move. **APPROVED**

The Committee also recommends that the House of Delegates APPROVE the following late resolution for consideration and action at the 2017 AOA House of Delegates.

H-637 AMERICAN OSTEOPATHIC ASSOCIATION OPPOSES THE MERGING OF STATE OSTEOPATHIC LICENSING BOARDS WITH STATE MEDICAL LICENSING BOARDS

And I so move. **APPROVED**

The Committee also recommends that the House of Delegates APPROVE the following late resolution for consideration and action at the 2017 AOA House of Delegates.

H-638 PRESCRIPTION DRUG PRICING

And I so move. **APPROVED**
The Committee also recommends that the House of Delegates APPROVE the following late resolution for consideration and action at the 2017 AOA House of Delegates.

H-506 DEFINING NEW PHYSICIANS IN PRACTICE

Explanatory Statement:
The Committee notes that the definition in the proposed resolution is not consistent with Article VIII; Section C of the AOA Constitution and is therefore out of order, but the Committee recommends that the resolution be reviewed by the Committee on Professional Affairs for specific consideration. The Committee also suggests that proposed definition could be referred to the AOA Board of Trustees for possible addition to the Administrative Guide.

And I so move. APPROVED

The Committee reviewed the 2017 edition of the AOA House of Delegates Primer and would recommend it be accepted as the handbook of the methods and rules under which this House operates.

And I so move. APPROVED

The Committee would like to remind the members of the House of Delegates of the standing rule as it applies to the introduction of new business on the last day of the meeting. No new business shall be introduced on the last day of the House of Delegate’s meeting except by two-thirds consent of those members present, provided two-thirds of the seated delegates are in attendance.

Mr. Speaker, this concludes the Committee's report. I would like to thank the members of the Committee.

Committee Members:
1. David Hitzeman, DO – CHAIR Oklahoma
2. Emily Hurst, DO – VICE CHAIR Michigan
3. Stephanie Aldret, DO Louisiana
4. Kevin Beyer, DO Michigan
5. Matt Byington, DO Nebraska
6. Jeffrey J. Dunkelberger, DO Pennsylvania
7. Talat Nazir, DO AOCP

STAFF
Chaunessie Baggett
Josh Prober, JD
CONSENT AGENDA – FOR COLLECTIVE ACTION BY THE HOUSE OF DELEGATES

Mr. Speaker, I present the following Consent Agenda, and the Committee recommends that it be APPROVED:

H-200 ENSURING THAT GRADUATE MEDICAL EDUCATION (GME) PROGRAMS CONTINUE TO SELECT RESIDENTS BASED ON MERIT (H201-A/12)
H-202 LOAN DEFERMENT DURING RESIDENCY (H203-A/12)
H-203 RESIDENCY FUNDING – ADDITIONAL METHODS OF (H208-A/12)
H-204 POSTDOCTORAL FELLOWSHIPS – INCREASING (H209-A/12)
H-206 DISABILITY DETERMINATIONS (H213-A/12)
H-208 OSTEOPATHIC LICENSING (H215-A/12)
H-209 OSTEOPATHIC MANIPULATIVE TREATMENT - SUPERVISION FOR (H216-A/12)
H-210 PRIMARY CARE PHYSICIANS – TRAINING REAFFIRMATION (H217-A/12)
H-212 OSTEOPATHIC GRADUATE MEDICAL EDUCATION (OGME) PROGRAMS (H219-A/12)

And I so move. APPROVED

H-231 AMERICAN OSTEOPATHIC ASSOCIATION TO BECOME AN ACCREDITATION COUNCIL FOR CONTINUING MEDICAL EDUCATION (ACCME) ACCREDITED PROVIDER TO OFFER AMA PHYSICIANS RECOGNITION AWARD (PRA) CATEGORY 1 CREDITS TO OSTEOPATHIC SUBSPECIALTY COLLEGES

Mr. Speaker, I present for consideration Resolution No. H-231, and the Committee recommends that it be APPROVED with the following AMENDMENTS and as required REFERRED to the Finance Committee:
SUBJECT: AMERICAN OSTEOPATHIC ASSOCIATION TO BECOME AN ACCREDITATION COUNCIL FOR CONTINUING MEDICAL EDUCATION (ACCME) ACCREDITED PROVIDER TO OFFER AMA PHYSICIANS RECOGNITION AWARD (PRA) CATEGORY 1 CREDITS TO OSTEOPATHIC STATE, SPECIALTY, AND SUBSPECIALTY COLLEGES

Page 1, line 6 …Osteopathic STATE, SPECIALTY, AND subspecialty colleges
Page 1, line 8 …Osteopathic STATE, SPECIALTY, AND subspecialty colleges
Page 1, line 10 …Osteopathic STATE, SPECIALTY, AND subspecialty colleges
Page 1, line 12 …Osteopathic STATE, SPECIALTY, AND subspecialty colleges
Page 1, line 20 …Osteopathic STATE, SPECIALTY, AND subspecialty colleges
Page 3, line 2 …Osteopathic STATE, SPECIALTY, AND subspecialty conferences

Explanatory Statement: Pending evaluation by the Finance Committee, this resolution should be implemented as soon as deemed feasible.

And I so move. APPROVED

H-223 ACCREDITATION COUNCIL ON CONTINUING MEDICAL EDUCATION (ACCME) ACCREDITOR STATUS FOR THE AOA

Mr. Speaker, I present for consideration Resolution No. H-223, and the Committee recommends that it be DISAPPROVED. To begin discussion, I move that it be approved.

Explanatory Statement: The Committee believes this resolution is addressed in amended resolution H-231.

And I so move. DISAPPROVED

H-201 AMBULATORY-BASED PRIMARY CARE RESIDENCY PROGRAMS (H202-A/12)

Mr. Speaker, I present for consideration Resolution No. H-201, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Line 6 Congress AND STATE LEGISLATURES
Line 7 …will lobby Congress AND STATE LEGISLATURES

And I so move. APPROVED
H-205  JOINING FORCES INITIATIVE (H212-A/12)

Mr. Speaker, I present for consideration Resolution No. H-205, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Line 6  Medical Colleges (AAMC)
Line 9  their families FAMILIES;

And I so move. APPROVED

H-207  GENDER DISCRIMINATION (H214-A/12)

Mr. Speaker, I present for consideration Resolution No. H-207, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Line 3  H214-A/12 GENDER NON-DISCRIMINATION
Line 5  …provide equally for their male and female ALL physicians and students

And I so move. APPROVED

H-215  LONGITUDINAL APPROACH TO CULTURAL COMPETENCY DIALOGUE ON ELIMINATING HEALTH CARE DISPARITIES

Mr. Speaker, I present for consideration Resolution No. H-215, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Page 2, line 19  …eliminating racial health care disparities…

And I so move. APPROVED

H-219  PROMOTING RESIDENCY POSITIONS FOR COCA MEDICAL STUDENT GRADUATES

Mr. Speaker, I present for consideration Resolution No. H-219, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Page 1, lines 1-4  WHEREAS, the Commission on Colleges of Accreditation (COCA) and Liaison Council of Medical Education (LCME) promote student enrollment through development of ACCREDIT new schools, branch campuses, additional sites or class size increases to meet the needs for the nationwide physician shortages; and
WHEREAS, the COCA has expressed concerns about its ability to limit the proliferation of new schools, branch campuses, additional sites or class size increases due to federal and state anti-trust legislation; and

...will MAY result in a transfer LOSS of funded spots POSITIONS from AOA programs not achieving ACGME accreditation into a pool for GME funds which will not immediately coincide with current filled total academic spots until such time as those spots or programs are developed further worsening the residency shortages

...placing more absolute number A HIGHER NUMBER BUT LOWER PERCENTAGE of their graduates into residency training programs but a smaller percentage due to the disparity of medical school class graduates and lack of available residency positions; and

...directly responsible A CONTRIBUTORY FACTOR FOR THE for a physician shortage in America; now,

RESOLVED, that the AOA advocate for the importance of GME first year positions being proportional to FOR graduating OSTEOPATHIC medical school students through annual public comment from the AOA Standards Review Coalition and TO THE Bureau of Osteopathic Graduate Medical Education Development and through AOA Presidential appointment of COCA members who are consistent with this resolution, until such time that there is a direct proportional development of graduate medical education training positions for all of the United States medical school graduates; and,

And I so move. APPROVED as AMENDED

AOA ACCREDITED GME PROGRAM EQUIVALENCY

Mr. Speaker, I present for consideration Resolution No. H-221, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Line 14 ...the American Osteopathic Association (AOA), provide DOCUMENTATION VERIFYING THE EQUIVALENCY OF AOA-APPROVED TRAINING TO ANY PHYSICIAN REQUESTING SUCH to any member requesting it, a document that expresses the fact that the member in question has received specialty training in an AOA approved residency program that is deemed equal to an American College of Graduate Medical Education (ACGME) residency program and, be it further

RESOLVED, that the AOA obtain REQUEST the same commitment from the ACGME... and, be it further
RESOLVED, that non-adherence to this policy would be considered a breach of professional ethics.

And I so move. APPROVED

H-222 UNITED STATES IMMIGRATION EXECUTIVE ORDER IMPACT ON MEDICAL EDUCATION

Mr. Speaker, I present for consideration Resolution No. H-222, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Lines 1-10 WHEREAS, there are over 25,000 international medical graduate resident physicians in the United States with over 10,000 IMG’s post-residency serving patients in the state of Michigan which ranks ninth in the US for the number of IMG’s in practice; and

WHEREAS, these colleagues, their children and families are valued members of our community; and

WHEREAS, these medical professionals are our friends, neighbors, confidants, employees, and contributing members of our society; and

WHEREAS, this executive order affects green card holders and Visa holders, many of which already have the clearance or authority to reside in the United States; and

WHEREAS, no green card holders have ever committed an act of terrorism on US soil; and

Lines 15-19 potential travel bans created against MEDICAL STUDENTS, INTERNS, RESIDENTS, FELLOWS, AND PHYSICIANS WITH visaS or green cardS holders; and be it further

RESOLVED, that the AOA works to support our patients, students, residents, fellows, and physicians affected by SUCH POLICIES through local hospitals, agencies, or aid programs; and be it further

RESOLVED, that the American Osteopathic Association adopt this position.

And I so move. APPROVED

H-224 AOA MEMBERSHIP – OSTEOPATHIC CME REQUIREMENT ENFORCEMENT

Mr. Speaker, I present for consideration Resolution No. H-224, and the Committee recommends that it be APPROVED with the following AMENDMENTS:
RESOLVED, that the American Osteopathic Association (AOA) House of Delegates believes that the AOA Board of Trustees decision to not enforce the 120 continuing medical education (CME) credit requirement for AOA membership is not in alignment with the intent of the AOA bylaws which state that the Board of Trustees “shall administer” the requirements; and, be it further

RESOLVED, that the AOA House of Delegates requests that the AOA Board of Trustees submit to the AOA House of Delegates, WITHIN ONE (1) YEAR, in the appropriate manner, the recommended bylaws change(s) necessary to accomplish the desired outcome; and, be it further

RESOLVED, that the above bylaws change recommendations be submitted with a thorough assessment AND REPORT of the FINANCIAL impact of such change(s) on the profession, AOA and its affiliates in light of the Board’s recent policy changes regarding Osteopathic Continuous Certification which occurred at the 2017 mid-year meeting; and, be it further

RESOLVED, that the AOA House of Delegates formally remind the AOA Board of Trustees to be transparent in their actions and to pursue perceived needs to change the AOA bylaws through the appropriate transparent mechanisms as outlined in the bylaws of the American Osteopathic Association, and not through loose interpretation of the bylaws and policies.

And I so move. APPROVED as AMENDED

H-226 THE IMPORTANCE OF EMPATHY IN OSTEOPATHIC MEDICAL EDUCATION AND PRACTICE

Mr. Speaker, I present for consideration Resolution No. H-226, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

RESOLVED, the AOA encourage the participation of osteopathic medical colleges, faculty and students in the study of empathy during osteopathic medical education; and, be it further

And I so move. APPROVED

H-213 A CLEARLY ARTICULATED PROTOCOL FOR SLEEP FACILITIES AND SAFE TRANSPORTATION IN ALL PHYSICIAN RESIDENCIES

Mr. Speaker, I present for consideration Resolution No. H-213, and the Committee recommends that it be REFERRED to the Student Osteopathic Medical Association for review and comment.

Explanatory Statement: The Committee recommends that SOMA strengthen the language in the resolved statements.

And I so move. APPROVED (for Referral to SOMA)
Mr. Speaker, I present for consideration Resolution No. H-225, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Lines 30-38 WHEREAS, the Certifying Board Task Force that made the recommendations to the BOS and Board of Trustees did not seek the input of all osteopathic stakeholders in the development of their recommendations as dictated in the resolution; and

WHEREAS, the intent of Resolution H-210 was to provide information and recommendations to the AOA Board of Trustees and House of Delegates in order that they could make sound decisions on OCC after thorough analysis; and

WHEREAS, it was not the intent of Resolution H-210 to provide this information to the House of Delegates after the Board of Trustees had already made decisions, but to allow conscientious discussion and decision making; now, therefore be it

Line 39 RESOLVED WHEREAS, that the American Osteopathic Association (AOA) House of Delegates believes

Line 44 RESOLVED, that the AOA House of Delegates disapprove BOARD OF TRUSTEES RE-EVALUATE all five policies COMPONENTS regarding OCC

Line 47 RESOLVED, that the AOA Board of Trustees submit a single resolution DOCUMENT TO THE 2018 AOA HOUSE OF DELEGATES regarding recommended changes to OCC with reference to an attached report detailing the new OCC process in its entirety. so that the AOA House of Delegates knows precisely what the new model will look like during the decision making process.

Explanatory Statement: This resolution requires the Board of Trustees to prepare a report for the 2018 House of Delegates that will provide the House with a thorough explanation and evaluation of changes to the five components of the Osteopathic Continuous Certification (OCC) approved by the Board of Trustees at the 2017 Midyear meeting. It does not require delay in the implementation of the changes to OCC.

And I so move. APPROVED as AMENDED

CONSENT AGENDA – FOR COLLECTIVE ACTION BY THE HOUSE OF DELEGATES FOR REFERRAL TO THE AOA BOARD OF TRUSTEES

Mr. Speaker, I present the following Consent Agenda, and the Committee recommends that it be REFERRED to the AOA Board of Trustees for review and comment:

H-214 KEEPING OUR OSTEOPATHIC PRACTICE OSTEOPATHIC

H-217 AOA 1-A CME FOR BOARD CERTIFICATION
H-228  CME REQUIREMENTS FOR AOA BOARD CERTIFICATION

Explanatory Statement: The committee recommends that these four resolutions be considered by the AOA Board of Trustees when addressing H-225.

And I so move.  APPROVED (for Referral to BOT)

H-220  REAFFIRMING AOA CME FOR AOA BOARD CERTIFIED PHYSICIANS

Mr. Speaker, I present the following Consent Agenda, and the Committee recommends that it be REFERRED to the AOA Board of Trustees for review and comment:

Explanatory Statement: The committee recommends that this resolution be considered by the AOA Board of Trustees when addressing H-225.

And I so move.  APPROVED (for Referral to BOT)

H-218  AOA SPECIALTY BOARD CERTIFICATIONS

Mr. Speaker, I present for consideration Resolution No. H-218, and the Committee recommends that it be DISAPPROVED. To begin discussion, I move that it be approved.

Explanatory Statement: The Committee believes that this resolution is addressed in B-5 A/17, which states:

RESOLVED, that the AOA Board of Trustees requests the AOA Bureau of Osteopathic Specialists to propose a mechanism for its specialty certifying boards to establish:

1) An osteopathic specialty certification for candidates (DO or MD) who have successfully completed an ACGME-accredited training program in an osteopathic recognized track position or successfully completed an AOA-approved training program; and,

2) A general specialty certification for candidates (DO or MD) who have successfully completed an ACGME-accredited training program; and, be it further

RESOLVED, that the AOA Bureau of Osteopathic Specialists report back to the AOA Board of Trustees at the 2018 Mid-year Board meeting.

And I so move.  DISAPPROVED
Mr. Speaker, I present for consideration Resolution No. H-227, and the Committee recommends that it be DISAPPROVED. To begin discussion, I move that it be approved.

**Explanatory Statement:** The Committee supports continuing the current policy as written.

**Line 11**  
WHILE THE AOA SUPPORTS.....

**Line 13**  
OCC as a condition for medical licensure, insurance reimbursement, HOSPITAL PRIVELEGES,...

And I so move. **APPROVED as AMENDED**

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**H-229**  
CME REQUIREMENTS FOR AOA MEMBERSHIP

The Speaker advised the Committee that H-229 was out-of-order, so this resolution will not be considered.

**Explanatory Statement:** AOA Bylaws, Article II, Section 4, Article II – Membership; Section 4-Continuing Medical Education

“Regular members shall be required to satisfy Continuing Medical Education (CME) requirements. The CME requirements shall be determined and administered by the Board of Trustees. Members who do not meet the CME requirement are subject to such disciplinary action as is determined to be appropriate by the Board of Trustees, including revocation of membership, suspension, censure or probation.”

Mr. Speaker, this concludes the Committee’s report. I would like to thank the members of the Committee.

**Committee Members:**

1. Dixie Tooke-Rawlins, DO – **CHAIR**  
Virginia

2. Jeff Postlewaite, DO – **VICE CHAIR**  
Michigan

3. Jenni Adams, OMS IV  
SOMA

4. Victoria Damba, DO  
Missouri

5. Gary Edwards, DO  
Arkansas

6. Wolfgang Gilliar DO  
New York

7. Craig Glines, DO  
Michigan

8. Eric Goldsmith, DO  
Florida

9. Jennifer L. Gwilyn, DO  
Ohio

10. John J. Kalata, DO  
Pennsylvania

11. John Kaufman, DO  
North Carolina

12. Joshua Lenchus, DO  
Florida

13. Gregg Silberg, DO  
Wisconsin

14. LeeAnn Van Houten-Sauter, DO  
New Jersey
15. Kayse M. Shrum, DO  Oklahoma
16. Daniel Waters, DO  Iowa

STAFF
Maura Biszewski
Kathy Kelly
Sharon McGill
RESOLVED, that the Bureau of Education recommend that the following policy be
REAFFIRMED:

H201-A/12  ENSURING THAT GRADUATE MEDICAL EDUCATION (GME) PROGRAMS CONTINUE TO SELECT RESIDENTS BASED ON MERIT

The American Osteopathic Association will work with the American Medical Association, the American Association of Colleges of Osteopathic Medicine, the Association of American Medical Colleges and other US stakeholders to ensure that US-based graduate medical education programs maintain their ability to select residents based on merit. 2012

ACTION TAKEN  APPROVED (for reaffirmation)

DATE  July 22, 2017
RESOLVED, that the Bureau of Education recommend that the following policy be REAFFIRMED:

H202-A/12 AMBULATORY-BASED PRIMARY CARE RESIDENCY PROGRAMS

The American Osteopathic Association supports and advocates for development and implementation of ambulatory-based primary care residency programs; encourages the US Congress AND STATE LEGISLATURES to strengthen its graduate medical education reimbursement policies to at least equivalently fund ambulatory-based primary care residency programs; and will lobby Congress AND STATE LEGISLATURES to support legislation funding demonstration models of ambulatory-based primary care residency programs. 2012

Explanatory Statement:

ACTION TAKEN APPROVED as AMENDED

DATE July 22, 2017
RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED as AMENDED:

**H203-A/12  LOAN DEFERMENT DURING RESIDENCY**

The American Osteopathic Association (AOA) supports legislation that would allow MEDICAL STUDENTS AND resident physicians to defer the repayment of their federal medical school loans interest free until the completion of residency training, and, until such time that interest-free loan deferment is available, the AOA will actively work to reinstate the qualification criterion referred to as the “20/220 pathway” for economic hardship deferment and support mechanisms that address the financial needs of resident physicians with medical school loan debt. 2012

Explanatory Statement:

ACTION TAKEN _APPROVED (as amended)_

DATE _July 22, 2017_
RESOLVED, that the Bureau of Education recommend that the following policy be SUNSET:

**H208-A/12 RESIDENCY FUNDING – ADDITIONAL METHODS OF**

The American Osteopathic Association will study, develop and promote additional funding methods for osteopathic graduate medical education (OGME). 2012

**Explanatory Statement:**
AOA has comprehensive policies in response to this directive. H329-A/16 GME FUNDING INCENTIVES H308-A/13 STATE GME FUNDING ALTERNATIVES

ACTION TAKEN _APPROVED (for sunset)_

DATE _July 22, 2017_
RESOLVED, that the Bureau of Osteopathic Education recommend that the following policy be REAFFIRMED:

H209-A/12 POSTDOCTORAL FELLOWSHIPS – INCREASING

The American Osteopathic Association (AOA) will collect fellowship data including type, certification, location and AOA resident eligibility; will propose methods to initiate or increase AOA fellowships in those areas of shortage; and will provide that information to osteopathic medical students and to the AOA specialty colleges for dissemination to its directors of medical education, program directors and residents. 2012

Explanatory Statement:

ACTION TAKEN APPROVED (for reaffirmation)

DATE July 22, 2017
RESOLVED, that the Bureau of Osteopathic Education recommend that the following policy be REAFFIRMED as AMENDED:

**H212-A/12 JOINING FORCES INITIATIVE**

The American Osteopathic Association will continue to encourage the American Association of Colleges of Osteopathic Medicine (AACOM) to partner with the Association of American Medical Colleges (AAMC) to promote and develop curriculum that will help osteopathic and allopathic medical students prepare to care for the unique issues our returning veterans and their families face; will encourage practicing osteopathic physicians to care for our veterans and their families and to accept Tri-Care; SHALL ADVOCATE FOR APPROPRIATE AND COMPETITIVE PAYMENT FROM TRI-CARE FOR PHYSICIANS PROVIDING CARE FOR VETERANS AND THEIR FAMILIES; will help develop continuing medical education that will help prepare our existing osteopathic work force to comprehend and be prepared to manage the unique issues faced by our veteran population and military families; will encourage the National Board of Osteopathic Medical Examiners (NBOME) to incorporate military service-related conditions in the development of case-based evaluation items for testing; and will support efforts to support our veterans and military families by partnering with organizations such as Joining Forces and other organizations that help our military members and their families.

**Explanatory Statement:**

**ACTION TAKEN** APPROVED as AMENDED

**DATE** July 22, 2017
RESOLVED, that the Bureau of Osteopathic Education recommend that the following policy be REAFFIRMED:

H213-A/12  DISABILITY DETERMINATIONS

The American Osteopathic Association supports education, training, and involvement of osteopathic physicians and medical students in the discipline of disability determinations. 2002; reaffirmed 2007; amended and reaffirmed 2012

Explanatory Statement:

ACTION TAKEN  APPROVED (for reaffirmation)

DATE  July 22, 2017
RESOLVED, that the Bureau of Osteopathic Education recommend that the following policy be REAFFIRMED:

H214-A/12 NON-GENDER DISCRIMINATION

The American Osteopathic Association requires all of its recognized training institutions, both osteopathic and allopathic, to provide equally for their male and female ALL physicians and students. 1992; revised 1997, 2002; 2007; reaffirmed 2012

Explanatory Statement:

ACTION TAKEN _APPROVED as AMENDED_

DATE _July 22, 2017_
RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED:

H215-A/12 OSTEOPATHIC LICENSING

The American Osteopathic Association reaffirms its position that the only examinations able to fully evaluate the ability and competency of osteopathic physicians for licensure are the examinations developed by the National Board of Osteopathic Medical Examiners, Inc. 1982; revised 1987, 1992, 1997, 2002; 2007; reaffirmed 2012

ACTION TAKEN  **APPROVED** (for reaffirmation)

DATE  **July 22, 2017**
RESOLVED, that the Bureau of Osteopathic Education recommend that the following policy be REAFFIRMED:

H216-A/12 OSTEOPATHIC MANIPULATIVE TREATMENT -- SUPERVISION FOR

The American Osteopathic Association strongly encourages all qualified supervising physicians to foster the appropriate utilization of osteopathic diagnosis and osteopathic manipulative treatment by students, interns and residents assigned to them. 1997; reaffirmed 2002; 2007; 2012

Explanatory Statement:

ACTION TAKEN  APPROVED (for reaffirmation)

DATE  July 22, 2017
SUBJECT: H217-A/12 PRIMARY CARE PHYSICIANS – TRAINING REAFFIRMATION

SUBMITTED BY: Bureau of Osteopathic Education

REFERRED TO: Committee on Education Affairs

RESOLVED, that the Bureau of Osteopathic Education recommend that the following policy be REAFFIRMED:

H217-A/12  PRIMARY CARE PHYSICIANS – TRAINING REAFFIRMATION


Explanatory Statement:

ACTION TAKEN  APPROVED (for reaffirmation)

DATE  July 22, 2017
RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED as AMENDED:

**H219-A/12 OSTEOPATHICALLY RECOGNIZED GRADUATE MEDICAL EDUCATION (OGME) PROGRAMS**

The American Osteopathic Association opposes any federal or state law or regulation that would prevent the development of additional osteopathically RECOGNIZED graduate medical education programs or training positions and will continue to take all measures possible to prevent the termination of distinctive osteopathic training programs. 1997; revised 2002; 2007; reaffirmed as amended 2012

Explanatory Statement:

ACTION TAKEN **APPROVED (as amended)**

DATE **July 22, 2017**
WHEREAS, in 2017, the Accreditation Council for Graduate Medical Education (ACGME) approved the updated Common Program Requirements for all ACGME-approved residencies, among the approved requirements is a provision that sponsoring institutions must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home; and

WHEREAS, according to the Common and Institutional Requirements of the ACGME 2017 revised Duty Hours, section VI.D.3, “The program, in partnership with its Sponsoring Institution, must ensure adequate sleep facilities and safe transportation options for residents who may be too fatigued to safely return home” ; and

WHEREAS, it remains unclear how these standards are being practically applied, and many residency programs do not articulate the availability of these services nor the restrictions in using them (e.g., minimum 24 hour shift requirement, mileage caps, etc.); and

WHEREAS, municipal governments are increasingly requiring employers to provide transportation for their full-time employees in accordance with the Internal Revenue Code section 132a ; and

WHEREAS, while the fiscal impacts of these regulations will vary amongst resident programs, Medicare DGME funds have been shown to cover a greater proportion of the cost associated with resident training and funding when ACGME guidelines explicitly state the services needed in their policies ; and

WHEREAS, as Medicare funding is contingent upon gaining ACGME accreditation, incorporating transportation regulations into ACGME accreditation language is a necessary step in increasing Medicare funding for hospital-provided transportation ; and

WHEREAS, with an increasing amount of medical students now entering residency with children and other significant responsibilities outside of the hospital, residencies with only on-site sleep facilities may not be adequately addressing these challenges ; and

WHEREAS, family-related stressors, including lack of time at home with family and being unable to reliably accommodate family needs, such as child illness, are frequently cited as factors of emotional exhaustion in resident-related burnout ; and

WHEREAS, previous studies have shown that the risk of a motor vehicle crash increase substantially in residents who routinely work longer hours, and post-call residents can be impaired as much as inebriated residents who are not post-call ; and
WHEREAS, other articles have also extensively documented cases of patient harm due to resident fatigue, and have advocated arranging transportation home for those to fatigued to adequately operate a motor vehicle; and

WHEREAS, these studies are also well in line with the ACGME’s own Task Force on Quality Care and Professionalism response to public comments, in which the authors’ state that “The primacy of resident safety, no matter the tactics employed, cannot be overstated”; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) supports the provision of safe transportation for residents, who may be too fatigued to safely return home; and, be it further

RESOLVED, that the AOA ask all physician residency programs to create and make publicly available via the Internet and in internal literature, such as resident physician program handbooks, a clearly articulated protocol for the use of their sleep facilities and transportation services for residents.

References

7. Centers for Medicare & Medicaid Services, Department of Health and Human Services. Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2008 Rates. 42 CFR Parts 411, 412, 413, and 489; [CMS-1533-P]; RIN 0938-AO70

Reference Committee Explanatory Statement:
The Committee recommends that SOMA strengthen the language in the resolved statements.

ACTION TAKEN _REFERRED_ (to Student Osteopathic Medical Association)

DATE _July 22, 2017_
WHEREAS, the osteopathic profession partly relies on continuing education of osteopathic principles and practices to maintain the specific identification of osteopathic physicians compared to their allopathic colleagues; and

WHEREAS, our osteopathic state societies have historically been heavily invested in providing continuing medical education to our members, both financially and culturally, and; and

WHEREAS, education outside of one’s specialty encourages a broader view of medicine and has been a strength within the osteopathic profession; and

WHEREAS, much of the available osteopathic conferences, especially state sponsored conferences, provide general and not specialty credits; and

WHEREAS, maintenance of specialty board certification under the AOA should require an understanding of and training in osteopathic philosophy and principles; and

WHEREAS, requiring credit from osteopathic CME for specialty board certification under the AOA increases the demand for and participation in osteopathic CME; and

WHEREAS, increased demand for and participation in osteopathic CME assists in maintaining the osteopathic distinction in the AOA; and

WHEREAS, all specialties are not identical in their need for specialty versus general credits; now, therefore be it

RESOLVED, that a requirement of maintenance of certification under the AOA include 90 1-A credits per 3-year cycle; and, be it further

RESOLVED, that 60 of these credits may be satisfied by either AOA or ACCME accredited CME hours; and, be it further

RESOLVED, that 30 of these hours must be AOA-accredited osteopathic CME from any specialty or general source per 3-year cycle; and, be it further

RESOLVED, that the American Osteopathic Association (AOA) delegate the decision on the amount of required specialty credits to each specialty board/college.
Explanatory Statement:
The resolution is in response to the AOA Board Resolution B9 from the March 2017 Board Meeting, which did the following:
1. Reduces 120 hr. requirement to a 60 hr. requirement, per 3 years.
2. Directs each board to set its CME requirements which may be higher than 60 hr.
3. Resolves that AOA or ACCME credits will be accepted for the OCC CME requirement. (Not just AOA like before)

Item #1 eliminates much if not all of the general 1A CME requirement, leaving a number of hours similar to most specialty board hour requirements. Item #3 eliminates much of the need for osteopathic CME. This resolution submitted by WAOPS seeks to address concerns raised by these resolutions.

FISCAL IMPACT: $
The fiscal impact of this resolution has not been assessed by WAOPS.

Reference Committee Explanatory Statement:
The committee recommends that these four resolutions be considered by the AOA Board of Trustees when addressing H-225.

ACTION TAKEN _REFERRED (to AOA Board of Trustees)

DATE _July 22, 2017_
WHEREAS, the Institute of Medicine (IOM) defines racial health care disparities as “racial or ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention”; and

WHEREAS, in our nation, minorities tend to receive a lower quality of health care than non-minorities, even when patients’ socioeconomic differences, such as insurance status and income, are controlled; and

WHEREAS, the American Medical Association emphasizes that the profession can increase awareness of racial and ethnic disparities in health care, as well as the role of professionalism and professional obligation of physicians, in efforts to reduce them by engaging in open and broad discussions about the issues within the medical school curriculum; and

WHEREAS, a needs assessment for medical student cultural competency training revealed that “…many of the participating students—38.8 percent of the total—do not view an understanding of diverse patient cultural beliefs as important or very important in the provision of effective patient care, and more than one-third of the total (33.8 percent) are uncomfortable with and unsure about how to approach culture-related issues arising in patient care”; and

WHEREAS, cultural competency is seen by the Accreditation Council for Graduate Medical Education as an important factor of patient care, professionalism, and interpersonal and communication skills; and

WHEREAS, promoting awareness of structural forces serves as a first step toward recognition of the relationship between interpersonal networks, environmental factors, and political/socioeconomic forces that surrounds clinical encounters and a better understanding of the cross-cultural conversations that take place there within; and

WHEREAS, the introduction of a longitudinal cultural competency curriculum during undergraduate medical education that combines classroom lectures with interactive components, such as standardized patient exercises and clinical clerkships, will help medical students gain the cultural competency skills needed to reduce health care disparities; and

WHEREAS, according to the Cochrane group meta analysis, cultural competency education has shown improvements in the care of patients from culturally and linguistically diverse backgrounds; and
WHEREAS, the dialogue on health disparities should include historical and institutional
implications, environmental factors, cultural considerations, and the production of
symptoms or gene methylation by the influence of socioeconomic forces, in order to
present knowledge about diseases and bodies in combination with expert analysis of
social systems to help put notions of structural stigma at the center of
conceptualizations of illness and health; and

WHEREAS, to assist medical schools in their efforts to integrate cultural competency content
into their curricula, the American Association of Medical Colleges, supported by a
Commonwealth Fund grant, has developed the Tool for Assessing Cultural
Competence Training (TACCT); and

WHEREAS, a revised, more user-friendly TACCT has been offered as a resource for
approaching integration of cultural competency training within medical school curricula;
and

WHEREAS, “…the process of becoming a culturally competent clinician is to have the
fundamental attitudes of empathy, curiosity, and respect that are constantly being
reshaped by self-reflection”; now, therefore be it

RESOLVED, that the American Osteopathic Association encourages osteopathic medical
institutions to engage in expert facilitated, evidence-based dialogue in cultural
competency and the physician’s role in eliminating racial health care disparities in
medical treatment as part of a longitudinal curriculum throughout undergraduate
medical education years 1-4.

Explanatory Statement:
REFERENCES

1. Cultural Competence Education for Medical Students. aamc.org

   AR, Smedley BD, Stith, AY. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health

3. Hansen H, Metzl JM. Structural Competency: Theorizing a New Medical Engagement with Stigma and


5. Jernigan VBB, Hearod JB, Tran K, Norris KC, Buchwald D. An Examination of Cultural Competence
   Training in US Medical Education Guided by the Tool for Assessing Cultural Competence Training.


8. Loue S., Wilson-Delfosse A., Limbach K. Identifying gaps in the cultural competence/sensitivity
   components of an undergraduate medical school curriculum: A needs assessment. Journal of Immigrant


ACTION TAKEN  **APPROVED as AMENDED**

DATE  **July 22, 2017**
WHEREAS, the American Osteopathic Association (AOA) has been in existence for over 119 years and has been the representative member organization for osteopathic physicians (D.O.s) during this time; and

WHEREAS, the AOA serves not only as a membership organization similar to the American Medical Association (AMA) but has many additional responsibilities such as the deeming authority for oversight of osteopathic board certifications and osteopathic continuing medical education; and

WHEREAS, the AOA has represented D.O.s at local, state and national levels and has met all challenges professionally, legally, and legislatively such that D.O.s are recognized as physicians equal in the practice of medicine; and

WHEREAS, the Association of Family Medicine Residency Directors has recently stated that “Patient care that is delivered within the context of Osteopathic Principles and Practices is aligned to patient-centered, high-value care and to the needs of our nation’s health care system.”; and

WHEREAS, osteopathic physicians are required in most states to obtain Continuing Medical Education (CME) to assure they maintain a current knowledge base; and

WHEREAS, the current knowledge base for osteopathic practice is increasing as osteopathic research expands the understanding of the scientific basis and application of osteopathic principles; and

WHEREAS, the mission of the AOA is to “advance the distinctive philosophy and practice of osteopathic medicine,” and

WHEREAS, one of the seven AOA Core Competencies is “Osteopathic Philosophy/Osteopathic Manipulative Medicine,” which in its description states that this involves, “dedication to lifelong learning and incorporating the practice of osteopathic philosophy and OMM in patient care,”; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) and its affiliate organizations promote osteopathic Continuing Medical Education (CME) which is distinctive and of
high value to all osteopathic and allopathic physicians pursuing osteopathic board certification; and, be it further

RESOLVED, that the AOA require certifying specialty boards to maintain requirements for a minimum of 30 AOA category 1-A credits of osteopathic CME per 3-year CME cycle obtained through an accredited AOA CME sponsor for continued osteopathic board certification to assure continued propagation of osteopathic knowledge, philosophy, principles and research to help insure the mission of the AOA and its core values are maintained.

Reference Committee Explanatory Statement:
The committee recommends that these four resolutions be considered by the AOA Board of Trustees when addressing H-225.

ACTION TAKEN  REFERRED (to AOA Board of Trustees)

DATE  July 22, 2017
WHEREAS, in 2014 the American Osteopathic Association’s House of Delegates passed Resolution H-800 directing the American Osteopathic Association (AOA) to proceed with a single accreditation process for graduate medical education, and

WHEREAS, osteopathic physicians traditionally trained in an Accreditation Council for Graduate Medical Education (ACGME) residency program have found it very challenging to obtain osteopathic board certification due to their training not being recognized by their osteopathic specialty board, and

WHEREAS, these osteopathic physicians often feel abandoned by the osteopathic profession due to their postgraduate training program choice and the difficulty they experience in trying to gain osteopathic approval for their allopathic training, and

WHEREAS, it is important to offer every osteopathic physician the opportunity to be a member of their osteopathic organizations and the opportunity to obtain osteopathic board certification, and

WHEREAS, the AOA is looking at options for offering allopathic physicians options for obtaining membership in the AOA due to the Single Accreditation System for postgraduate medical education programs, and

WHEREAS, the Single Accreditation System under the ACGME offers an opportunity for the AOA to offer board certification to allopathic physicians; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) and the Bureau of Osteopathic Specialties (BOS) develop the necessary strategies to ensure that any osteopathic or allopathic physician who has completed an accredited postgraduate training program be allowed to sit for osteopathic board exams.

Explanatory Statement:
In the past, osteopathic physicians completing allopathic training programs have had hurdles to completing osteopathic Board certification. To encourage all osteopathic medical graduates, as well as allopathic medical graduates wishing to become osteopathic board certified, it is prudent to develop strategies now to ensure maximum utilization of osteopathic board certification. If a physician, whether osteopathic or allopathic, can pass the board certification exams, they should be allowed to be osteopathically board certified.
Reference Committee Explanatory Statement:
The Committee believes that this resolution is addressed in B-5 A/17, which states:

RESOLVED, that the AOA Board of Trustees requests the AOA Bureau of Osteopathic Specialists to propose a mechanism for its specialty certifying boards to establish:

1) An osteopathic specialty certification for candidates (DO or MD) who have successfully completed an ACGME-accredited training program in an osteopathic recognized track position or successfully completed an AOA-approved training program; and,

2) A general specialty certification for candidates (DO or MD) who have successfully completed an ACGME-accredited training program; and, be it further

RESOLVED, that the AOA Bureau of Osteopathic Specialists report back to the AOA Board of Trustees at the 2018 Mid-year Board meeting.

ACTION TAKEN  **DISAPPROVED**

DATE  **July 22, 2017**
WHEREAS, the Commission of Osteopathic Colleges of Accreditation (COCA) and Liaison Council of Medical Education (LCME) promote student enrollment through development of ACCREDIT new schools, branch campuses, additional sites or class size increases to meet the needs for the nationwide physician shortages; and

WHEREAS, no graduate of a COCA medical school or LCME medical school may practice medicine until they have completed some graduate medical education (GME) training as determined by their state medical board; and

WHEREAS, the COCA has standards that Colleges of Osteopathic Medicine (COM) must strive to develop graduate medical education to meet the needs of its graduates within the defined service area, consistent with the mission of the COM, that the COM must demonstrate policy, structure and procedures including undergraduate, graduate, and continuing medical education to support the continuum of osteopathic education, and the COM must provide a mechanism to assist graduate medical education programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) in meeting the requirements of osteopathic recognition; and

WHEREAS, the LCME has standards for active review of GME development but does not require any increased student enrollment to be proportional to the development of new schools, branch campuses, additional sites or class size increases; and

WHEREAS, the COCA has expressed concerns about its ability to limit the proliferation of new schools, branch campuses, additional sites or class size increases due to federal and state anti-trust legislation; and

WHEREAS, the Memorandum of Understanding (MOU) between the American Osteopathic Association (AOA) and American Association of Colleges of Osteopathic Medicine (AACOM) and the Accreditation Council of Graduate Medical Education (ACGME), developing the Single Accreditation System, will MAY result in a transfer LOSS of funded spots POSITIONS from AOA programs not achieving ACGME accreditation into a pool for GME funds which will not immediately coincide with current filled total academic spots until such time as those spots or programs are developed, further worsening the residency shortages; and

WHEREAS, some COCA medical schools and LCME medical schools in the United States are placing more absolute number A HIGHER NUMBER BUT LOWER PERCENTAGE of their graduates into residency training programs but a smaller percentage due to the disparity of medical school class graduates and lack of available residency positions; and
WHEREAS, the influx of graduates from non-LCME accredited allopathic medical schools from foreign countries and the Caribbean are diluting the GME opportunities for COCA and LCME graduates; and

WHEREAS, the AOA is forbidden to directly influence the COCA under the rules of the Department of Education; and

WHEREAS, the AOA acknowledges current and projected insufficiencies as published for the 2017 ERAS and NRMP match in the number of accredited graduate medical education (ACGME) residency first year positions (28,849) and the number of NRMP applicants 35,969 which include 18,539 US Allopathic graduates, 3,590 US Osteopathic graduates, and 12,783 IMGs (5,069 US IMGs and 7,284 non-US IMGs), as well as 1,059 US Medical Students that did not receive residency positions and that this residency position deficiency is directly responsible a CONTRIBUTORY FACTOR FOR THE for a physician shortage in America; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) states concern about the proliferation of undergraduate medical education without a concurrent increase in graduate medical education (GME) during discussions about the subject; and, be it further

RESOLVED, that the AOA advocate for the importance of GME first year positions being proportional to graduating OSTEOPATHIC medical school students through annual public comment from the AOA Standards Review Coalition and TO THE Bureau of Osteopathic Graduate Medical Education Development and through AOA Presidential appointment of COCA members who are consistent with this resolution, until such time that there is a direct proportional development of graduate medical education training positions for all of the United States medical school graduates; and, be it further

RESOLVED, the AOA shall continue investigating and promoting innovative solutions to opening new GME residency positions.

ACTION TAKEN APPROVED as AMENDED

DATE July 22, 2017
WHEREAS, the American Osteopathic Association (AOA) has been in existence for over 119 years and has been the representative member organization for osteopathic physicians (D.O.s) during this time; and

WHEREAS, the AOA serves not only as a membership organization similar to the American Medical Association (AMA) but has many additional responsibilities such as the deeming authority for oversight of osteopathic board certifications and osteopathic continuing medical education; and

WHEREAS, the AOA has represented D.O.s at local, state and national levels and has met all challenges professionally, legally, and legislatively such that D.O.s are recognized as physicians equal to allopathic physicians in the practice of medicine; and

WHEREAS, the Association of Family Medicine Residency Directors has recently stated that “Patient care that is delivered within the context of Osteopathic Principles and Practices is aligned to patient-centered, high-value care and to the needs of our nation’s health care system.”; and

WHEREAS, osteopathic physicians are required in most states to obtain Continuing Medical Education (CME) to assure they maintain a current knowledge base; and

WHEREAS, the current knowledge base for osteopathic practice is increasing as osteopathic research expands the understanding of the scientific basis and application of osteopathic principles; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) and its affiliate organizations promote osteopathic Continuing Medical Education (CME) which is distinctive and of high value to all osteopathic physicians; and, be it further

RESOLVED, that the AOA require certifying specialty boards to maintain requirements for osteopathic CME for continued osteopathic board certification to assure continued propagation of osteopathic knowledge and research.
Reference Committee Explanatory Statement:
The committee recommends that these four resolutions be considered by the AOA Board of Trustees when addressing H-225.

ACTION TAKEN REFERRED (to AOA Board of Trustees)

DATE July 22, 2017
WHEREAS, ads in medical journals advertising for physician positions frequently request that applicants possess a D.O. or M.D. degree, are Board Eligible or Board Certified and must have ACGME training; and

WHEREAS, this puts Osteopathic physicians who have trained in an American Osteopathic Association (AOA) accredited residency ineligible to apply for that position; and

WHEREAS, both the AOA and the Accreditation Council for Graduate Medical Education (ACGME) consortium have repeatedly espoused the equality of the two certifying bodies; and

WHEREAS, the equivalence of the AOA-ACGME programs are well established in federal policy; and

WHEREAS, it is understood that the AOA-ACGME consortium would find it impossible to alert all employers that AOA residency trained is equivalent to ACGME residencies; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA), provide DOCUMENTATION VERIFYING THE EQUIVALENCY OF AOA-APPROVED TRAINING TO ANY PHYSICIAN REQUESTING SUCH; to any member requesting it, a document that expresses the fact that the member in question has received specialty training in an AOA approved residency program that is deemed equal to an American College of Graduate Medical Education (ACGME) residency program and, be it further

RESOLVED, that the AOA obtain REQUEST the same commitment from the ACGME. and, be it further

RESOLVED, that non adherence to this policy would be considered a breach of professional ethics.

ACTION TAKEN  **APPROVED as AMENDED**

DATE  **July 22, 2017**
WHEREAS, here are over 25,000 international medical graduate resident physicians in the United States with over 10,000 IMG’s post-residency serving patients in the state of Michigan which ranks ninth in the US for the number of IMG’s in practice; and

WHEREAS, these colleagues, their children and families are valued members of our community; and

WHEREAS, these medical professionals are our friends, neighbors, confidants, employees, and contributing members of our society; and

WHEREAS, this executive order affects green card holders and Visa holders*, many of which already have the clearance or authority to reside in the United States; and

WHEREAS, no green card holders have ever committed an act of terrorism on US soil*; and

WHEREAS, the American Osteopathic Association (AOA) continues to support our patients, physicians, colleagues and neighbors regardless of their race, color or creed as a part of our family, community and lives; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) strongly opposes any potential travel bans created against MEDICAL STUDENTS, INTERNS, RESIDENTS, FELLOWS, AND PHYSICIANS WITH visaS or green cardS holders; and be it further

RESOLVED, that the AOA works to support our patients, students, residents, fellows, and physicians affected by SUCH POLICIES this or future legislation through local hospitals, agencies, or aid programs; and be it further

RESOLVED, that the American Osteopathic Association adopt this position.

Explanatory Statement

References


https://www.theatlantic.com/international/archive/2017/01/trump-immigration-ban-terrorism/514361

**ACTION TAKEN** _APPROVED as AMENDED_

**DATE** _July 22, 2017_
WHEREAS, at their July 2016 meeting, the AOA Board of Trustees unanimously voted to suspend enforcement of the bylaws requirement that members of the American Osteopathic Association (AOA) obtain 120 continuing medical education (CME) credits per 3-year CME cycle; and

WHEREAS, at the 2017 mid-year meeting the AOA Board of Trustees established policy that Accreditation Council on Continuing Medical Education (ACCME) CME credits be accepted as credit for AOA Board certification requirements; and

WHEREAS, in combination these two decisions make AOA CME credit unnecessary for Board certification; and

WHEREAS, AOA accredited CME sponsors, especially state and specialty affiliates, rely on income from CME programs as a non-dues revenue source, providing funding for their member services including advocacy and representation at the AOA House of Delegates, and are now financially vulnerable, and

WHEREAS, the AOA Board of Trustees has not indicated a plan to assist affiliates in developing new non-dues revenue sources to ensure sustainability in the future; and

WHEREAS, ACCME accreditation is now the only type of CME credit required for either American Board of Medical Specialties or AOA Board certified physicians making AOA CME and associated bureaus, councils, and support staff unnecessary; and

WHEREAS, most state and specialty affiliates are not accredited by ACCME due to cost and time constraints on staff; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) become an accredited Accreditation Council on Continuing Medical Education (ACCME) continuing medical education (CME) accreditor and serve as an accreditor for osteopathic state and specialty affiliates; and, be it further

RESOLVED, that by September 1, 2017, the AOA informs the House of Delegates and all current accredited AOA CME providers the date at which they will be able to achieve ACCME accreditor status so that affiliates can plan accordingly; and, be it further

RESOLVED, that the AOA conduct a thorough analysis of the costs, roles and necessities of all bureaus, councils, committees and staff resources currently associated with AOA continuing medical education, and develop a new simplified model to ensure that state and specialty affiliates are provided the necessary resource (including staff) support in
becoming accredited ACCME CME providers, as well as in maintaining this accreditation.

Reference Committee Explanatory Statement:
The Committee believes this resolution is addressed in amended resolution H-231.

ACTION TAKEN **DISAPPROVED**

DATE _July 22, 2017_
WHEREAS, the American Osteopathic Association (AOA) bylaws state that regular members “shall be required to satisfy continuing medical education (CME) requirements,” and that the AOA Board of Trustees “shall” administer the requirements; and

WHEREAS, in July 2016 the AOA Board of Trustees affirmed policy to not enforce the CME requirement of 120 credits per CME cycle as set forth in AOA policy for AOA membership; and

WHEREAS, the AOA Board of Trustees, by not administering the CME requirement, is not honoring the spirit or intent of the current bylaws, and has usurped the authority of the House of Delegates with its loose interpretation of the bylaws; and

WHEREAS, the AOA Board of Trustees approved this change in policy days prior to the beginning of the 2016 AOA House of Delegates bypassing an excellent opportunity to gain the perspective of the membership as represented by over 500 elected delegates; and

WHEREAS, the AOA Board of Trustees also approved policy changes to Osteopathic Continuous Certification, that when coupled with the non-enforcement of the 120-credit hour CME requirement for AOA membership have a far-reaching and potentially devastating impact on the future of osteopathic profession, the AOA and its affiliates; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) House of Delegates believes the AOA Board of Trustees decision to not enforce the 120 continuing medical education (CME) credit requirement for AOA membership is not in alignment with the intent of the AOA bylaws which state that the Board of Trustees “shall administer” the requirements; and, be it further

RESOLVED, that the AOA House of Delegates requests that the AOA Board of Trustees submit to the AOA House of Delegates, WITHIN ONE (1) YEAR in the appropriate manner, the recommended bylaws change(s) necessary to accomplish the desired outcome; and, be it further

RESOLVED, that the above bylaws change recommendations be submitted with a thorough assessment AND REPORT of the FINANCIAL impact of such change(s) on the profession, AOA and its affiliates in light of the Board’s recent policy changes regarding Osteopathic Continuous Certification which occurred at the 2017 mid-year meeting; and, be it further
RESOLVED, that the AOA House of Delegates formally remind the AOA Board of Trustees to be transparent in their actions and to pursue perceived needs to change the AOA bylaws through the appropriate transparent mechanisms as outlined in the bylaws of the American Osteopathic Association, and not through loose interpretation of the bylaws and policies.

ACTION TAKEN  **APPROVED as AMENDED**

**DATE**  July 22, 2017
WHEREAS, the mission of the American Osteopathic Association (AOA) is to “advance the distinctive philosophy and practice of osteopathic medicine,”; and

WHEREAS, one of the seven AOA Core Competencies is “Osteopathic Philosophy/Osteopathic Manipulative Medicine,” which in its description states that this involves, “dedication to lifelong learning and incorporating the practice of osteopathic philosophy and Osteopathic Manipulative Medicine in patient care,”; and

WHEREAS, resolution no. B-9 – M/2017 was unanimously affirmed by the AOA Board of Trustees at the 2017 mid-year meeting which eliminated the requirements for any osteopathic continuing medical education (CME) for Osteopathic Continuous Certification (OCC) by allowing acceptance of Accreditation Council on Continuing Medical Education (ACCME) credit, meaning upon completion of medical school an osteopathically board certified physician is not required to ever take osteopathic specialty CME or general CME on osteopathic principles and philosophy to ensure lifelong learning of osteopathic principles and philosophy; and

WHEREAS, the AOA Board of Trustees also approved four other separate resolutions changing the osteopathic continuous certification process, which would have better been considered together with the proposed revised OCC process fully described; and

WHEREAS, the decisions regarding CME and OCC made by the Board of Trustees will substantially impact the ability of the AOA and its affiliates to fulfill its mission of advancing the distinctive philosophy and practice of osteopathic medicine; and

WHEREAS, organizational decisions that can profoundly impact the profession and the mission of the AOA should be vetted by the AOA House of Delegates prior to implementation; and

WHEREAS, resolution H-210 was passed by the AOA House of Delegates in 2016 that directs the AOA to seek “input from all osteopathic stakeholders and AOA Certifying Boards on the redesign of OCC and review all current and alternative pathways to Osteopathic Continuous Certification,” and that the “AOA Bureau of Osteopathic Specialists (BOS) provide an update to the AOA Board of Trustees at its 2017 Midyear meeting and to the 2017 AOA House of Delegates,”; and

WHEREAS, the Certifying Board Task Force that made the recommendations to the BOS and Board of Trustees did not seek the input of all osteopathic stakeholders in the development of their recommendations as dictated in the resolution; and
WHEREAS, the intent of Resolution H-210 was to provide information and recommendations to the AOA Board of Trustees and House of Delegates in order that they could make sound decisions on OCC after thorough analysis; and

WHEREAS, it was not the intent of Resolution H-210 to provide this information to the House of Delegates after the Board of Trustees had already made decisions, but to allow conscientious discussion and decision making; now, therefore be it

RESOLVED WHEREAS, that the American Osteopathic Association (AOA) House of Delegates believes that recent decisions by the AOA Board of Trustees to change the Osteopathic Continuous Certification (OCC) process have far reaching impacts on the profession and therefore should be approved by the AOA House of Delegates before implementation; and be it further

RESOLVED, that the AOA House of Delegates disapprove BOARD OF TRUSTEES RE-EVALUATE all five policies COMPONENTS regarding OCC approved by the AOA Board of Trustees at the 2017 mid-year meeting; and, be it further

RESOLVED, that the AOA Board of Trustees submit a single resolution DOCUMENT TO THE 2018 AOA HOUSE OF DELEGATES regarding recommended changes to OCC with reference to an attached report detailing the new OCC process in its entirety so that the AOA House of Delegates knows precisely what the new model will look like during the decision making process.

Reference Committee Explanatory Statement:
This resolution requires the Board of Trustees to prepare a report for the 2018 House of Delegates that will provide the House with a thorough explanation and evaluation of changes to the five components of the Osteopathic Continuous Certification (OCC) approved by the Board of Trustees at the 2017 Midyear meeting. It does not require delay in the implementation of the changes to OCC.

ACTION TAKEN  APPROVED as AMENDED

DATE  July 22, 2017
WHEREAS, empathy has been defined as “a predominately cognitive attribute which involves an understanding of the inner experiences and perspectives of the patient combined with a capability to communicate this understanding to the patient and an intention to help”; and

WHEREAS, empathy is a characteristic that has been quantified and studied as an aspect of physicians and other health professionals’ patient interactions; and

WHEREAS, research has shown that empathy is a significant component of overall clinical competence; and

WHEREAS, multiple studies have shown the importance that empathy plays in the physician-patient relationship; and

WHEREAS, empathy is a critical component of physician-patient communication; and

WHEREAS, empathy builds trust and can increase patient satisfaction and compliance; and

WHEREAS, clinical outcomes have been demonstrated to be improved amongst physicians with greater empathy; and

WHEREAS, empathy is consistent with the osteopathic principles and practice; and

WHEREAS, a number of studies have demonstrated that empathy of medical students tends to decline during the course of medical education; and

WHEREAS, empathy has been demonstrated to be able to be taught and sustained during the course of medical education and practice; and

WHEREAS, empathy has been demonstrated to be inversely associated with “burnout”; and

WHEREAS, some studies have suggested that osteopathic medical students may be at less risk of losing empathy during the course of medical school than their allopathic counterparts; and

WHEREAS, the American Association of Colleges of Osteopathic Medicine has initiated a profession-wide study of empathy in osteopathic medical education; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) recognize the importance of empathy in osteopathic medical education and practice; and, be it further
RESOLVED, the AOA encourage the participation of osteopathic medical colleges, faculty and students in the study of empathy during osteopathic medical education; and, be it further

RESOLVED, the AOA recognize the relationship between empathy and well-being in physicians-in-training and in-practice.

Explanatory Statement:

REFERENCES


ACTION TAKEN _APPROVED as AMENDED

DATE _July 22, 2017_
SUBJECT: H215-A/15 EQUIVALENCY POLICY FOR OSTEOPATHIC CONTINUOUS CERTIFICATION

SUBMITTED BY: Bureau of Osteopathic Specialists

REFERRED TO: Committee on Educational Affairs

RESOLVED, that the Bureau of Osteopathic Specialists recommend that the following policy be amended as follows:

H215-A/15 EQUIVALENCY POLICY FOR OSTEOPATHIC CONTINUOUS CERTIFICATION

The American Osteopathic Association (AOA), through its bureaus, councils and committees, will ensure that osteopathic continuous certification (OCC) is comparable to other maintenance of certification programs so that OCC can be recognized by the federal government, state governments and other regulatory agencies and credentialing bodies as an equivalent of other national certifying bodies’ “maintenance” or “continuous” certification programs.

WHILE THE AOA SUPPORTS THE USE OF BOARD CERTIFICATION AS A MARK OF ACADEMIC ACHIEVEMENT, the AOA opposes any efforts to require OCC as a condition for medical licensure, insurance reimbursement, HOSPITAL PRIVILEGES, network participation, malpractice insurance coverage or as a requirement for physician employment. EXCELLENCE, AND SUPPORTS ITS USE BY ENTITIES TO PROTECT THE PUBLIC AND ASSURE THE DELIVERY OF HIGH QUALITY PATIENT CARE.

That the AOA through the Bureau of Osteopathic Specialists (BOS) will review the OCC process so as to make it more manageable and economically feasible. 2010; revised 2015.

Explanatory Statement:

ACTION TAKEN APPROVED as AMENDED

DATE July 22, 2017 ____________
SUBJECT: AMERICAN OSTEOPATHIC ASSOCIATION TO BECOME AN ACCREDITATION COUNCIL FOR CONTINUING MEDICAL EDUCATION (ACCME) ACCREDITED PROVIDER TO OFFER AMA PHYSICIANS RECOGNITION AWARD (PRA) CATEGORY 1 CREDITS TO OSTEOPATHIC STATE, SPECIALTY, AND SUBSPECIALTY COLLEGES

SUBMITTED BY: American College of Osteopathic Pediatricians (ACOP)

REFERRED TO: Committee on Educational Affairs

WHEREAS, Nearly 1,900 organizations, accredited with the Accreditation Council for Continuing Medical Education (ACCME) system, offer relevant, practice based continuing medical education; and

WHEREAS, these organizations include 26 million interactions with health professional participants annually; and

WHEREAS, the Osteopathic STATE, SPECIALTY, AND subspecialty colleges desire to attract allopathic physicians to their free-standing annual meetings; and

WHEREAS, the Osteopathic STATE, SPECIALTY, AND subspecialty colleges who participate in OMED desire to attract allopathic physicians; and

WHEREAS, the Osteopathic STATE, SPECIALTY, AND subspecialty colleges desire to attract allopathic physicians to submit abstracts for presentation at their meetings; and

WHEREAS, the Osteopathic STATE, SPECIALTY, AND subspecialty colleges desire to attract allopathic physicians to become members; and

WHEREAS, a majority of Osteopathic medical school graduates are residency trained and board certified through the ACGME accredited programs requiring AMA PRA Category 1 Credits to maintain board certification; and

WHEREAS, the acceptance of AMA, AAFP, or credits from any other certifying body by the CCME in order to fulfill American Osteopathic Association (AOA) CME requirement does not convert said credits to AOA credits; and

WHEREAS, the AOA is parent organization of the Osteopathic STATE, SPECIALTY, AND subspecialties and provides the CME hours through the Council of Continuing Medical Education for Osteopathic CME conferences; and

WHEREAS, the AOA currently has policies, procedures and regulations in place to approve and provide AOA category 1-A, 1-B, 2-A and 2-B CME hours; now, therefore be it
RESOLVED, that the American Osteopathic Association, AOA should apply for and maintain accreditation as an ACCME accredited provider. The AOA should provide Osteopathic and Allopathic physicians the required AOA or AMA CME hours to maintain board certification and enhance the benefits of OMED and Osteopathic STATE, SPECIALTY, AND Subspecialty conferences and Membership.

The following Osteopathic specialty colleges have reviewed this resolution and have agreed to sign on:

- American College of Osteopathic Surgeons (ACOS)
- American Osteopathic Academy of Orthopedics (AOAO)
- American Osteopathic College of Anesthesiologists (AOCA)
- American Osteopathic College of Pathologists (AOCP)
- American Osteopathic College of Radiology (AOCR)

Explanatory Statement:
The American Osteopathic Association and affiliate organizations requires and has provided category 1-A, 1-B, 2-A and 2-B continuing medical education hours for osteopathic physicians to maintain their license and board certification. Osteopathic physicians have received training through osteopathic and allopathic graduate medical education program while allopathic physicians receive their training through allopathic programs. As an affiliate organization of the AOA, the ACOP and the other sponsoring organizations would like to have the AOA become a sponsoring ACCME organization to provide to Allopathic physicians AMA PRA Category 1 credit. This can enhance the AOA and its affiliate organization in providing a single source for all the CME requirements for both osteopathic and allopathic physicians. This could create a significant advantage to the AOA and its affiliate organization for opening its membership to all physicians, for providing CME to all physicians, strengthening organizational financial resources and improvement to the healthy and viable status of the entire organization.

FISCAL IMPACT:
ACCME Pre-application Fee for the consideration of a Pre-application for ACCME Accreditation - $1,200.

ACCME Initial Accreditation Fee for the consideration of a Self-Study for Initial Accreditation - $8,400.

Reimbursement for expenses incurred by ACCME for the survey portion of the initial process. The standard format for the survey is a conference call. ACCME may, at its discretion, require a televideo or on-site survey, the expenses for which the provider would be responsible. Conference Call - $100.00. Face-to-Face Televideo or On-site – actual costs for the surveyors’ actual travel, meal and incidental expenses for which the provider would be responsible. Average is ~$2,000. The provider may incur additional expenses, e.g., travel expenses for representatives of the provider to come to Chicago, rental of a facility for a televideo connection, cost of the televideo connection itself, etc. These additional costs are the responsibility of the provider.
Reference Committee Explanatory Statement:
Pending evaluation by the Finance Committee, this resolution should be implemented as soon as deemed feasible.

ACTION TAKEN  **APPROVED as AMENDED with REFERRAL (to AOA Finance Committee)**

DATE  **July 22, 2017**
American Osteopathic Association
House of Delegates
Committee on Professional Affairs

Joan M. Grzybowski, DO, Chair
John Sealy, DO, Vice-Chair

July 21, 2017
A/2017

CONSENT AGENDA – FOR COLLECTIVE ACTION BY THE HOUSE OF DELEGATES

Mr. Speaker, I present the following Consent Agenda, and the Committee recommends that it be APPROVED:

H-301 SPINAL MANIPULATION LEGISLATION OR REGULATION (H255-A/04)
H-302 STATE LICENSURE OF MANAGED CARE ORGANIZATIONS (MCO) MEDICAL DIRECTORS (H257-A/04)
H-303 NATIONAL PRACTITIONER DATA BANK, AOA REPORTING (H300-A/12)
H-304 ADMINISTRATIVE RULE-MAKING PROCESS (H301-A/12)
H-305 ADVANCE DIRECTIVES (H302-A/12)
H-306 DRUGS – NON-GENERIC (H303-A/12)
H-309 HEALTH CLINICS – FEDERALLY FUNDED (H306-A/12)
H-310 HEALTH CARE DELIVERY SYSTEMS (H307-A/12)
H-311 RURAL AND URBAN PRACTICES – DISPARITIES BETWEEN (H309-A/12)
H-312 PRESERVATION OF ANTIBIOTICS FOR MEDICAL TREATMENT (H310-A/12)
H-313 PHYSICIAN ROLE IN GOVERNANCE OF FEDERALLY CONTRACTED QUALITY IMPROVEMENT ORGANIZATIONS (QIOS) – REDUCED (H311-A/12)
H-314 PHYSICIAN CONSULTATION FOR FORMULARIES (H312-A/12)
H-315 DIETARY SUPPLEMENTS – GUIDELINES FOR NUTRITIONAL AND (H313-A/12)
H-316 SEXUAL HARASSMENT (H318-A/12)
H-317  DUE PROCESS IN AGENCY DETERMINATIONS (H321-A/12)
H-318  ETHICAL AND SOCIOLOGICAL CONSIDERATIONS FOR MEDICAL CARE (H322-A/12)
H-319  HEALTH CARE – REGULATION OF (H323-A/12)
H-322  PRESCRIPTION DRUGS SAMPLES (H327-A/12)
H-323  END-OF-LIFE CARE FOR THE DEVELOPMENTALLY DISABLED (H411-A/12)
H-324  DO NOT RESUSCITATE (DNR) ORDERS ON ELDER ADULTS IN LONG TERM OR EXTENDED-CARE FACILITIES (H413-A/12)
H-325  SCHOOL BASED HEALTH EDUCATION – PROMOTION (H426-A/12)
H-327  FORMULARY CHANGES (H614-A/12)
H-328  DISPENSING OF MEDICATION BY PHYSICIANS (H630-A/12)
H-329  OSTEOPATHIC MANIPULATIVE TREATMENT – PAYMENT FOR (H632-A/12)
H-330  ABOLISHMENT OF PATIENT LOAD RESTRICTIONS TO INCREASE PHARMACOLOGICAL OPIOID ADDICTION TREATMENT ACCESS
H-342  SHARED PRINCIPLES OF PRIMARY CARE
H-343  OVERALL AOA PHYSICIAN WELLNESS STRATEGY
H-347  RANSOMWARE AND CYBERSECURITY
H-349  DEFINING NEW PHYSICIANS IN PRACTICE

And I so move.  **APPROVED**

H-307  FAMILY AND MEDICAL LEAVE ACT (FMLA) DOCUMENTATION (H304-A/12)

Mr. Speaker, I present the Resolution No. H-307, and the Committee recommends that it be **APPROVED** (for sunset) **REAFFIRMED**:  

And I so move. **APPROVED** *(for reaffirmation)*

H-308  GENERIC DRUGS (H305-A/12)

Mr. Speaker, I present for consideration Resolution No. H-308, and the Committee recommends that it be **APPROVED** with the following **AMENDMENTS**:  

...
Line 22 MEDICATIONS TO THEIR PATIENTS; AND (7) URGE THE FDA TO ENSURE SAFE AND CONSISTENT DRUG SUPPLY THAT AVOIDS SHORTAGES AND ENSURES ADEQUATE GENERIC PHARMACEUTICAL MANUFACTURE AND SUPPLY FOR U.S. PATIENTS AND PHYSICIANS. 1990; reaffirmed 1995, 1997; revised 2002; 2007;

And I so move. APPROVED

H-320 OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (OSHA) REGULATIONS (H324-A/12)

Mr. Speaker, I present for consideration Resolution No. H-320, and the Committee recommends that it be APPROVED with the following AMENDMENTS:


And I so move. APPROVED

H-321 PATIENT SAFETY (H326-A/12)

Mr. Speaker, I present for consideration Resolution No. H-321, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Line 5 encourages payers to provide adequate payment so that hospitals HEALTH CARE FACILITIES can provide the best quality

And I so move. APPROVED

H-326 RECOUPMENT LAWS (H316-A/12)

Mr. Speaker, I present for consideration Resolution No. H-326, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Line 6 time frame for billing, PAYMENT REIMBURSEMENT and appeal. 2002; 2007; reaffirmed as

And I so move. APPROVED

H-331 INTERSTATE OPIOID DATABASE

Mr. Speaker, I present for consideration Resolution No. H-331, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Line 27 – 28 national opioid database that allows authorized personnel PRESCRIBERS, DISPENSERS OR THEIR DESIGNATED STAFF in any state to
access a patient's prescription history, regardless of their residing state AT NO COST TO THE PRESCRIBER OR DISPENSER.

And I so move. APPROVED

H-333 IMPROVE LIFE-SAVING ACCESS TO EPINEPHRINE AUTO-INJECTORS

Mr. Speaker, I present for consideration Resolution No. H-333, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

SUBJECT: IMPROVE LIFE-SAVING ACCESS TO EPINEPHRINE AUTO-INJECTORS

Page 1, Lines 3 – 5 WHEREAS, THERE IS A RISING INCIDENCE OF ANAPHYLAXIS (1); and there are over 100,000 cases of anaphylaxis each year in the United States, 60% of these are first-time events resulting in greater than 1500 deaths annually and

Lines 6 – 8 WHEREAS, THERE EXISTS IN EPINEPHRINE AN EFFECTIVE SHORT-TERM MEDICATION THAT ALLOWS A PATIENT TO GET DEFINITIVE HELP (2); and early treatment of anaphylaxis with epinephrine is the treatment of choice and

Lines 11 – 13 WHEREAS, clear and universal labeling of epinephrine will aid in certified epinephrine administrators' ability to recognize, obtain, and administer available epinephrine in a timely manner and

Lines 14 – 17 WHEREAS, the states of Wisconsin have adopted legislation in Act 35 and proposed further legislation in "Dillon's Law" to help alleviate this issue by increasing availability of epinephrine IN ALL FORMS auto-injectors to properly trained individuals; now, therefore be it

Lines 18 – 22 RESOLVED, that the American Osteopathic Association (AOA) ADVOCATE FOR STATES TO ENACT COMPREHENSIVE EPINEPHRINE TRAINING PROTOCOLS FOR MEDICAL AND NON-MEDICAL PROFESSIONALS WORKING IN PUBLIC FACILITIES; House of Delegates supports increased availability of epinephrine auto-injectors to properly trained individuals; and be it further

Lines 23 – 24 RESOLVED that the House encourage states to enact legislation for anaphylaxis training programs; and, be it further

Lines 25 – 27 RESOLVED that the House support the recognition of a universal emblem that signifies epinephrine is available (yellow circle with black and yellow outlines with “Epi” boldly placed with black lettering) [image attached below]; and, be it further

Lines 28 – 29 RESOLVED, that the American Osteopathic Association (AOA) House of Delegates supports increased availability of epinephrine in all forms to properly trained individuals.
Committee on Professional Affairs

Page 2, Lines 1 – 2  house supports the recognition of a universal signal that epinephrine is needed. (swing fist to lateral thigh).

FISCAL IMPACT:
The fiscal impact of this resolution has not been assessed by WAOPS.

Explanatory Statement: This policy combines H-333-A/2017 and H-338-A/2017 to provide a more cohesive epinephrine policy for consideration by the committee.

And I so move. APPROVED

H-339  EQUITY IN MEDICARE & MEDICAID PAYMENTS

Mr. Speaker, I present for consideration Resolution No. H-339, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Page 2, Line 3 reporting and evaluation of healthcare provider reimbursement in all Medicare AND MEDICAID pay for

Line 8 RESOLVED, that AOA supports federal legislation, rules or regulations to improve Medicare AND MEDICAID

And I so move. APPROVED

H-340  NALOXONE

Mr. Speaker, I present for consideration Resolution No. H-340, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Line 13 protection in evaluation for and prescribing prescription of Naloxone, regardless of route of

And I so move. APPROVED

H-344  RIGHT TO TRY – EXPERIMENTAL DRUGS

Mr. Speaker, I present for consideration Resolution No. H-344, and the Committee recommends that it be APPROVED with the following AMENDMENTS REFERRED:

Lines 19 – 23 RESOLVED, that since such experimental therapies in terminally ill patients are highly unlikely to fundamentally alter the course of their disease, physicians and drug manufacturers should be protected from legal action by patients who choose to try an investigative treatment but experience adverse effects or no noticeable improvements in their condition; and, be it further

And I so move. APPROVED (for referral to MAOPS - Missouri)
H-300-A/17 RURAL HEALTH CLINICS – LOCATION AND QUALITY OF CARE  
(H253-A/04)

Mr. Speaker, I present for consideration Resolution No. H-300, and the Committee recommends that it be REFERRED to the Bureau of Federal Health Programs (BFHP) for review and comment.

Explanatory Statement: Referred to BFHP for intent and propriety with regard to laws and regulations which may impact the resolution and for investigation as to whether it may be expanded to include institutions.

And I so move. APPROVED (for referral to BFHP)

H-334 OSTEOPATHIC MANIPULATIVE TREATMENT FOR LOW BACK PAIN –  
EVIDENCE BASED EFFICACY AND PRACTICE GUIDELINES

Mr. Speaker, I present for consideration Resolution No. H-334, and the Committee recommends that it be REFERRED to the Bureau of Osteopathic Clinical Education and Research (BOCER) for review and comment.

Explanatory Statement: Referred to BOCER for review and consideration of existing AOA guidelines on the treatment of low back pain.

And I so move. APPROVED (for referral to BOCER)

H-336 RECOMMENDED GUIDELINES FOR PELVIC EXAMINATION AND  
TREATMENT

Mr. Speaker, I present for consideration Resolution No. H-336, and the Committee recommends that it be REFERRED to the American Academy of Osteopathy (AAO) for review and comment.

Explanatory Statement: Referred to AAO due to the potential unintended consequences of this overly prescriptive position paper.

And I so move. APPROVED (for referral to AAO)

H-337 TAKE BACK THE HOUSE

Mr. Speaker, I present for consideration Resolution No. H-337, and the Committee recommends that it be REFERRED to the AOA Committee on AOA Governance and Organization Structure (CAGOS) for review and comment.

Explanatory Statement: Referred to CAGOS, which has been charged by the Board of Trustees as part of the Strategic Plan Phase II to address governance, including Bureaus, Councils and Committees, Board of Trustees and the House of Delegates.

And I so move. APPROVED (for referral to CAGOS)
H-348 PROTECTION OF LICENSURE FOR OSTEOPATHIC MEDICAL STUDENTS, RESIDENTS AND PRACTICING PHYSICIANS SUFFERING FROM DEPRESSION

Mr. Speaker, I present for consideration Resolution No. H-348, and the Committee recommends that it be REFERRED to the Physician Wellness Task Force for review and comment.

Explanatory Statement: The AOA Physician Wellness Strategy’s Challenges to Wellness section recognizes this issue. It will be addressed by the Physician Wellness Task Force.

And I so move. APPROVED (for referral to Physician Wellness Task Force)

H-332 THE OSTEOPATHIC OATH

Mr. Speaker, I present for consideration Resolution No. H-332, and the Committee recommends that it be DISAPPROVED. To begin discussion, I move that it be approved.

Explanatory Statement: The Committee believes that House Resolution 341, if approved, will develop a consistent policy for the AOA in regard to end-of-life issues.

And I so move. DISAPPROVED

H-338 EPINEPHRINE

Mr. Speaker, I present for consideration Resolution No. H-338, and the Committee recommends that it be DISAPPROVED. To begin discussion, I move that it be approved.

Explanatory Statement: The Committee believes that the issues addressed in House Resolution 338 have been combined in the amended House Resolution 333.

And I so move. DISAPPROVED

Mr. Speaker, this concludes the Committee’s report. I would like to thank the members of the Committee.

Committee Members:
1. Joan M. Grzybowski, DO – CHAIR Pennsylvania
2. John Sealy, DO – VICE CHAIR Michigan
3. John Bailey, DO Missouri
4. Steve Bander, DO Texas
5. Nicole Bixler, DO Florida
6. Scott Blickensderfer, DO ACOS
7. Jerome Dixon, DO Kentucky
8. Robert S. Dolansky, Jr., DO Pennsylvania
9. Michael Farrel, DO California
11. Jeffrey Grove, DO Florida
12. Stephen Kabel, DO  New Jersey
13. Lori Kemper, DO  Arizona
14. Isaac J. Kirstein, DO  Ohio
15. Harry Lausen, DO  Illinois
16. Marc Lynch, DO  California
17. Jenny Kendall Thomas, DO  Minnesota
18. Mary Jo Voelpel, DO  Michigan

**STAFF**
Lauren Lattany
Raine Richards
SUBJECT: H253-A/04 RURAL HEALTH CLINICS—LOCATION AND QUALITY OF CARE

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED:

H253-A/04 RURAL HEALTH CLINICS—LOCATION AND QUALITY OF CARE

The American Osteopathic Association supports the concept that federal and state tax dollars should not be used to support rural health clinics that choose to locate within the vicinity of an established, private physician's healthcare facility rather than other sites within medically underserved areas. 1999; revised 2004

Reference Committee Explanatory Statement:
Referred to BFHP for intent and propriety with regard to laws and regulations which may impact the resolution and for investigation as to whether it may be expanded to include institutions.

ACTION TAKEN REFERRED (to AOA Bureau of Federal Health Programs)

DATE July 22, 2017
RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be SUNSET:

H255-A/04  SPINAL MANIPULATION LEGISLATION OR REGULATION

The American Osteopathic Association opposes all legislation or regulatory changes that could be interpreted to exclude osteopathic physicians from the right to practice spinal manipulation and all other forms of osteopathic manipulative treatment; and will works with legislators and state licensing boards to preserve the osteopathic profession's right to establish and maintain standards of practice of osteopathic manipulative treatment. 1999; revised 2004

Explanatory Statement:
Combined under H632-A/12 OSTEOPATHIC MANIPULATIVE TREATMENT -- PAYMENT FOR

ACTION TAKEN  APPROVED (for sunset)

DATE  July 22, 2017
RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED:

H257-A/04 STATE LICENSURE OF MANAGED CARE ORGANIZATIONS (MCO) MEDICAL DIRECTORS

The American Osteopathic Association supports legislation or regulations that would require all managed care organization (MCO) medical directors to be fully-licensed physicians of the state where the care is being provided; and supports state medical boards' rights to oversee and discipline any medical director of an MCO licensed as a physician in their state. 1999; reaffirmed 2004; 2009

ACTION TAKEN  APPROVED (for reaffirmation)

DATE  July 22, 2017
SUBJECT: H300-A/12 NATIONAL PRACTITIONER DATA BANK – AOA REPORTING

SUBMITTED BY: Bureau of Membership

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of Membership recommend that the following policy be

REAFFIRMED:

H300-A/12 NATIONAL PRACTITIONER DATA BANK – AOA REPORTING

Adverse membership action based on a physician’s loss of license do not need to be reported to
the National Practitioner Data Bank (NPDB) by the American Osteopathic Association (AOA)
because state licensing boards report separately to the NPDB on their adverse actions. The
AOA will not report membership actions based on failure to pay dues or complete AOA
requirements for continuing medical education to the NPDB. The AOA shall report adverse
membership actions to the NPDB that are related to quality of care issues and will report on
adverse membership actions if the action is based on ethical or professional misconduct that
affected or could have affected patient care. 2012

ACTION TAKEN APPROVED (for reaffirmation)

DATE July 22, 2017
RESOLVED, that the Bureau on Federal Health Programs and the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED:

H301-A/12  ADMINISTRATIVE RULE-MAKING PROCESS

The American Osteopathic Association supports closer federal and state legislative scrutiny of the administrative rule-making process to more effectively monitor the development of regulations and assure their conformity with expressed legislative intent. 1986; revised 1992; reaffirmed 1997; revised 2002; reaffirmed 2007; reaffirmed as amended 2012

ACTION TAKEN  APPROVED (for reaffirmation)

DATE  July 22, 2017
RESOLVED, that the Bureau on Federal Health Programs and the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED:

H302-A/12 ADVANCE DIRECTIVES

The American Osteopathic Association supports advance directives and will proactively assist in introducing this concept into federal legislation. 1997, revised 2002; reaffirmed 2007; reaffirmed as amended 2012

Explanatory Statement:
Content is not covered under H431-A/2015 END OF LIFE CARE POLICY STATEMENT

ACTION TAKEN _APPROVED (for reaffirmation)_

DATE _July 22, 2017_
RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be SUNSET:

H303-A/12 DRUGS – NON-GENERIC

The American Osteopathic Association urges the development and passage of legislation that would mandate that prescription drug plans provide for name-brand medications when evidence-based treatment protocols recommend their use. 2002, revised 2007; reaffirmed 2012

Explanatory Statement:
Combined under H305-A/12 GENERIC DRUGS

ACTION TAKEN _APPROVED (for sunset)___

DATE _July 22, 2017_
RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be **SUNSET REAFFIRMED**: 

**H304-A/12 FAMILY AND MEDICAL LEAVE ACT (FMLA) DOCUMENTATION**

The American Osteopathic Association will work with patient advocacy groups and other similar groups to assure uniform family and medical leave act documentation requirements that provide adequate information for employers while ensuring the patient's right to privacy. 2002; revised 2007; reaffirmed 2012

**Explanatory Statement:**
The Department of Labor includes a template certification document on its website, and encourages employers to use it. Regardless, it sets uniform documentation requirements of:
- Contact information for the health care provider including name, address, telephone, fax and type of medical practice/specialty;
- When the health condition began;
- How long the serious health condition is expected to last;
- If the employee is the patient, whether the employee is unable to work and the likely duration of this inability; if a family member is the patient, whether the family member needs care and an estimate of the frequency and duration of the leave;
- Whether the employee’s need for leave is continuous or intermittent; and
- Appropriate medical facts about the condition.

**ACTION TAKEN** _APPROVED as AMENDED_

**DATE** _July 22, 2017_
RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED as AMENDED:

H305-A/12 GENERIC PRESCRIPTION DRUGS

The American Osteopathic Association (AOA): (1) urges the FDA to strengthen its inspection and approval procedures and equivalency standards to ensure that generic drugs approved by the FDA are therapeutically equivalent to the brand drug for which they are to be substituted; (2) opposes mandatory USE OF GENERIC DRUGS OR generic substitution programs that remove control of the treatment program from the physician; and (3) until the FDA has effected such policies, standards and procedures, consistent with its distinguished and longstanding stewardship of drug safety and effectiveness, the AOA opposes the mandatory use of generic drugs. (3) URGES THE DEVELOPMENT AND ENACTMENT OF PUBLIC POLICY THAT WOULD MANDATE THAT PRESCRIPTION DRUG PLANS COVER NAME-BRAND MEDICATIONS WHEN EVIDENCE-BASED TREATMENT PROTOCOLS RECOMMEND THEIR USE; (4) ACTS TO EDUCATE HEALTHCARE INSURERS AND MANAGED CARE COMPANIES ON THE POTENTIAL DANGERS OF FORMULARY SUBSTITUTIONS; (5) SUPPORTS PUBLIC POLICY THAT REQUIRES A PHYSICIAN BE AVAILABLE FOR CONSULTATION IN A TIMELY MANNER ON PHARMACEUTICAL FORMULARY AND DRUG SUBSTITUTION DECISIONS; AND (6) OPPOSES ANY ATTEMPT BY FEDERAL OR STATE GOVERNMENTS TO RESTRICT, PROHIBIT, OR OTHERWISE IMPED THE PREROGATIVE OF PHYSICIANS TO PRESCRIBE AND DISPENSE APPROPRIATE MEDICATIONS TO THEIR PATIENTS; AND (7) URGE THE FDA TO ENSURE SAFE AND CONSISTENT DRUG SUPPLY THAT AVOIDS SHORTAGES AND ENSURES ADEQUATE GENERIC PHARMACEUTICAL MANUFACTURE AND SUPPLY FOR U.S. PATIENTS AND PHYSICIANS. 1990; reaffirmed 1995, 1997; revised 2002; 2007; reaffirmed as amended 2012

ACTION TAKEN APPROVED as AMENDED

DATE July 22, 2017
SUBJECT: H306-A/12  HEALTH CLINICS – FEDERALLY FUNDED

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

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RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED as AMENDED:

H306-A/12  HEALTH CLINICS – FEDERALLY FUNDED
The American Osteopathic Association supports eliminating the requirement to have a nurse practitioner or physician assistant in federally funded health clinics; supports instead, adequate staffing for the physicians providing medical care in FEDERALLY FUNDED HEALTH CLINICS AND OPPOSES REQUIREMENTS TO HAVE A NURSE PRACTITIONER OR PHYSICIAN ASSISTANT IN FEDERALLY FUNDED HEALTH CENTERS the clinics; and take steps necessary to eliminate the present requirement. 2002; 2007; reaffirmed 2012

Explanatory Statement:

ACTION TAKEN  APPROVED (as amended)

DATE  July 22, 2017
RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be SUNSET:

H307-A/12 HEALTH CARE DELIVERY SYSTEMS

The American Osteopathic Association will continue to have as a high priority the education of osteopathic physicians and the general public as to the importance of continued availability of osteopathic services in all health care delivery systems. 1987; reaffirmed 1992; revised 1997, 2002; 2007; reaffirmed 2012

Explanatory Statement:
Covered by the various other OMT policies we have supporting its use and payment: H632-A/12 OMT, PAYMENT FOR H647-A/15 OMT, COVERAGE DETERMINATION GUIDANCE

ACTION TAKEN _APPROVED (for sunset)_

DATE _July 22, 2017_
RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED:

**H309-A/12 RURAL AND URBAN PRACTICES – DISPARITIES BETWEEN**

The American Osteopathic Association supports federal legislation that would sustain a minimum geographic cost-of-practice index value for physicians’ services at or above 1.000.

2002; revised 2007; reaffirmed 2012

ACTION TAKEN **APPROVED** (for reaffirmation)

DATE **July 22, 2017**
SUBJECT: H310-A/12 PRESERVATION OF ANTIBIOTICS FOR MEDICAL TREATMENT

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED as AMENDED:

H310-A/12 PRESERVATION OF ANTIBIOTICS FOR MEDICAL TREATMENT

The American Osteopathic Association supports legislation OR REGULATORY EFFORTS that would ban feed additive uses of antibiotics for non-therapeutic uses in animals such as for growth promotion, feed efficiency, weight gain, routine disease prevention or other routine purposes. 2007; reaffirmed 2012

ACTION TAKEN _APPROVED (as amended)_

DATE _July 22, 2017_
RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be SUNSET:

H311-A/12 PHYSICIAN ROLE IN GOVERNANCE OF FEDERALLY CONTRACTED QUALITY IMPROVEMENT ORGANIZATIONS (QIOS) – REDUCED

The American Osteopathic Association supports the concept of improving diversity of representation on the governing bodies of Quality Improvement Organizations (QIOs) via the inclusion of non-physician professionals and consumers; and expresses deep concern and will forcefully advocate against any guidelines that would seek to link federal contracting with QIOs when the governing bodies of these organizations are comprised of a majority of non-physicians, since this is antithetical to the fundamental principles of physician peer review and evidence based quality improvement. 2007; reaffirmed 2012

ACTION TAKEN  APPROVED (for sunset)

DATE  July 22, 2017
RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be SUNSET:

H312-A/12 PHYSICIAN CONSULTATION FOR FORMULARIES

The American Osteopathic Association supports legislation that requires a physician be available for consultation in a timely manner on pharmaceutical formulary and drug substitution decisions. 2007; reaffirmed 2012

Explanatory Statement:
Combined under H305-A/12 GENERIC DRUGS

ACTION TAKEN _APPROVED (for sunset)_

DATE _July 22, 2017_
RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED as AMENDED:

H313-A/12  DIETARY SUPPLEMENTS – GUIDELINES FOR NUTRITIONAL AND

The American Osteopathic Association requests: (1) the Food and Drug Administration (FDA) to be diligent in their monitoring of all products marketed for human consumption, including nutritional supplements, and that there be close attention to reported adverse events directly caused by any of these products; and (2) that the US Congress PASS LEGISLATION amend the Dietary Supplement Health and Education Act (DSHEA) so that REQUIRING dietary supplements will TO undergo pre-market safety and efficacy evaluation by the FDA. 2002; amended 2007; reaffirmed as amended 2011; 2012

ACTION TAKEN _APPROVED (as amended)_

DATE _July 22, 2017_
RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED:

H318-A/12  SEXUAL HARASSMENT


ACTION TAKEN  APPROVED (for reaffirmation)

DATE  July 22, 2017
RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED:

**H321-A/12 DUE PROCESS IN AGENCY DETERMINATIONS**

The American Osteopathic Association declares its opposition to any and all existing or proposed federal and state rules or procedures, and their underlying laws, which vest any administrative personnel with final authority, in matters affecting the rights and/or property of individuals, where no provision is made for a prior, fair, formal hearing. 1982; revised 1987; reaffirmed 1992, 1997, 2002; 2007; reaffirmed as amended 2012

ACTION TAKEN **APPROVED** (for reaffirmation)

DATE **July 22, 2017**
SUBJECT: H322-A/12 ETHICAL AND SOCIOLOGICAL CONSIDERATIONS FOR MEDICAL CARE

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED:

H322-A/12 ETHICAL AND SOCIOLOGICAL CONSIDERATIONS FOR MEDICAL CARE

The American Osteopathic Association encourages Congress and the Department of Health and Human Services to consult with the osteopathic and allopathic medical professions to determine the necessary, proper and acceptable role of government in ethical and sociological matters regarding medical care. 1985; reaffirmed 1990, 1995, 1997; revised 2002; reaffirmed 2007; 2012

ACTION TAKEN _APPROVED (for reaffirmation)_

DATE _July 22, 2017_
RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED:

**H323-A/12 HEALTH CARE – REGULATION OF**

The policy of the American Osteopathic Association with respect to regulation in health care is as follows:

1. The need for any new regulation must demonstrate that access to care, or the quality of health care provided, will be improved by the proposed regulatory action and that the claimed improvement can be accomplished at an acceptable cost to the public.

2. In all matters where the health profession has demonstrated its capacity for quality self-regulation, government at all levels should not impose additional or preemptive regulation.

3. Where the need for regulation has been demonstrated, it should emanate from the lowest applicable level of government.

Where there is a demonstrated necessity for regulation of health care, such regulation must be drawn and implemented in such a way as to promote pluralism and preserve the free enterprise system in health care. 1981; revised 1986, 1992; reaffirmed 1997; revised 2002; 2007; reaffirmed as amended 2012

**ACTION TAKEN** APPROVED (for reaffirmation)

**DATE** July 22, 2017
SUBJECT: H324-A/12 OCCUPATIONAL SAFETY AND HEATH ADMINISTRATION (OSHA) REGULATIONS

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED as AMENDED:

H324-A/12 OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (OSHA) REGULATIONS

The American Osteopathic Association urges that the Occupational Safety and Health Administration (OSHA) emphasize PRIORITIZE education and training to create a safe work place rather than BEFORE CONSIDERING assessment of punitive fines WHEN APPROPRIATE. 1992; revised 1997, 2002; 2007; reaffirmed 2012

ACTION TAKEN APPROVED as AMENDED

DATE July 22, 2017
RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be REAFFIRMED:

H326-A/12  PATIENT SAFETY

The American Osteopathic Association endorses the policy of patient safety in health care that encourages payers to provide adequate payment so that hospitals HEALTH CARE FACILITIES can provide the best quality care in the safest of environments. 2002; 2007; reaffirmed as amended 2012

ACTION TAKEN  APPROVED as AMENDED

DATE  July 22, 2017
SUBJECT: H327-A/12 PRESCRIPTION DRUGS SAMPLES

SUBMITTED BY: Bureau on Federal Health Programs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be SUNSET:

H327-A/12 PRESCRIPTION DRUGS SAMPLES

The American Osteopathic Association supports the enactment of appropriate criminal penalties for those who illegally divert such samples; opposes any legislation which intends to restrict drug sampling; and encourages pharmaceutical manufacturing companies to continue the effective practice of drug sampling. 1994; revised 1997, 2002, 2007; reaffirmed as amended 2012

Explanatory Statement:
Significant overlap with H327-A/16 DRUG SAMPLES; and H335-A/15 PRESCRIPTION DRUG DIVERSION AND ABUSE – EDUCATION, RESEARCH, AND ADVOCACY addresses law enforcement and deterrents to stop prescription drug abuse, misuse, and diversion.

ACTION TAKEN APPROVED (for sunset)

DATE July 22, 2017
SUBJECT: H411-A/12 END-OF-LIFE CARE FOR THE DEVELOPMENTALLY DISABLED

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Professional Affairs

RESOLVED, that the Bureau of State Government Affairs Bureau on Federal Health Programs recommend that the following policy be SUNSET:

H411-A/12 END-OF-LIFE CARE FOR THE DEVELOPMENTALLY DISABLED

The American Osteopathic Association will work with component state societies and advocacy groups for the developmentally disabled to develop and implement policies to ensure dignity at the time of death for all individuals, including the developmentally challenged; and will support development and implementation of policies designed to permit the provision of hospice and palliative services to the developmentally disabled. 2012

Explanatory Statement:
Combined under newly edited policy H431-A/15 END OF LIFE CARE POLICY STATEMENT.

ACTION TAKEN  APPROVED (for sunset)

DATE  July 22, 2017
RESOLVED, that the Bureau on Federal Health Programs and the Bureau of State Government Affairs recommend that the following policy be SUNSET:

H413-A/12  DO NOT RESUSCITATE (DNR) ORDERS ON ELDER ADULTS IN LONG TERM OR EXTENDED-CARE FACILITIES

The American Osteopathic Association (1) will work in conjunction with the component state societies and elder care advocacy organizations to encourage legislation which upholds a patient’s right to a “Do Not Attempt Resuscitation” (DNAR) and/or Allow Natural Death (AND), designation, determined by the patient or, if the patient is incompetent, by the family, attending physicians, patient advocate, and/or durable power of health care attorney (DPOA); (2) supports policies or legislative initiatives to make hospice and palliative care available to allow the patient the dignity of comfort measures when resuscitation is futile; and (3) will work with other key stakeholders to educate physicians in their understanding of the intent of this legislation and to enhance their ability to conduct discussion of this issue with families and facilities where these patients may be treated. 2012

Explanatory Statement:
Combined under newly edited policy H431-A/15 END OF LIFE CARE POLICY STATEMENT

ACTION TAKEN _APPROVED (for sunset)___

DATE _July 22, 2017____________
RESOLVED, that the Bureau on Federal Health Programs and the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED:

H426-A/12 SCHOOL BASED HEALTH EDUCATION – PROMOTION
The American Osteopathic Association will continue to urge the state legislatures to enact measures establishing programs that meet with the Centers for Disease Control and Prevention definition of comprehensive school health education. 1992; reaffirmed 1997, revised 2002; 2007; reaffirmed 2012

ACTION TAKEN __APPROVED (for reaffirmation)___

DATE _July 22, 2017_
RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be REAFFIRMED as AMENDED:

H316-A/12 PAYMENT RECOUPMENT LAWS
The American Osteopathic Association SUPPORTS PUBLIC POLICIES WHICH calls upon the U.S. Congress to pass federal legislation which subjects all parties to the same terms and time frame for billing, payment REIMBURSEMENT PAYMENT and appeal. 2002; 2007; reaffirmed as amended 2012

ACTION TAKEN _APPROVED as AMENDED_

DATE _July 22, 2017_
RESOLVED, that the Bureau of State Government Affairs and the Bureau on Federal Health Programs recommend that the following policy be SUNSET:

H614-A/12 FORMULARY CHANGES
The American Osteopathic Association will act to educate healthcare insurers and managed care companies on the potential dangers of formulary substitutions. 2002; 2007; reaffirmed 2012

Explanatory Statement:
Combined under policy H305-A/12 GENERIC DRUGS.

ACTION TAKEN **APPROVED (for sunset)**

DATE **July 22, 2017**
RESOLVED, that the Bureau of Socioeconomic Affairs, the Bureau on Federal Health Programs, and the Bureau of State Government Affairs recommend that the following policy be SUNSET:

H630-A/12 DISPENSING OF MEDICATION BY PHYSICIANS

The American Osteopathic Association opposes any attempt by Congress, the federal government or state governments to restrict, prohibit or otherwise impede the prerogative of physicians to prescribe and dispense appropriate medications to their patients. 1987; reaffirmed 1992; revised 1997; reaffirmed 2002; amended 2007; [Editor's note: This policy has been referred to develop a policy that is more reflective of the government’s role in protecting public safety – 2012]

Explanatory Statement:
Combined under policy H305-A/12 GENERIC DRUGS.

ACTION TAKEN _APPROVED (for sunset)_

DATE _July 22, 2017_
RESOLVED, that the Bureau of Socioeconomic Affairs, the Bureau on Federal Health Programs, and the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED as AMENDED:

**H632-A/12 OSTEOPATHIC MANIPULATIVE TREATMENT – RIGHT TO PRACTICE AND PAYMENT FOR**

The American Osteopathic Association will pursue any and all legal and legislative recourse to protect PATIENT ACCESS AND the rights of its member physicians to deliver approved and beneficial modalities of healthcare; WILL WORK WITH LEGISLATORS AND STATE LICENSING BOARDS TO PRESERVE THE OSTEOPATHIC PROFESSION’S RIGHT TO ESTABLISH AND MAINTAIN STANDARDS OF PRACTICE OF OSTEOPATHIC MANIPULATIVE TREATMENT; objects to any attempt by third party PAYERS to deny or restrict payment for osteopathic manipulative treatment when appropriately rendered by an osteopathic physician WITH APPROPRIATE TRAINING IN OSTEOPATHIC PRINCIPLES AND PRACTICE; and will continue to oppose any attempt by third-party payers to interchange and/or combine osteopathic manipulative treatment codes with codes used to describe other forms of manual therapy. 1986; revised 1991, 1992, 1997, revised 2002; 2007; reaffirmed as amended 2012

Explanatory Statement:
Combined with policy H255-A/04 SPINAL MANIPULATION LEGISLATION OR REGULATION.

ACTION TAKEN  APPROVED (for reaffirmation)

DATE  July 22, 2017
WHEREAS, opioid overdose is the leading cause of accidental death in the United States1; and
WHEREAS, there were 47,055 fatal drug overdoses in 2014 alone, the majority of which were caused by prescription pain medications2; and
WHEREAS, first line therapy involves pharmacological treatment with drugs like buprenorphine, which requires the patient to have in-office appointments multiple times a month for monitoring; and
WHEREAS, the majority of physicians licensed to treat opioid addiction are located in large metropolitan areas, creating a barrier to patients located in rural areas3; and
WHEREAS, the Comprehensive Addiction Recovery Act (2016) expands treatment numbers for providers certified in addiction medicine or psychiatry to 275, but states are allowed to lower the number to 30, potentially reducing the impact of this bill and treatment availability to an already underserved population4; now, therefore be it
RESOLVED, that the American Osteopathic Association (AOA) advocates to states to not lower opioid addiction treatment numbers below the 275 maximum patient load allowed under the Comprehensive Addiction Recovery Act (2016).

Explanatory Statement:
Although Comprehensive Addiction Recovery Act (2016) has made great strides in improving access to pharmacological treatment of opioid abuse, it does not go far enough to battle this public health crisis. The restrictions imposed on opioid abuse treatment are unprecedented in any other disease and denies the patient autonomy in their care. With the advent of DEA monitored state drug prescribing programs and improved treatment guidelines, regulation has already increased that allows for control of this medication.

References


**FISCAL IMPACT:**
Unknown

**ACTION TAKEN** APPROVED

DATE **July 22, 2017**
WHEREAS, the American Osteopathic Association (AOA) House of Delegates approved Resolution H-331 A/16, Common Osteopathic Oath, which calls for the establishment of a task force to review the Osteopathic Oath due to concern that it may be in conflict with states' laws and that some schools are no longer be using it; and

WHEREAS, the AOA President nominated and the AOA Board of Trustees approved an Osteopathic Oath Task Force, comprised of Clinton Adams, DO, COM President, James Froelich, DO, Texas Delegate, Virginia Johnson, DO, California Delegate, John Kauffman, DO, North Carolina Delegate, Anita Showalter, DO, Washington Delegate, and Fritz Stein, OMS IV and Board of Trustees advisor; and

WHEREAS, the Osteopathic Oath Task Force met four times by conference call to review and discuss the Osteopathic Oath, its history, use, compatibility with modern medicine and the role in passing the osteopathic ethos to the next generation; and

WHEREAS, after considerable debate both for and against modifying the Osteopathic Oath, the Task Force voted to modify the Osteopathic Oath to make it compatible with state law and at the same time preserve the essence of what it means to be an osteopathic physician; now, therefore be it

RESOLVED, that the Osteopathic Oath be amended as follows:

I do hereby affirm my loyalty to the profession I am about to enter. I will be mindful always of my great responsibility to preserve the health and the life of my patients, to retain their confidence and respect both as a physician and a friend who will guard their secrets with scrupulous honor and fidelity, to perform faithfully my professional duties, to employ only those recognized methods of treatment consistent with good judgment and with my skill and ability, keeping in mind always nature's laws and the body's inherent capacity for recovery.

I will be ever vigilant in aiding in the general welfare of the community, sustaining its laws and institutions, not engaging in those practices which will in any way bring shame or discredit upon myself or my profession. I will give no drugs for deadly ILLEGAL purposes to any person, though it be asked of me.
I will endeavor to work in accord with my colleagues in a spirit of progressive cooperation and never by word or by act cast imputations upon them or their rightful practices.

I will look with respect and esteem upon all those who have taught me my art. To my college AND MY PROFESSION, I will be loyal and strive always for its best interests and for the interests of the students who will come after me. I will be ever alert to further the application of basic biologic truths to the healing arts and to develop the principles of osteopathy OSTEOPATHIC MEDICINE which were first enunciated by Andrew Taylor Still. (Revised 2017)

; and, be it further

RESOLVED, that the American Osteopathic Association House of Delegates encourage all American Osteopathic Association Commission on Osteopathic College Accreditation accredited schools to have graduates recite the Osteopathic Oath, revised 2017, at the time of graduation; and, be it further

RESOLVED, that the attached reports be filed.

Explanatory Statement:
See attached report.

Reference Committee Explanatory Statement:
The Committee believes that House Resolution 341, if approved, will develop a consistent policy for

ACTION TAKEN **DISAPPROVED**

DATE **July 22, 2017**
REPORT OF THE OSTEOPATHIC OATH TASK FORCE
March 29, 2017

Background
Resolution H-331 A/16, Common Osteopathic Oath, was approved by the 2016 AOA House of Delegates. The Resolution calls for the appointment of a Task Force to review the osteopathic oath. AOA President Boyd R. Buser, DO, nominated and the AOA Board of Trustees approved a Task Force in the Fall of 2016. The Task Force members were:

Clinton E. Adams, DO, MPA, Chair, COM President
James Froelich, DO, Texas Delegate
Virginia Johnson, DO, California Delegate
John Kauffman, DO, North Carolina Delegate
Anita Showalter, DO, Washington Delegate
Frederick Stine, OMS IV, Board of Trustees Advisor

History of the Osteopathic Oath
The current version of the Hippocratic Oath for administration to osteopathic college graduates was initiated by a suggestion from Frank E. MacCracken, DO, of California to his state society. Within a year, the suggestion went from the state to the national association, and a committee was formed under the Associated Colleges of Osteopathy to prepare the text. Members of that committee included Dr. MacCracken, as chairman, and Drs. R.C. McCaughan, Walter V. Goodfellow, and Edward T. Abbott. The first version was used from 1938 until 1954, at which time minor amendments were adopted. This version has been in use since 1954:

I do hereby affirm my loyalty to the profession I am about to enter. I will be mindful always of my great responsibility to preserve the health and the life of my patients, to retain their confidence and respect both as a physician and a friend who will guard their secrets with scrupulous honor and fidelity, to perform faithfully my professional duties, to employ only those recognized methods of treatment consistent with good judgment and with my skill and ability, keeping in mind always nature’s laws and the body’s inherent capacity for recovery.

I will be ever vigilant in aiding in the general welfare of the community, sustaining its laws and institutions, not engaging in those practices which will in any way bring shame or discredit upon myself or my profession. I will give no drugs for deadly purposes to any person, though it be asked of me.

I will endeavor to work in accord with my colleagues in a spirit of progressive cooperation and never by word or by act cast imputations upon them or their rightful practices.

I will look with respect and esteem upon all those who have taught me my art. To my college I will be loyal and strive always for its best interests and for the interests of the students who will come after me. I will be ever alert to further the application of basic biologic truths to the healing arts and to develop the principles of osteopathy which were first enunciated by Andrew Taylor Still.
**Information Review**

The Task Force met via conference call 4 times. The group reviewed the history of the Osteopathic Oath and publications that discussed the Oath. Additionally, the Task Force reviewed the results of a recent survey conducted by the American Association of Colleges of Osteopathic Medicine (AACOM) looking at the Osteopathic Oath usage among the colleges of osteopathic medicine.

<table>
<thead>
<tr>
<th>Uses Oath without Modification</th>
<th>Uses a modified oath</th>
<th>No graduates yet but will use the oath without modification</th>
<th>No graduates and no decision made regarding the oath</th>
<th>No graduates but plan to use the osteopathic pledge of commitment</th>
<th>No information</th>
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<tbody>
<tr>
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<td>9</td>
<td>3</td>
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A total of 38 colleges of osteopathic medicine (COMs) and branch campuses responded to the survey. Half of the respondents (19) indicated that they use the osteopathic oath without modification. Nine schools use a modified oath. Seven COMs had not graduated a class. Three COMs responded to the survey but provided no information.

The Task Force also found there are five states that have death with dignity laws: Oregon, California, Vermont, Washington, and Montana. These laws allow physicians to aid their terminally ill patients with self-euthanasia. The laws are fairly similar requiring the patient to be an adult, to be mentally competent, to be diagnosed with a terminal illness that will lead to death within six months, to be approved by two different physicians, and must provide multiple requests.

Policies and ethical guidelines from the American Osteopathic Association and the American Medical Association were reviewed, including:

- H431-A/15 End Of Life Care--Policy Statement
- H441-A/12 Physician Assisted Death
- H331-A/14 End-Of-Life Care -- Use Of Placebos In
- AOA Code of Ethics on Physician Assisted Suicide
- AMA Code Of Ethics: Chapter 5: Opinions On Caring For Patients At The End Of Life

A recent article in the New England Journal of Medicine on “Lessons from Oregon in Embracing Complexity in End-of-Life Care” (March 16, 2017) was reviewed.

**Discussion**

After reviewing the background information, the Task Force discussed the purpose of an oath. The Task Force believes the oath is a historic document of the profession, it represents the sacred role of osteopathic physicians with their patients, and it creates a bond of values from one generation of DOs to the next.

There was extensive discussion on the sentence in the oath, “I will give no drugs for deadly purposes to any person, though it be asked of me.” Several options were considered regarding that sentence, including: 1) dropping the sentence, 2) maintaining the current oath and allowing schools to make modifications as they saw fit and 3) modifying the sentence.

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1 Reinsch S, Seffinger M, Tobis J: The Merger: MDs and DOs in California.
2 [http://www.osteopathic.org/inside-aoa/about/leadership/Pages/osteopathic-oath.aspx](http://www.osteopathic.org/inside-aoa/about/leadership/Pages/osteopathic-oath.aspx)
The Task Force recommended that sentence be modified by substituting the word “illegal” for the word “deadly.” Those opposed to the change emphasized that the oath should not depend on legal changes or societal changes; rather, the oath represents the sacred commitment of physicians to their patients. Those in favor of the change believed that the substitution allows for the difficult balancing between life and suffering and draws a clear boundary between what is wrong, the provision of illegal drugs, and the practice by some colleagues in the difficult provision of end-of-life care. The Task Force voted in favor of the substitution. The second change recommended by the Task Force is to change the fourth paragraph to update the terminology about the profession and the osteopathic medicine.

**Conclusion**

The Task Force believes the osteopathic oath is important and helps promote the osteopathic ethos to the next generation. Thus, a common osteopathic oath should be used by all colleges of osteopathic medicine. The Task Force concluded that updating the oath by substituting “illegal” for “deadly” provides the flexibility needed in modern medicine. While physician-assisted suicide is a reality in several states, the Task Force supports the AOA and its policies that encourage osteopathic physicians to consider alternatives to physician-assisted suicide. “Community resources such as hospice programs should be made available to all patients.”

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3 H431-A/15 End of Life Care--Policy Statement
MINORITY OPINION: AOA OSTEOPATHIC OATH TASK FORCE
May 25, 2017

John M. Kauffman Jr. DO, FACOI, FACP
Anita Showalter DO, FACOOG (Dist)

As members of the Osteopathic Oath Task force voting in the minority not to approve the proposed changes to the Osteopathic Oath, we appreciate the opportunity to share our specific concerns. We have outlined points for consideration before our profession makes a substantial change to the Osteopathic Oath. Specifically, we would like to leave intact the phrase that states, “I will give no drugs for deadly purposes to any person, though it be asked of me.” Following are points for consideration regarding physician-assisted suicide (PAS):

1. **The Osteopathic Oath as it now reads is consistent with the Hippocratic traditions of honoring and respecting the patient’s life, secrets and maintaining the patient’s highest level of trust as a medical professional.**
   - Physicians are uniquely trained to use science and art to improve the life and health of their patients.
   - For several millennia, it has been considered the role of physicians to preserve life.
   - Physicians are ill-trained to determine or advise patients on the timing of one’s death.
   - The concept of patient autonomy in determining that there is no more value in one’s life is interpreted as a sign of mental illness in all other circumstances of medical care, and physicians are charged to seek appropriate mental health referral and treatment to help patients recognize value in their lives until their natural end.
   - When physicians see themselves as appropriate participants in counseling patients and prescribing lethal doses of medications, the physician’s role becomes blurred. Physicians may not read signs appropriately, and bringing up counseling on the option of physician-assisted suicide may give patients the message that they are in the way and their life is no longer a value to society.
   - The AMA Code of Ethics States: Physician-assisted suicide is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks.
   - Dr. Kevorkian could not be controlled when euthanasia was not legal – what makes us think that it could have been controlled if it was legal?
   - When physicians start seeing their role in taking of life, doing so without consent also becomes more acceptable. In a study of physicians in the Netherlands in 1995, 6 years before euthanasia became legal in that country, 23% said that at some time they had ended a patient’s life without explicit request, and 32% said that they had not done so but could conceive of a situation in which they would. 45% said that they had never euthanized a patient and could not conceive of any situation in which they would. (Van der Maas, Paul J, et. al 1996)
2. The current US laws in place regarding PAS apply when a patient has been given a terminal diagnosis with six month or less to live.
   - Five states and the District of Columbia have PAS laws in place, Montana has provided immunity to physicians via patient consent, but no statute).
   - The fact that the laws are in place sends a message to patients that once a terminal diagnosis is made with six months or less to live, the patient is now in a new classification of individuals whose life is not protected in the same manner as everyone else.
   - The laws do not require the patient’s treatment to be futile, so patients with possible extended longevity given appropriate treatment may still participate. We are notoriously bad at guessing life expectancy.
   - Studies have shown that when patients receive adequate palliative care, the requests for physician assisted suicide decrease dramatically. According to one study, about 50% of terminally ill patients think they may wish to consider PAS in the future. About 10% seriously consider it. Of that 1%, only 1 in 10 actually receive and take a lethal prescription. Furthermore, in most patients, the desire for PAS diminishes as their needs are met. (Bascom, Tolle, 2002).
   - Mental illness may play a significant role in requests for PAS. One study showed that for people at the end of life, depression, hopelessness, and psychosocial distress are among the strongest correlates of desire for hastened death. Furthermore, in 2007 none of the people who died by lethal ingestion in Oregon had been evaluated by a psychiatrist or a psychologist. (Ganzini, et al. 2008.)
   - The right to die easily becomes a “duty to die” for vulnerable populations. A review of Oregon PAS statistics for 2013 showed Of the 71 patients who died, 35 gave “burden on family, friends/caregivers” as a reason for their request. (McIlroy, 2014).
   - Physician-assisted suicide may begin as an option, but if it becomes a patient’s right, physicians may become obligated to participate against their conscience. In Canada, patients have a right to Medical Aid in Dying, and physicians have been charged with failure to provide standard of care for not participating or referring.

3. A professional code of conduct should not be dependent on laws that may change.
   - The resolution is not well-written in assuming that if something is legal, it’s OK.
   - State law is sometimes in conflict with federal law, as in legalization of marijuana. If this becomes the case in regard to physician-assisted suicide, which law should be followed?
   - Laws have been notoriously bad in the past – let’s learn our lessons from history.
   - Everything physicians participated in during the Nazi regime was legal. Many individuals who suffered and died during World War II would have survived if physicians had followed the Hippocratic Oath.

4. The slippery slope is real.
   - The Netherlands, the first country to legalize euthanasia in 2001 (though widely practiced before the law was enacted) is now considering legislation to allow healthy elderly to “die with dignity” with the assistance of a medical professional. The bill, expected to be
drafted this year, will apply to “older people who do not have the possibility to continue life in a meaningful way, who are struggling with the loss of independence and reduced mobility, and who have a sense of loneliness, partly because of the loss of loved ones, and who are burdened by general fatigue, deterioration and loss of personal dignity.” (Bilefsky, Schuetze, 2016) Once the idea of taking the lives of those who are marginalized by declining health takes hold, where does it stop?

5. **Our allopathic colleagues have not made an official change to the Hippocratic Oath.**
   - Allopathic medical schools use their own variations of the oath without an official change.
   - If the Osteopathic community makes a variation in the oath to permit PAS, we send a message to the nation and world that we have turned from our traditional code of behavior, to preserve life – this is not a message that will be welcomed by the majority of our patients.
   - In the Netherlands where physician-assisted suicide has been legal for 16 years, 6000 members of the Dutch Patients Association carry cards asking physicians not to euthanize them. (Beckford, 2017). Do we want our patients carrying such cards? Furthermore, patients report hiring advocates to sit at the bedside and watch all medications to make sure they are not euthanized.

6. **All organizations must weigh decisions based on their most deeply held philosophies.**
   - How is participation in physician-assisted suicide consistent with the four basic tenets of osteopathic medicine?
   - Conversely, excellent palliative care addresses the mind, body and spirit of the patient.

7. **We as a profession are sympathetic to suffering and dedicate our lives to relieving it. This is consistent with osteopathic philosophy.**
   - The science of end of life care has advanced dramatically, but we can do better still.
   - We can help relieve suffering while permitting a patient to live and interact until their last breath.
   - We can kill the pain without killing the patient.
   - There is a significant difference between withholding futile treatment and allowing the natural end of life to come and actively participating in taking a patient’s life.
   - We do not understand enough about the process of death and the physiologic, psychologic, and relational processes that occur before life leaves the body to take it upon ourselves to interfere with it.
References

Bascom PB, Tolle SW. Responding to Requests for Physician-Assisted Suicide "These Are Uncharted Waters for Both of Us. . . .". JAMA. 2002;288(1):91-98. doi:10.1001/jama.288.1.91


Mclroy, Gillian. Some data on assisted dying from Oregon are worrying. BMJ 2014; 349 doi: https://doi-org.proxy.pnwu.org/10.1136/bmj.g4961 (Published 05 August 2014 )Cite this as: BMJ 2014;349:g4961

SUBJECT: COMMON OSTEOPATHIC OATH

SUBMITTED BY: Osteopathic Physicians and Surgeons of California

REFERRED TO: Committee on Professional Affairs

1. WHEREAS, the Osteopathic Oath was first written in 1934 by Frank E. MacCrackin, DO, for pledge ceremonies by graduating osteopathic students, with few revisions; and

2. WHEREAS, the Osteopathic Oath is distinctively different from other medical school oaths in its emphasis on acknowledgment of nature’s role in health and recovery from disease; and

3. WHEREAS, having an Osteopathic Oath promotes a unified culture within the profession; and

4. WHEREAS, the current Osteopathic Oath maybe in conflict with some states’ law; and

5. WHEREAS, some schools are no longer administering a common Osteopathic Oath; now, therefore be it

6. RESOLVED, the AOA appoint a task force to review the Osteopathic Oath and make recommendations on its review to the 2017 AOA House of Delegates.

Explanatory Statement:

REFERENCE: http://www.osteopathic.org/inside-aoa/about/leadership/Pages/osteopathic-oath.aspx

Fiscal Impact: $

ACTION TAKEN _APPROVED_

DATE _July 22, 2016_
WHEREAS, the philosophy of Osteopathic Medicine stresses the importance of preventive medicine, patient education, and promoting wellness; and

WHEREAS, THERE IS A RISING INCIDENCE OF ANAPHYLAXIS (1); there are over 100,000 cases of anaphylaxis each year in the United States, 60% of these are first-time events resulting in greater than 1500 deaths annually and

WHEREAS, THERE EXISTS IN EPINEPHRINE AN EFFECTIVE SHORT-TERM MEDICATION THAT ALLOWS A PATIENT TO GET DEFINITIVE HELP (2); early treatment of anaphylaxis with epinephrine is the treatment of choice and

WHEREAS, there is often significant delay, especially in rural areas, in obtaining epinephrine; and

WHEREAS, clear and universal labeling of epinephrine will aid in certified epinephrine administrators’ ability to recognize, obtain, and administer available epinephrine in a timely manner and

WHEREAS, the stateS HAVE of Wisconsin has adopted legislation in Act 35 and proposed further legislation in "Dillon's Law" to help alleviate this issue by increasing availability of epinephrine IN ALL FORMS auto-injectors to properly trained individuals; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) ADVOCATE FOR STATES TO ENACT COMPREHENSIVE EPINEPHRINE TRAINING PROTOCOLS FOR MEDICAL AND NON-MEDICAL PROFESSIONALS WORKING IN PUBLIC FACILITIES House of Delegates supports increased availability of epinephrine auto-injectors to properly trained individuals; and be it further

RESOLVED that the House encourage states to enact legislation for anaphylaxis training programs; and, be it further

RESOLVED that the House support the recognition of a universal emblem that signifies epinephrine is available (yellow circle with black and yellow outlines with “Epi” boldly placed with black lettering) [image attached below]; and, be it further

RESOLVED, that the AOA house supports the recognition of a universal signal that epinephrine is needed. (swing fist to lateral thigh).
RESOLVED, THAT THE AOA HOUSE OF DELEGATES SUPPORTS INCREASED AVAILABILITY OF EPINEPHRINE IN ALL FORMS TO PROPERLY TRAINED INDIVIDUALS

Reference Committee Explanatory Statement:
This policy combines H333 – A/2017 and H338 – A/2017 to provide a more cohesive epinephrine policy for consideration by the committee.

ACTION TAKEN  APPROVED as AMENDED

DATE  July 22, 2017
WHEREAS, the broader U.S. medical community has recently published practice guidelines for the treatment of non-radicular low back pain without an osteopathic perspective; and

WHEREAS, the American Osteopathic Association represents the osteopathic physicians and surgeons most qualified to comment on the management of non-radicular low back pain; and

WHEREAS, federal payment guidelines do not recognize osteopathic manipulative treatment (OMT) for the management of chronic low back pain; and

WHEREAS, a significant evidence-base now exists in the osteopathic medical literature for the efficacy and safety of OMT of low back pain; now, therefore be it

RESOLVED, that a white paper should be created with the express intent to review and advocate for the use of osteopathic principles and practices with regard to the management of non-radicular low back pain; and, be it further

RESOLVED, that the white paper include a review of and recommendations pertaining to use of OMT for the management for chronic low back pain; and, be it further

RESOLVED, that the American Osteopathic Association (AOA) assign the drafting of this white paper to the Bureau on Scientific Affairs and Public Health to be completed within the next 12 months.

Explanatory Statement:
It is well recognized that low back pain is a frequent complaint of patients presenting to physicians in the United States. The American College of Physicians has recently published low back pain management guidelines, which only mentions “spinal manipulation” in a cursory manner, not specifically addressing osteopathic manipulative treatment (Qaseem, Wilt, McLean, & Forciea, 2017). Similarly, a recent review published in the Journal of the American Medical Association does not adequately utilize osteopathic medical research in its dataset, but rather focuses on chiropractic and physical therapy modalities (Paige, et al., 2017). As historical and contemporary leaders in musculoskeletal manipulation, the osteopathic community should publish practice guidelines that take into account the significant evidence-base for osteopathic manipulative treatment of low back pain as well as advocate for the use of OMT in the management of chronic low back pain.

References


Reference Committee Explanatory Statement:
Referred to BOCER for review and consideration of existing AOA guidelines on the treatment of low back pain.

ACTION TAKEN _REFERRED_ (to AOA Bureau of Osteopathic Clinical Education and Research)

DATE _July 22, 2017_
WHEREAS, due to the integral relationship of the pelvis to the musculoskeletal system and overall health of the patient; and

WHEREAS, osteopathic physicians often perform internal and external examination of the pelvis and related areas as part of their routine care for evaluation of patient symptoms, or in response to complaints where somatic dysfunction may play a role; and

WHEREAS, as such, the following recommendations from the American Academy of Osteopathy (AAO) are for the indications and procedure for examination and treatment of the pelvis and related areas; and

WHEREAS, osteopathic physicians should take all appropriate measures to ensure patient comfort, privacy and modesty; now, therefore be it

RESOLVED, that the American Osteopathic Association recommend the following guidelines for examination and treatment of the pelvis and related areas as developed by the American Academy of Osteopathy.

American Academy of Osteopathy Position Paper:
Recommended Guidelines for Examination and Treatment of the Pelvis and Related Areas

Abstract

Due to the integral relationship of the pelvis to the health of the patient, osteopathic physicians often perform both internal pelvic examinations and external physical and structural evaluation as part of their routine patient care. As such, the American Academy of Osteopathy (AAO) recommends the following in regards to examination and treatment of the pelvis and related areas:

1. Prior to examination of the pelvis, anorectal region, external genitalia and related musculoskeletal structures, informed consent should be obtained.

2. Examination should be done in a manner that maintains the patient’s modesty and encourages the patient to speak up if they are uncomfortable either physically or emotionally.

3. Indications for a complete pelvic examination in both the adult and pediatric patient may include but are not limited to the following: persistent vaginal discharge, dysuria or urinary tract symptoms in a sexually active female, dysmenorrhea unresponsive to nonsteroidal anti-inflammatory drugs, amenorrhea, abnormal vaginal bleeding, lower abdominal pain, contraceptive testing for an intrauterine device (IUD) or diaphragm, to perform a Papanicolaou test, suspected/reported rape or sexual abuse, and pregnancy.
4. Clinical conditions related to somatic dysfunction that may prompt a pelvic examination in addition to structural exam of the pelvis, sacrum, coccyx, pelvic diaphragm and related structures may include but are not limited to the following: pelvic floor dysfunction, abdominal pain, pelvic pain, coccydynia, dysmenorrhea, dyspareunia, infertility, lower back pain, stress incontinence, benign prostatic hypertrophy, urinary tract complaints, lower gastrointestinal issues, and neuralgia of the lower extremities.3

5. A complete pelvic examination that involves the use of a speculum and/or bimanual examination is not indicated in the asymptomatic pediatric patient. External genitalia examinations are recommended as part of routine screening/care in the pediatric patient.

6. A chaperone should be offered to patients for examinations that require the patient to disrobe and/or provided upon patient request.

7. Documentation should include subjective, objective, assessment and plan sections that support the need for examination and treatment of the pelvis and related structures and should document if a chaperone was present and during what parts of the examination and treatment. Documentation also should note if a chaperone was offered and declined.

Background

There were approximately 60,000,000 pelvic examinations performed in the United States in 2011.1 Pelvic examinations may be performed by medical doctors (MDs), doctors of osteopathic medicine (DOs), certified nurse midwives (CNMs), certified midwives (CMs)4 and advanced practice registered nurses (APRNs).5 The scope of practice of a physician assistant (PA) varies based on experience, state law, policies of employers/facilities, and the needs of the patient/practice.6 Gender-specific examinations are permitted in many jurisdictions for doctors of chiropractic as well.7 Medical students also may assist in pelvic examinations. Physical therapists perform internal manual treatment for a variety of urological, gynecological and musculoskeletal conditions.8

Due to the integral relationship of the pelvis to the musculoskeletal system and overall health of the patient, osteopathic physicians often perform pelvic examinations as part of routine examinations or in response to complaints where somatic dysfunction may play a role. As such, the AAO recommends the following indications and procedure for examination and treatment of the pelvis, anorectal region, pelvic floor, external genitalia and related musculoskeletal structures.

Recommendations

Informed Consent

Prior to any examination and treatment of the pelvis, genitalia and related areas, the physician should engage the patient in a discussion regarding the nature of the procedure about to be performed. This discussion is called informed consent: “In health care, informed consent refers to the process whereby the patient and the health care practitioner engage in a dialogue about a proposed medical treatment’s nature, consequences, harms, benefits, risks, and alternatives.[1] Informed consent is a fundamental principle of health care.”9 Informed consent is important to patient safety, and failing to obtain informed consent prior to performing a procedure on a patient could be considered a form of battery in extreme cases.9
Modesty and Comfort

Once informed consent has been obtained from the patient, the physician may begin to perform the pelvic examination or treatment. The physician should reassure the patient that nothing will be done without informing them first. The physician should also advise the patient that the examination should not be painful unless there is a pelvic abnormality present. The patient should be encouraged to let the physician know if they become uncomfortable during the examination either physically or emotionally. The exam should be performed in a professional and a private environment that ensures patient privacy, modesty and comfort. Patient modesty should be maintained by utilizing a drape to cover areas that do not need to be exposed. The physician should wear gloves unless palpating through clothing. Lubrication should be used for patient comfort when necessary. Some forms of evaluation for pelvic pathology may not require the patient to disrobe. For example, an osteopathic physician may need to evaluate for hypertonicity of the pelvic floor musculature. Such an evaluation can be accomplished through clothing, but there are times that disrobing is necessary for complete evaluation of the pelvic floor musculature. If the patient is required to disrobe for complete evaluation, a chaperone may be present. The AAO recommends that a chaperone be present during examination and treatment of the pelvis and related areas if the patient is disrobed or in any treatment of a minor. The presence of a chaperone is physician-dependent but should be available upon patient request.

Pelvic Examinations

In the case of the pediatric patient, the American Academy of Pediatrics (AAP) recommends that examination of the external genitalia should be included as part of the annual comprehensive physical examination of children and adolescents of all ages. However, most adolescents do not require a complete pelvic examination that involves internal pelvic examination utilizing a speculum or bimanual examination due to changes in recommendations for initiation of Papanicolaou (Pap) test. There are newer screening tests for sexually transmitted infection that can be performed on urine specimens and vaginal swabs as well. History of sexual activity in an asymptomatic patient is no longer an indication for a complete pelvic examination with a speculum. A complete pelvic examination also is no longer a prerequisite for prescribing hormonal contraception.

Indications for a complete pelvic examination for both adolescent and adult females include persistent vaginal discharge, dysuria or urinary tract symptoms in a sexually active female, dysmenorrhea unresponsive to nonsteroidal anti-inflammatory drugs, amenorrhea, abnormal vaginal bleeding, lower abdominal pain, contraceptive testing for an intrauterine device (IUD) or diaphragm, to perform a Papanicolaou test, suspected/reported rape or sexual abuse, and pregnancy.

Osteopathic Indications

In addition to a comprehensive medical education, osteopathic physicians have additional training in osteopathic manipulative medicine (OMM). As such, there are other indications for examination of the pelvis and other related areas which apply to OMM due to involvement of the musculoskeletal system.

Vertebral function, including cervical and cranial regions, the thoracoabdominal diaphragm, the urogenital diaphragm, the pelvis and sacrum, and the lower extremities, can all be affected by restriction of motion (somatic dysfunction) of the pelvic girdle. According to Foundations of
**Osteopathic Medicine**, “common complaints that require evaluation of the sacrum and pelvis include but are not limited to abdominal pain, pelvic pain, dysmenorrhea, lower back pain, urinary tract complaints, lower gastrointestinal issues, and neuralgia of the lower extremities.”

Other common diagnoses often addressed osteopathically include dyspareunia, infertility and stress incontinence.

Structural examination of the sacrum, coccyx, innominates including the pubic region, and related areas is a routine part of osteopathic care in these and many other clinical situations. After informing the patient of the intended exam, this is typically performed with the patient clothed. A chaperone is not required, but it may be appropriate for patient comfort due to the sensitive nature of the anatomy of the region. A parent, guardian or chaperone should be present for examination and treatment of minors.

**Documentation**
Appropriate documentation of the encounter supports the medical necessity of the procedure and aids in clarification if there are subsequent concerns regarding any potential misconduct. The subjective portion should indicate the patient’s reasons for the visit in adequate detail to support performance of the pelvic examination. The objective section should document the physician’s findings and should be sufficiently detailed to support the indication for any further internal or external manual treatment if performed. The assessment should be the physician’s diagnoses addressed at that encounter, and the plan should detail the physician’s treatment as well as other recommendations, including at which portions of the visit a chaperone was present.

**Conclusion**
Examination of the pelvis and related areas is important to routine care for both the adult and pediatric patient. External genital examination rather than a complete pelvic examination is recommended for the asymptomatic patient. In symptomatic patients, a complete pelvic examination may be warranted. All examination and treatment of these regions should be conducted in a manner that ensures patient safety and comfort. These recommendations conform to national guidelines.

**Explanatory Statement:**
Accept the American Academy of Osteopathy Position Paper: Recommended Guidelines for Examination and Treatment of the Pelvis and Related Areas in the following documents

**References**


8. Hungate JS. Position statement on internal physical therapy pelvic examinations and interventions: 
Section on women’s health, APTA [PDF]. http://www.womenshealthapta.org/wp-
content/uploads/2017/02/Approved-Position-Statement-on-Internal-Physical-Therapy-Pelvic-

Care Safer II: An Updated Critical Analysis of the Evidence for Patient Safety Practices. 

10. Bignell, CJ. Chaperone for genital examination: Provide comfort and support for the patient and 

11. Carusi DA. The gynecologic history and pelvic examination. UpToDate website. 

Reference Committee Explanatory Statement: 
Referred to AAO due to the potential unintended consequences of this overly prescriptive position 
paper.

ACTION TAKEN _REFERRED (to American Academy of Osteopathy)

DATE _July 22, 2017_
RES. NO. H-337 - A/2017 – Page 1

SUBJECT: TAKE BACK THE HOUSE

SUBMITTED BY: Minnesota Osteopathic Medical Society

REFERRED TO: Committee on Professional Affairs

1  WHEREAS, osteopathic physicians have historically fought for equal representation and equal voice, and

2  WHEREAS, The American Osteopathic Association’s (AOA) House of Delegates (House) is the representative body of the osteopathic profession, and

3  WHEREAS, the delegates meet as the House annually to establish and reaffirm AOA policies, and

4  WHEREAS, the delegates meet as the House to advise the AOA Board of Trustees (Board) and AOA administration on the direction the profession will follow, and

5  WHEREAS, to set such policies there must be resolutions, discussions, debates and votes to direct the Board and administration as to their efforts in leading the profession through the year, and

6  WHEREAS, the Speaker of the House’s job is to promote such orderly discussion, debate and voting, and

7  WHEREAS, individual delegates are elected or appointed to represent their state members and are expected to do so as individuals, and

8  WHEREAS, House elections are, as outlined in our constitution, to “be by ballot” and not by consensus, and

9  WHEREAS, voting by House delegates is no longer limited to 3 days in July but now due to electronic communications can be accomplished with short notice regarding any major issues; now, therefore, be it

10 RESOLVED, that the American Osteopathic Association (AOA) House of Delegates (HOD) will meet once yearly to debate resolutions and set policy for the future of the profession, and to elect a Board of Trustees (BOT), Speaker, and Vice Speaker who represent policies enacted by the House, placing all other activities as secondary to such debate and elections; and, be it further

11 RESOLVED, that the HOD be called together with 2 weeks’ notice to vote electronically on any major decisions regarding the future of the profession; and, be it further

12 RESOLVED, BOT, Speaker, and Vice Speaker election be by open nominations and ballot as outlined in the constitution; and, be it further
RESOLVED, the Speaker, and Vice Speaker be elected by the HOD based on their commitment to serving the AOA House of Delegates and promoting discussion, debate and free voting.

Reference Committee Explanatory Statement:
Referred to CAGOS, which has been charged by the Board of Trustees as part of the Strategic Plan Phase II to address governance, including Bureaus, Councils and Committees, Board of Trustees and the House of Delegates.

ACTION TAKEN  **REFERRED**  (to AOA Committee on AOA Governance and Organizational Structure)

DATE  **July 22, 2017**
WHEREAS, there a rising incidence of anaphylaxis (1); and
WHEREAS, there exists in epinephrine an effective short term medication that allows a patient
to get definitive help (4); and
WHEREAS, the current cost of the epinephrine auto-injectors is financially unaffordable for
many patients (2); and
WHEREAS, the cost of injectable epinephrine in single use aliquots is more affordable; and
WHEREAS, we trust and train people with failing eyesight, peripheral neuropathy, cardiac
failure, and other conditions to self-draw and administer other medications such as
insulin; and
WHEREAS, epinephrine has a wide margin of safety (3); and
WHEREAS, providing physicians with liability protection for providing a potentially life-saving
intervention at a lower cost will encourage adoption; now, therefore, be it
RESOLVED, that the American Osteopathic Association (AOA) advocate for statutory
protection of prescribing epinephrine for allergic and anaphylactic reactions when used
outside a medical setting regardless of the form of epinephrine used.

Explanatory Statement:

References

   Immunol 2014 Apr.
2. “EpiPen Price Increase Puts Some Patients At Risk”,
   http://www.webmd.com/allergies/news/20160817/epipen-price-increase
   Joseph P Wood, Stephen J Traub, Christopher Lipinski, Department of Emergency Medicine, Mayo
   Clinic Hospital, Phoenix, AZ 85054, US
   Int Arch Allergy Immunol 2013;162:193–204
Reference Committee Explanatory Statement:
The Committee believes that the issues addressed in House Resolution 338 have been combined in the amended House Resolution 333.

ACTION TAKEN DISAPPROVED

DATE July 22, 2017
WHEREAS, healthcare reimbursement continues to transition from volume-based fee-for-service procedural services to value-based care with a focus on financial incentives for improved clinical or economic outcomes and penalties for poor clinical outcomes or economic inefficiencies; and

WHEREAS, Medicare program represents the largest single purchaser of and payer for healthcare services in the United States and has served as a lead organization in this reimbursement transformation; and

WHEREAS, the transition to value-based purchasing in healthcare includes calculating incentive versus penalty by attributed patient population panels; and

WHEREAS, any use of population metrics for quality or other performance metrics require risk adjustment of those populations attributed to various healthcare providers; and

WHEREAS, low socioeconomic status, minority or ethnic background, gender discrimination, successful independent living, and educational levels within medically underserved communities, such as populations residing in metropolitan inner cities or in rural communities, represent attributes requiring statistical risk adjustment for valid application to clinical quality and economic outcome metrics for providers serving these disadvantaged populations; and

WHEREAS, physicians in these medically underserved communities with reduced access to healthcare have a disproportionate number of uninsured and Medicaid beneficiaries when compared to private healthcare benefit insurers adding to a significant funding deficit based on the absence of commercial insurers; and

WHEREAS, current Medicare value based purchasing generally does not account for social risk factors and disadvantaged providers participating in plans that serve greater numbers of patients with social risk factors; and

WHEREAS, these disadvantages may potentially lead some providers to avoid socially at-risk populations, subsequently reducing their access to care, lowering their quality of care and producing as unintended consequences widening health disparities; and

WHEREAS, access to timely, appropriate, effective, and efficient primary care and preventive services is recognized as a cost-effective critical element in achieving and maintaining desired clinical outcomes for at risk patient populations; now, therefore, be it
RESOLVED, that the American Osteopathic Association (AOA) actively supports federal legislation, rules or regulations to include socioeconomic risk stratification in public reporting and evaluation of healthcare provider reimbursement in all Medicare AND MEDICAID pay for performance value-based purchasing incentives or penalties to account for the challenges serving socioeconomically or medically underserved disadvantaged patient populations to ensure continued timely access to appropriate clinical services; and, be it further

RESOLVED, that AOA supports federal legislation, rules or regulations to improve Medicare AND MEDICAID reimbursements to physicians working in socioeconomic, disadvantaged medically underserved areas to ensure an adequate workforce to address the burden of care associated with complex comorbid conditions in these areas.

ACTION TAKEN _APPROVED as AMENDED_

DATE _July 22, 2017_
WHEREAS, the United States is unprecedented in deaths from opioid overdoses resulting in a public health crisis (2); and

WHEREAS, opioids have an effective reversal which is naloxone; and

WHEREAS, naloxone has no adverse effects if administered to a person not on opioids; and

WHEREAS, the cost of Naloxone is predominantly in the format of an auto-injectors; and

WHEREAS, Persons with poor eyesight, neuropathy, renal failure, etc. are trusted to possess, self-draw and self-administer a much more dangerous drug, such as insulin; and

WHEREAS, naloxone can be dispensed in unit-of-use aliquots; and

WHEREAS, physicians are reluctant to prescribe Naloxone as a self-drawn medicine; and

WHEREAS, Good Samaritan laws may not protect the physician in certain situations; and

WHEREAS, a public health crisis permits altered standards; now, therefore, be it

RESOLVED, that the American Osteopathic Association work with legislators to give statutory protection in evaluation for and prescribing PRESCRIPTION of Naloxone regardless of route of administration (1).

Explanatory Statement

References

1. H429-A/13 “OPIOID OVERDOSE” DEATHS IN AMERICA, EPIDEMIC The American Osteopathic Association recommends systematic evaluation of all available interventions to prevent opioid overdose deaths including patient education and the normalization of take home Naloxone. 2013 Page 113 AOA Policy Compendium 2017


ACTION TAKEN  APPROVED as AMENDED

DATE  July 22, 2017
RESOLVED, that the American Osteopathic Association (AOA) endorse the attached “Shared Principles of Primary Care” as developed and published by the Patient-Centered Primary Care Collaborative (PCPCC).

ACTION TAKEN  APPROVED

DATE  July 22, 2017
Shared Principles of Primary Care

Primary care is widely acknowledged to be essential for better health and wellbeing in the US health care system and should be foundational to all health care systems worldwide (WHO, 2008) (IOM, 1994) (Starfield, 1992). Access to high quality primary care can help people live longer, feel better, and avoid disability (Commonwealth Fund, 2013).

Primary care has experienced significant changes in the way it is organized, financed and delivered in response to greater demand for high quality services, rising health care costs, and increasing burden of disease across populations (Bitton et al 2016). Concepts such as the Patient Centered Medical Home emerged to describe a more advanced model of primary care. Based on lessons learned over the past decade and the continued rapid pace of change, the time is right to revisit the future of primary care.

Realizing the ideal vision of primary care occurs faster when all stakeholders can speak with one voice. These Shared Principles—developed by stakeholders representing all aspects of health care—are designed to move the United States toward a vibrant future of person-centered, team-based, community aligned primary care that will help achieve the goals of better health, better care, and lower costs. Achieving this future requires a common vision as well as appropriate payment, investment, training, workforce and other resources to support it.

1. Person & Family Centered.
   o Primary care is focused on the whole person - their physical, emotional, psychological and spiritual wellbeing, as well as cultural, linguistic and social needs.
   o Primary care is grounded in mutually beneficial partnerships among clinicians, staff, individuals and their families, as equal members of the care team. Care delivery is customized based on individual and family strengths, preferences, values, goals and experiences using strategies such as care planning and shared decision making.
   o Individuals are supported in determining how their family or other care partners may be involved in decision making and care.
   o There are opportunities for individuals and their families to shape the design, operation and evaluation of care delivery.

2. Continuous.
   o Dynamic, trusted, respectful and enduring relationships between individuals, families and their clinical team members are hallmarks of primary care. There is continuity in relationships and in knowledge of the individual and their family/care partners that provides perspective and context throughout all stages of life including end of life care.

3. Comprehensive and Equitable.
   o Primary care addresses the whole-person with appropriate clinical and supportive services that include acute, chronic and preventive care, behavioral and mental health, oral health, health promotion and more. Each primary care practice will decide how to provide these services in their clinics and/or in collaboration with other clinicians outside the clinic.
   o Primary care providers seek out the impact of social determinants of health and societal inequities. Care delivery is tailored accordingly.
4. **Team-Based and Collaborative.**
   - Interdisciplinary teams, including individuals and families, work collaboratively and dynamically toward a common goal. The services they provide and the coordinated manner in which they work together are synergistic to better health.
   - Health care professional members of the team are trained to work together at the top of their skill set, according to clearly defined roles and responsibilities. They are also trained in leadership skills, as well as how to partner with individuals and families, based on their priorities and needs.

5. **Coordinated and Integrated.**
   - Primary care integrates the activities of those involved in an individual’s care, across settings and services.
   - Primary care proactively communicates across the spectrum of care and collaborators, including individuals and their families/care partners.
   - Primary care helps individuals and families/care partners navigate the guidance and recommendations they receive from other clinicians and professionals, including supporting and respecting those who want to facilitate their own care coordination.
   - Primary care is actively engaged in transitions of care to achieve better health and seamless care delivery across the life span.

6. **Accessible.**
   - Primary care is readily accessible, both in person and virtually for all individuals regardless of linguistic, literacy, socioeconomic, cognitive or physical barriers. As the first source of care, clinicians and staff are available and responsive when, where and how individuals and families need them.
   - Primary care facilitates access to the broader health care system, acting as a gateway to high-value care and community resources.
   - Primary care provides individuals with easy, routine access to their health information.

7. **High-Value.**
   - Primary care achieves excellent, equitable outcomes for individuals and families, including using health care resources wisely and considering costs to patients, payers and the system.
   - Primary care practices employ a systematic approach to measuring, reporting and improving population health, quality, safety and health equity, including partnering with individuals, families and community groups.
   - Primary care practices deliver exceptionally positive experiences for individuals, families, staff and clinicians.

The vision outlined in these Shared Principles of Primary Care will result in excellent outcomes for individuals and families, and more satisfying and sustainable careers for clinicians and staff. It is a vision that is aspirational yet achievable when stakeholders work together.

The following organizations are committed to the implementation of these Shared Principles:
Signers (in alphabetical order):
Family Medicine for America’s Health
Patient-Centered Primary Care Collaborative

Works Cited


WHEREAS, the 2016 House of Delegates approved a resolution from the Michigan Osteopathic Association (MOA) regarding physician wellness, burnout prevention and mental health (H339-A/16); and

WHEREAS, the 2016 House of Delegates approved a resolution from the Student Osteopathic Medical Association (SOMA) on the creation of a mental health task force (H334-A/16) to address physician wellness; and

WHEREAS, the AOA Task Force on Physician Wellness was created and charged with the development of a series of programs to assist physicians in early identification and management of stress, recognition of impaired physicians, overcoming physician burnout and recognizing risk factors among colleagues; and

WHEREAS, the Task Force on Physician Wellness has held numerous meetings to develop strategies that address the physical, emotional and psychological aspects of responding to and handling stress in physicians’ professional and personal lives, and how/when to seek professional assistance for stress-related difficulties; now, therefore be it

RESOLVED, that the House of Delegates adopt the attached Final Report of the Task Force on Physician Wellness on the Overall AOA Physician Wellness Strategy.

Explanatory Statement:
See attached Final Report entitled “Overall AOA Physician Wellness Strategy.”

FISCAL IMPACT:
The AOA budget for FY2018 includes funding to support the Physician Wellness Strategy.

ACTION TAKEN  APPROVED

DATE  July 22, 2017
WHEREAS, “Right to Try” legislation permits a terminally ill patient to access an investigational treatment that has not received approval by the United States Food and Drug Administration (FDA); and

WHEREAS, “Right to Try” legislation has been passed in Missouri and is being discussed or has passed in most others, but federal laws and regulations may still prevent patient access to the investigational treatments; and

WHEREAS, terminally ill patients who have exhausted existing treatment options currently can join a clinical trial to access experimental treatments, the criteria for acceptance into these trials is often very rigorous; and

WHEREAS, terminally ill patients can apply for the FDA’s “compassionate use” exception, this is often a slow process not conducive to someone with a terminal illness; and

WHEREAS, producers of experimental drugs may be hesitant to offer drugs outside of clinical trials because they fear reporting negative and adverse effects could negatively impact future FDA approval of the drug; now, therefore be it

RESOLVED, the American Osteopathic Association (AOA) supports the ability of terminally ill patients to access investigational treatments that have passed Phase 1 clinical trials of the Food and Drug Administration approval process for their disease if the patient has exhausted approved treatments and gives informed consent; and, be it further

RESOLVED, that since such experimental therapies in terminally ill patients are highly unlikely to fundamentally alter the course of their disease, physicians and drug manufacturers should be protected from legal action by patients who choose to try an investigative treatment but experience adverse effects or no noticeable improvements in their condition; and, be it further

RESOLVED, physicians be protected from legal liability for not informing patients of potential experimental therapies as experimental/investigational therapies have not yet been accepted as meeting the appropriate standard of care; and, be it further

RESOLVED, that the American Osteopathic Association (AOA) support “Right to Try” legislation at the federal level that protects the patient, physician and drug manufacturer; and, be it further
RESOLVED, that the AOA work with the United States Food and Drug Administration to simplify and expedite the application and approval process of terminally ill patients seeking a compassionate use exception for investigational treatments.

ACTION TAKEN **REFERRED** *(to MAOPS - Missouri)*

DATE **July 22, 2017**
WHEREAS, the delivery of healthcare in modern America is becoming increasingly reliant upon electronic health records at various different levels and locations in the process; and

WHEREAS, the utilization of such a milieu of electronic destinations places health information in a potentially vulnerable position when it comes to insuring its safety and security; and

WHEREAS, the many cybersecurity threats now in existence which include ransomware (1, 2), which exploit human and technical weaknesses to gain access to an organization’s infrastructure in order to deny the organization access to its own data by encrypting that data, releasing it from encryption only after significant payment is made (i.e., "ransom"); and

WHEREAS, private offices, hospital institutions, and their associated businesses (such as, but not limited to, billing services) have found themselves victimized by this process, jeopardizing the welfare of their patients (as well as the solvency of their businesses) (3,4); and

WHEREAS, the apprehension of the criminals—sometimes outside of the United States—perpetrating these actions against the American health care system is fraught with difficulty while patient safety lies in the balance in a race against time; and

WHEREAS, protecting each element of the health information process from such attack would incur significant expenditures of a facility’s labor and capital; now, therefore be it

RESOLVED, that the American Osteopathic Association partner with the Office of the National Coordinator for Health IT (ONC-Health IT) in bringing its members greater awareness regarding available tools and methods to better safeguard against cybersecurity and ransomware threats, such as the Safety Assurance Factors for EHR Resilience (SAFER) Guides (5), as well as encouraging promotion and support for a Health IT Safety Center (6).

Explanatory Statement:

References
1) HHS FACT SHEET: Ransomware and HIPAA
   http://www.hhs.gov/sites/default/files/RansomwareFactSheet.pdf
2) HHS Letter to AHA Chief Information Officers
   http://www.aha.org/content/16/160620cybersecransomware.pdf
3) example of office data breach https://www.professionaldermatologycare.com/data-breach-information.html
4) example of billing service data breach

5) HHS makes progress on Health IT Safety Plan with release of the SAFER Guides

6) Health IT Safety Center Roadmap http://www.healthitsafety.org/

   ACTION TAKEN  APPROVED
   DATE  July 22, 2017
WHEREAS, the House of Delegates referred H-347-A/2016 PROTECTION OF LICENSURE FOR OSTEOPATHIC MEDICAL STUDENTS, RESIDENTS AND PRACTICING PHYSICIANS SUFFERING FROM DEPRESSION to the Bureau of State Government Affairs (BSGA) for further clarification of the intent of the resolution.

WHEREAS, BSGA has reviewed resolution H-347-A/2016 and recommends that the resolution should help the licensure applicant not discriminate against; therefore be it RESOLVED, that the House of Delegates refer the resolution back to Iowa Osteopathic Association for rewrite and refinement.

Explanatory Statement:
Original resolution attached

Reference Committee Explanatory Statement:
The AOA Physician Wellness Strategy’s Challenges to Wellness section recognizes this issue. It will be addressed by the Physician Wellness Task Force.

ACTION TAKEN  REFERRED (to AOA Physician Wellness Task Force)

DATE  July 22, 2017
WHEREAS, physician suicide is at an alarming level when compared to the general population, and
WHEREAS, medical student and resident suicides and suicidal ideation far exceed the general population, and
WHEREAS, there is a reluctance of self-reporting of severe depression or suicidal ideation, and
WHEREAS, there is also a reluctance or indifference of fellow physicians or students reporting those colleagues that they believe to be at risk for depression and suicidal ideation, and
WHEREAS, some of this reluctance is based on the reality that they may suffer a loss of professional esteem among colleagues, be subject to undo scrutiny by employers and suffer adverse financial and career punishments for admitting they have a problem and need help, and
WHEREAS, the medical community should have the same compassion and advocacy for its members that it has for their patients; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA), in partnership with all interested parties, including the Federation of State Medical Boards, take the necessary steps to ensure the current and future practice rights and licensure of osteopathic physicians, residents and students who suffer depression requiring treatment or who have suicidal ideation or attempts; and, be it further

RESOLVED, that steps be taken to insure that participation by an osteopathic physician in acts contributing to discrimination of individuals who self report their depression or suicidal ideation, is considered unethical and grounds for discipline by the American Osteopathic Association.

Reference Committee Explanatory Statement:
The Committee believes the further clarification of the intent of the resolution by the authors is needed. The AOA does not have jurisdiction over state licensing boards. In addition, physicians have an ethical obligation to protect the public by reporting impaired physicians.

ACTION TAKEN  REFERRED (to AOA Bureau of State Government Affairs)

DATE  July 23, 2016
WHEREAS, a “new physician in practice” is not defined in the AOA Constitution and Bylaws; and,

WHEREAS, there are conflicting descriptions of a “new physician in practice” referenced in the AOA Constitution, Article VIII, Section C.; and

WHEREAS, the need for osteopathic leadership among new physicians in practice is reflected by the growth of the profession and the increasing numbers of new physicians in practice, while also investing in leadership development for DOs who will one day lead the osteopathic medical profession; now, therefore be it

RESOLVED, that the AOA define a new physician in practice as a “physician is no more than 5 years past the completion of postdoctoral training”.

Explanatory Statement:
There is no absolute definition of a New Physician in Practice; however, there are two references to New Physician in Practice contained in the AOA Constitution. Article VIII, Section C. states, “…an osteopathic physician who has completed his/her postdoctoral training within the last five years or graduated from a college of osteopathic medicine approved by the Commission on Osteopathic College Accreditation within the last 10 years…”

It should be noted that the resolution definition is intended to be inclusive of post graduate osteopathic physicians in fellowships.

FISCAL IMPACT:
None

ACTION TAKEN  APPROVED

DATE  July 22, 2017
American Osteopathic Association

House of Delegates

Committee on Public Affairs

Lawrence Prokop, DO, Chair
George D. Vermeire, DO, Vice-Chair

July 21, 2017

CONSENT AGENDA – FOR COLLECTIVE ACTION BY THE HOUSE OF DELEGATES

Mr. Speaker, I present the following Consent Agenda, and the Committee recommends that it be APPROVED:

H-341 TASK FORCE TO STUDY PHYSICIAN AID IN DYING
H-346 PHYSICIAN ASSISTED DEATH (H441-A/12)
H-400 DRUGS – PRESCRIPTION DISCOUNTS-SENIORS (H314-A/12)
H-401 SINGLE USE DEVICE (SUD) – PROCESSED (H432-A/12)
H-402 IMPROVEMENT OF THE AMERICAN HEALTH CARE SYSTEM (H320-A/12)
H-403 ABUSED PERSONS (H414-A/12)
H-404 CHILDREN ON AIRPLANES – RESTRAINTS (H419-A/12)
H-406 PUBLIC HEALTH SERVICE – AOA SUPPORT (H424-A/12)
H-407 REPRODUCTIVE ISSUES – COUNSELING FEMALE PATIENTS ON (H425-A/12)
H-408 BREAST CANCER PREVENTION, DETECTION, DIAGNOSIS AND TREATMENT – ACCESSIBILITY (H428-A/12)
H-411 HOSPICE CARE PROGRAMS – AOA SUPPORT FOR (H435-A/12)
H-412 GENETIC TESTING (H437-A/12)
H-414 OBESITY – TREATMENT OF (H440-A/12)
H-416 WOMEN’S CONTRACEPTIVE COVERAGE LEGISLATION (H234-A/09)
H-417 FLAME-RETARDANT CLOTHING FOR CHILDREN – SLEEPING OR LOUNGING (H315-A/12)
H-418 AUTOMATED EXTERNAL DEFIBRILLATOR (AED) TO TREAT COMMOTIO CORDIS – PROMOTION FOR THE REQUIREMENT OF ALL SPORTING EVENTS TO HAVE ACCESS TO AN (H401-A/12)

H-421 NARCO-TERROIRSM (H406-A/12)

H-422 PROSTATE CANCER – PSA-BASED SCREENING FOR (H407-A/12)

H-423 FOOD ALLERGIES AND MANDATES ON SCHOOL LUNCHES (H409-A/12)

H-424 MEDICAL CARE DURING MEDICAL MISSIONS – PROVIDING (H410-A/12)

H-425 ANTIMICROBIAL – JUDICIOUS USE OF (H415-A/12)

H-426 ANTI-BULLYING LAW (H416-A/12)

H-427 BREASTFEEDING – FRIENDLY WORKPLACE (H417-A/12)

H-429 EMERGENCY MEDICAL IDENTIFICATION – PROTOCOL AND GUIDELINES (H420-A/12)

H-430 ORGAN DONATION – OPPOSITION TO FINANCIAL INCENTIVES FOR ORGAN DONORS (H422-A/12)

H-431 ORGAN DONOR IDENTIFICATION (H423-A/12)

H-432 VIOLENCE IN THE ENTERTAINMENT MEDIA (H427-A/12)

H-433 STEM CELL RESEARCH (H430-A/12)

H-434 HUMAN PAPILLOMAVIRUS VACCINATION – EDUCATION ON (H434-A/12)

H-435 PHYSICAL EDUCATION FOR GRADES K-12 – DAILY (H436-A/12)

H-436 SMOKING – USE TOBACCO PRODUCTS (H442-A/12)

H-437 OVERWEIGHT AND OBESITY – RECOGNITION AS BILLABLE DIAGNOSES (H623-A/12)

H-438 END OF LIFE CARE

H-440 HEALTH INSURANCE COVERAGE FOR RESIDENTIAL TREATMENT AND INPATIENT TREATMENT OF EATING DISORDERS

H-441 RESPONSE TO H-400-A/16 VIOLENCE AND ABUSE PREVENTION AND EDUCATION
H-442 RECREATIONAL MARIJUANA USE BY PHYSICIANS, STUDENTS, AND PATIENTS (RESPONSE TO RES. NO. H-436 – A/2016)

H-444 MEDICATION FOR INDIGENT PATIENTS (H405-A/11)

And I so move. APPROVED

H-409 PRENATAL AND PEDIATRIC HOSPICE AND PALLIATIVE CARE – SUPPORT FOR (H429-A/12)

Mr. Speaker, I present the Resolution No. H-409, and the Committee recommends that it be APPROVED as AMENDED:

Line 9 POTENTIALLY LIKELY…..

And I so move. APPROVED as AMENDED

H-413 DRINKING/DRIVING (H438-A/12)

Mr. Speaker, I present the Resolution No. H-413, and the Committee recommends that it be APPROVED as AMENDMENT:

Line 3: H438-A/12 DRINKING/ SUBSTANCE IMPAIRED AND DISTRACTED DRIVING (H438-A/12)

Line 5: …SUBSTANCE IMPAIRED AND DISTRACTED drinking/IMPAIRED….

And I so move. APPROVED as AMENDED

H-439 POWDERED CAFFEINE

Mr. Speaker, I present the Resolution No. H-413, and the Committee recommends that it be APPROVED as AMENDED

Line 19 ……PURE CONCENTRATED powdered …

And I so move. APPROVED as AMENDED


Mr. Speaker, I present the Resolution No. H-413, and the Committee recommends that it be APPROVED.

And I so move. APPROVED
H-211 END-OF-LIFE CARE FOR CHILDREN (H218-A/12)

Mr. Speaker, I present for consideration Resolution No. H-211 and the Committee recommends that it be APPROVED with the following AMENDMENT:

Line 1-2 RESOLVED, that the Bureau of Osteopathic Education recommend that the following policy be REAFFIRMED as AMENDED SUNSET:

Explanatory Statement: This content is contained in H-438.

And I so move. APPROVED (for sunset)

H-405 ENVIRONMENTAL TOXINS AND OUR CHILDREN’S HEALTH (H421-A/12)

Mr. Speaker, I present for consideration Resolution No. H-405 and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Line 1-2 RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED SUNSET:

Explanatory Statement: These guidelines already exist.

And I so move. APPROVED (for sunset)

H-410 END OF LIFE CARE – CULTURAL SENSITIVITY (H431-A/12)

Mr. Speaker, I present for consideration Resolution No. H-410 and the Committee recommends that it be APPROVED with the following AMENDMENT:

Line 1-2 RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that the following policy be REAFFIRMED SUNSET:

Explanatory Statement: This content is contained in H-438.

And I so move. APPROVED (for sunset)

H-419 MENINGOCOCCAL VACCINE (MCV4) BOOSTER – RECOMMENDATION FOR UNIVERSAL ADOLESCENT (H404-A/12)

Mr. Speaker, I present for consideration Resolution No. H-419 and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Line 1-2 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED AS AMENDED:

Line 3-7 H404-A/12 MENINGOCOCCAL VACCINES (MCV4) BOOSTER – RECOMMENDATIONS FOR UNIVERSAL ADOLESCENT
The American Osteopathic Association supports the administration of a booster dose of the meningococcal vaccine S (MCV4) at 16 years of age for those adolescents that receive an initial MCV4 dose at 11—12 years of age, as recommended by the Centers for Disease Control and Prevention’s (CDC) Advisory Committee on Immunization Practices (ACIP); and urges adequate public and private insurance coverage for vaccines in patient populations as recommended by the ACIP.

Explanatory Statement: These amendments ensure that the resolution remains consistent with rapidly changing vaccination guidelines as established by the ACIP.

And I so move, APPROVED

H-420 MENINGOCOCCAL VACCINE (MCV4) PRIMARY SERIES IN PATIENTS WITH SICKLE CELL ANEMIA (H405-A/12)

Mr. Speaker, I present for consideration Resolution No. H-420 and the Committee recommends that it be APPROVED with the following AMENDMENT:

Line 1-2 RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED SUNSET:

Explanatory Statement: This resolution is combined with H-419.

And I so move, APPROVED (for sunset)

H-428 BREASTFEEDING-PROMOTION – PROTECTION AND SUPPORT OF (H418-A/12)

Mr. Speaker, I present for consideration Resolution No. H-428 and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Line 5-9 The American Osteopathic Association urges its membership to take a role in the protection, promotion and support of breastfeeding AND IN PROVIDING TO ENCOURAGE THE PROVISION OF BREASTFEEDING FRIENDLY ENVIRONMENTS IN THEIR PLACES OF STUDY AND WORK, INCLUDING BUT NOT LIMITED TO COLLEGES, HOSPITALS, AND OFFICES OTHER HEALTHCARE FACILITIES.

And I so move, APPROVED
Mr. Speaker, this concludes the Committee’s report. I would like to thank the members of the Committee.

Committee Members:
1. Lawrence Prokop, DO – **CHAIR**  
   Michigan
2. George D. Vermeire, DO – **VICE CHAIR**  
   Pennsylvania
3. Gregory Allen, DO  
   Rhode Island
4. Stephen Bell, DO  
   Michigan
5. Teresa Brennan, DO  
   Military
6. Cleanne Cass, DO  
   Ohio
7. Jone Geimer-Flanders, DO  
   Hawaii
8. Dianna Glessner, DO  
   Georgia
9. Melanie Jessen, DO  
   Illinois
10. Tony Kahn, DO  
    California
11. John Lynch, DO  
    Maryland
12. Sonia Rivera-Martinez, DO  
    New York
13. Julieanne Sees, DO  
    Delaware
14. Adam Smith, DO  
    Texas

**STAFF**
Gloria Dillard
Stephanie Townsell
RESOLVED, that the Bureau of Osteopathic Education recommend that the following policy be REAFFIRMED as AMENDED SUNSET:

H218-A/12 END-OF-LIFE CARE FOR CHILDREN
The American Osteopathic Association CONTINUES TO support the development, distribution and implementation of comprehensive curricula to train medical students, interns, residents and physicians in end-of-life issues relating to children and their families; and the AOA will also be available as a resource to other organizations. 2002; revised and reaffirmed 2007; reaffirmed as amended 2012

Reference Committee Explanatory Statement:
This policy is contained in H-438

ACTION TAKEN APPROVED as AMENDED (for sunset)

DATE July 22, 2017
WHEREAS, the definition of physician-aid-in-dying refers to a process by which a physician can prescribe and a patient can self-administer, a life-ending medication provided that specific requirements are met; and

WHEREAS, physician-aid-in-dying is distinct from euthanasia, where medications are administered by a physician in order to end life; and

WHEREAS, five states currently authorize physician aid in dying, through a ballot referendum (Oregon; Washington, Vermont, Montana, and New Mexico); and

WHEREAS, 25 additional states and the District of Columbia are considering addressing aid in dying; and

WHEREAS, legislation in the states authorizing physician-aid-in-dying prescribe the requirements for physician-aid-in-dying have based their laws on the Death With Dignity Act adopted in Oregon in 1997 that include that (1) patients must be terminally ill, which by definition means their physician opines natural death will occur within six months or less, be able to administer the medicine themselves, have the mental capacity to be aware of their actions and the subsequent consequences, document two verbal requests, 15 days apart, and one written request with two witnesses; and (2) two physicians—one a currently attending physician and another a consulting physician—must verify that the patient meets all the criteria; and

WHEREAS, while that process took shape in Oregon two decades ago, the cultural and political context surrounding it has changed considerably; now, therefore be it,

RESOLVED, that the American Osteopathic Association (AOA) Department of Professional Affairs examine AOA ethical policy concerning physician aid-in-dying including a review relevant literature, data current state laws, and deliberate whether current AOA ethical policy should be reaffirmed or amended, and report the results of its deliberations to the 2018 AOA HOD.

Explanatory Statement
Reference

ACTION TAKEN APPROVED

DATE July 22, 2017
RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that
the following policy be REAFFIRMED:

H441-A/12  PHYSICIAN ASSISTED DEATH

The American Osteopathic Association: (1) will provide information on the care of the
seriously ill to physicians and the public; (2) will provide osteopathic physicians with continuing
medical education on palliative therapies utilized to provide patients with an improved quality
of life; (3) recommends that osteopathic medical colleges and osteopathic post-graduate medical
education programs include specific courses of study on pain management and palliative care of
the seriously ill, specifically addressing the goals, objectives and value of hospice and palliative
medicine; (4) urges that continuing medical education programs include information and
resources for physicians on supportive care valuable to their patients, including, but not limited
to hospice and palliative care; (5) urges that the osteopathic profession take a leadership role in
providing the public with information on the alternatives to physician assisted death; (6)
recognizes that physician assisted death (“death with dignity”) is a complex biomedical and
ethical issue that merits serious discussion within our profession; and (7) opposes legislation
that mandates or legalizes individual physician participation in physician assisted death. 1997;
reaffirmed 2002; 2007; reaffirmed as amended 2012

ACTION TAKEN  APPROVED (for reaffirmation)

DATE  July 22, 2017
RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED as AMENDED:

**H314-A/12 DRUGS – PRESCRIPTION DISCOUNTS-SENIORS**

The American Osteopathic Association encourages pharmaceutical companies to continue to provide prescription medicines at reduced or no cost to low-income, uninsured, and underinsured patients through their patient assistance programs. 2002, revised 2007; reaffirmed as amended 2012

ACTION TAKEN _APPROVED (as amended)_

DATE _July 22, 2017_
RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that the following policy be SUNSET:

H432-A/12 SINGLE USE DEVICE (SUD) – PROCESSED

The American Osteopathic Association recommends that more studies are needed to investigate the safety of reprocessed single use devices (SUDs) and that physicians be given the option of using the original device from the original equipment manufacturer. 2007; reaffirmed 2012

Explanatory Statement:
The Food and Drug Administration (FDA) has established regulatory requirements on reprocessed single-use devices that are published in the Federal Register. Physicians should follow these rules and regulations.

ACTION TAKEN _APPROVED (for sunset)_

DATE _July 22, 2017_
RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be SUNSET:

H320-A/12 IMPROVEMENT OF THE AMERICAN HEALTH CARE SYSTEM

The American Osteopathic Association, as a physician led effort, will continue to collaborate with other health care associations to improve in developing a health care plan focusing on the medical needs of patients. 2007; reaffirmed as amended 2012

Explanatory Statement:
Concept incorporated into various policies including H633-A/16 HEALTH INSURANCE EXCHANGES; H643-A/16 HEALTH INSURER CONSOLIDATION; and H223-A/08 HEALTH CARE THAT WORKS FOR ALL AMERICANS.

ACTION TAKEN _APPROVED (for sunset)_

DATE _July 22, 2017_
RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be SUNSET:

H414-A/12 ABUSED PERSONS

The American Osteopathic Association continues to encourage its membership to participate in programs designed for the treatment of the abused and the rehabilitation of the abuser and will continue to encourage public health agencies to provide special training in: advocacy for abused persons; effective assessment and intervention techniques to assist those in abuse situations; legal procedures; special needs of young and elderly, building links with local shelters, and related community resources. 1982; revised 1987; reaffirmed 1992, 1997; revised 2002; reaffirmed 2007; 2012 [Editor’s note: This policy has been referred to develop a single comprehensive policy on violence and abuse – 2016]

Explanatory Statement:
Language from this policy has been combined into one policy in the RESPONSE TO RESOLUTION H400-A/16 resolution submitted by the Bureau of Scientific Affairs and Public Health.

ACTION TAKEN _APPROVED (for sunset)_

DATE _July 22, 2017_
RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be SUNSET:

H419-A/12 CHILDREN ON AIRPLANES – RESTRAINTS

The American Osteopathic Association encourages the Federal Aviation Administration to develop guidelines on infant and child safety for air travel. 2002; amended and reaffirmed 2007; 2012

Explanatory Statement:
These guidelines already exist.

ACTION TAKEN  APPROVED (for sunset)

DATE  July 22, 2017
SUBJECT: H421-A/12 ENVIRONMENTAL TOXINS AND OUR CHILDREN’S HEALTH

SUBMITTED BY: Bureau of State Government Affairs

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED:

H421-A/12 ENVIRONMENTAL TOXINS AND OUR CHILDREN’S HEALTH

The American Osteopathic Association encourages the Federal Aviation Administration to develop guidelines on infant and child safety for air travel. 2002; amended and reaffirmed 2007; 2012

Explanatory Statement:
These guidelines already exist.

ACTION TAKEN APPROVED as AMENDED (for sunset)

DATE July 22, 2017
RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED:

H424-A/12  PUBLIC HEALTH SERVICE – AOA SUPPORT


ACTION TAKEN  APPROVED (for reaffirmation)

DATE  July 22, 2017
RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED:

H425-A/12 REPRODUCTIVE ISSUES – COUNSELING FEMALE PATIENTS ON

The American Osteopathic Association will take whatever actions are necessary to ensure that osteopathic physicians can continue to offer their patients complete, objective, informed advice in a confidential, culturally sensitive manner on all aspects of reproductive issues. 1992; reaffirmed 1997; revised 2002; 2007; reaffirmed as amended 2012

ACTION TAKEN  APPROVED (for reaffirmation)

DATE  July 22, 2017
SUBJECT: H428-A/12  BREAST CANCER PREVENTION, DETECTION, DIAGNOSIS AND TREATMENT – ACCESSIBILITY

SUBMITTED BY: Bureau of Osteopathic Clinical Education and Research

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that the following policy be REAFFIRMED:

H428-A/12  BREAST CANCER PREVENTION, DETECTION, DIAGNOSIS AND TREATMENT – ACCESSIBILITY

The American Osteopathic Association supports development and application of the latest advances in breast cancer prevention, detection, diagnosis and treatment, with dissemination as rapidly as possible to the medical community and the public it serves; and urges adoption of measures and programs to improve access to breast cancer screening for all appropriate patient populations. 2007; reaffirmed as amended 2012

ACTION TAKEN  APPROVED (for reaffirmation)

DATE  July 22, 2017
RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that
the following policy be REAFFIRMED as AMENDED:

H429-A/12  PRENATAL AND PEDIATRIC HOSPICE AND PALLIATIVE CARE – SUPPORT FOR

The American Osteopathic Association endorses the practice of hospice and palliative medicine
in prenatal and pediatric patient populations; urges that osteopathic physicians providing
prenatal care or consultation be knowledgeable about the existence and availability of prenatal
hospice and palliative care, and offer it as an option to parents of a baby with a
POTENTIALLY LIKELY fatal fetal anomaly; and supports organizations dedicated to the
promotion, education and provision of prenatal and pediatric hospice and palliative care. 2007;
reaffirmed 2012

ACTION TAKEN  **APPROVED** as AMENDED

DATE  **July 22, 2017**
RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that the following policy be REAFFIRMED SUNSET:

H431-A/12 END OF LIFE CARE – CULTURAL SENSITIVITY

The American Osteopathic Association (AOA) urges that osteopathic physicians recognize the importance of cultural diversity in perspectives on death, suffering, bereavement and rituals at the end of life, and incorporate cultural assessment into their comprehensive evaluation of the patient and family; the AOA will work to identify sources of culturally appropriate information on advance directives, palliative care, and end of life ethical issues in populations served by osteopathic physicians. 2007; reaffirmed 2012

Reference Committee Explanatory Statement:
These guidelines already exist.

ACTION TAKEN  APPROVED as AMENDED (for sunset)

DATE  July 22, 2017
RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that the following policy be REAFFIRMED as AMENDED:

H435-A/12 HOSPICE CARE PROGRAMS – AOA SUPPORT FOR

The American Osteopathic Association (1) continues to encourage its membership to educate themselves and their patients regarding the availability and benefits of hospice care programs, in concurrence with traditional medical and palliative care; (2) encourages its membership to advocate for participation in and/or utilization of hospice care programs; and (3) urges adoption of measures and programs to improve access to hospice care for all patient populations, including hospice and palliative care services as a benefit under ALL PAYORS. Medicare / Medicaid and health industry policies. 2007; reaffirmed as amended 2012

Explanatory Statement:
The Bureau felt the original was not inclusive and wanted to make sure all payors were represented.

ACTION TAKEN: APPROVED (as amended)

DATE: July 22, 2017
RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED:

**H437-A/12 GENETIC TESTING**

The American Osteopathic Association supports the public interest in prohibiting discrimination in employment, insurance coverage, and access to care on the basis of genetic information. 1997; revised 2002; 2007; reaffirmed 2012

ACTION TAKEN _APPROVED (for reaffirmation)_

DATE _July 22, 2017_
RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED as AMENDED:

H438-A/12 DRINKING/DRIVING

The American Osteopathic Association pledges its support to law enforcement agencies in their efforts to enforce SUBSTANCE IMPAIRED AND DISTRACTED drinking/IMPAIRED driving statutes; encourages agencies in government and in the private sector to promote greater public awareness of the problem; and encourages its members, through discussions with their patients and their communities, to actively assist in the effort by making the problem and its prevention more visible to the public. 1974; revised 1978; reaffirmed 1983; revised 1986, 1991, 1992, 1997; revised 2002; reaffirmed 2007; 2012

Explanatory Statement:

ACTION TAKEN APPROVED as AMENDED

DATE July 22, 2017
RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that
the following policy be REAFFIRMED:

H440-A/12 OBESITY – TREATMENT OF

The American Osteopathic Association recognizes obesity as a disease, and that obesity
treatment and prevention requires a chronic care model, by encouraging research at colleges of
osteopathic medicine; endorses continued curriculum enhancement for osteopathic students,
interns, and residents to receive specific training in obesity education and approve continuing
medical education for physicians with established practices; supports efforts to close the gap
between current and desirable practice patterns, by soliciting grants to collect and study the
extent to which obesity treatment and prevention services are covered by third party insurers
and advocate for adequate coverage for obesity treatment and prevention and will develop
comprehensive efforts, commensurate with available funding, to disseminate knowledge to the
treating community, media, legislature and employer groups directed at controlling the obesity
epidemic by improving treatment access and encouraging physical activity in the United States.
2002; 2007; reaffirmed as amended 2012

ACTION TAKEN APPROVED (for reaffirmation)

DATE July 22, 2017
SUBJECT: H315-A/12 FLAME-RETARDANT CLOTHING FOR CHILDREN – SLEEPING OR LOUNGING

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be SUNSET:

H315-A/12 FLAME-RETARDANT CLOTHING FOR CHILDREN – SLEEPING OR LOUNGING

The American Osteopathic Association supports legislation to cause manufacturers to produce only flame retardant sleep and lounge clothing for infants and children. 2002; revised 2007; reaffirmed 2012

Explanatory Statement:
Legislation was already passed at the federal level mandating this, as well as a number of states. Regardless, there is also significant evidence that the flame-retardant treatment has been linked to cognitive and other health issues.

ACTION TAKEN _APPROVED (for sunset)_

DATE _July 22, 2017_
SUBJECT: H401-A/12 AUTOMATED EXTERNAL DEFIBRILLATOR (AED) TO TREAT COMMOTIO CORDIS – PROMOTION FOR THE REQUIREMENT OF ALL SPORTING EVENTS TO HAVE ACCESS TO AN

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED:

H401-A/12 AUTOMATED EXTERNAL DEFIBRILLATOR (AED) TO TREAT COMMOTIO CORDIS – PROMOTION FOR THE REQUIREMENT OF ALL SPORTING EVENTS TO HAVE ACCESS TO AN

The American Osteopathic Association encourages professional athletic programs, the National Collegiate Athletics Association, the National Association of Intercollegiate Athletics, the National Federation of State High School Associations, and local sporting organizations to have a readily accessible automated external defibrillator that has been annually tested, and when possible, training has been provided to responsible individuals. 2012

ACTION TAKEN _APPROVED (for reaffirmation)_

DATE _July 22, 2017_
RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED:

**H404-A/12 MENINGOCOCCAL VACCINES (MCV4) BOOSTER – RECOMMENDATIONS FOR UNIVERSAL ADOLESCENT**

The American Osteopathic Association supports the administration of a booster dose of the meningococcal vaccines (MCV4) at 16 years of age for those adolescents that receive an initial MCV4 dose at 11 – 12 years of age AS RECOMMENDED BY THE CENTERS FOR DISISEASE CONTROL AND PREVENTION’S (CDC) ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES (ACIP); AND URGES ADEQUATE PUBLIC AND PRIVATE INSURANCE COVERAGE FOR VACCINES IN PATIENT POPULATIONS AS RECOMMENDED BY THE ACIP. 2012

Reference Committee Explanatory Statement:
These amendments ensure that the resolution remains consistent with rapidly changing vaccination guidelines as established by the ACIP.

ACTION TAKEN _APPROVED (as amended)_

DATE _July 22, 2017_
RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED SUNSET:

H405-A/12 MENINGOCOCCAL VACCINE (MCV4) PRIMARY SERIES IN PATIENTS WITH SICKLE CELL ANEMIA

The American Osteopathic Association supports the administration of a 2 dose primary series of the meningococcal vaccine (MCV4), given 2 months apart, in patients between 2 and 54 years of age with sickle cell anemia. 2012

Reference Committee Explanatory Statement:
This resolution is combined with H-419.

ACTION TAKEN  APPROVED as AMENDED (for sunset)

DATE  July 22, 2017
RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be SUNSET:

H406-A/12  NARCO-TERRORISM

The American Osteopathic Association will commit its efforts to address narco-terrorism by emphasizing patient and community addiction education and treatment efforts.

Explanatory Statement:
Covered under policies H415-A/13 SUBSTANCE ABUSE and H440-A/16 SUBSTANCE USE DISORDERS (SUD) -- EVIDENCE BASED TREATMENT PROGRAMS FOR.

ACTION TAKEN  _APPROVED (for sunset)_

DATE  July 22, 2017
SUBJECT: H407-A/12  PROSTATE CANCER – PSA-BASED SCREENING FOR

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED:

H407-A/12  PROSTATE CANCER – PSA-BASED SCREENING FOR

The American Osteopathic Association recognizes and promotes the importance of the integrity of the patient-physician relationship and recommends that prostate cancer clinical preventive screenings be individualized. 2012

ACTION TAKEN  APPROVED (for reaffirmation)

DATE  July 22, 2017
RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED as AMENDED:

H409-A/12 FOOD ALLERGIES AND MANDATES ON SCHOOL LUNCHES

The American Osteopathic Association advocates a holistic approach with respect to childhood nutrition and wellness without mandates that force potentially food allergic children to purchase school lunches. 2012

ACTION TAKEN _APPROVED (as amended)_

DATE _July 22, 2017_
RESOLVED, that the Bureau of International Osteopathic Medicine recommend that the following policy be SUNSET:

**H410-A/12 MEDICAL CARE DURING MEDICAL MISSIONS – PROVIDING**

DOCARE International will not sponsor medical missions where the mission would be asked to withhold care from individuals based on political or religious beliefs; DOCARE International will not sanction activities or missions where a mission director who is not in a health care related field and does not have patient care as a primary goals; and the American Osteopathic Association supports the idea that medical missions should provide medical treatment without discrimination. 2012

Explanatory Statement:
Neither DOCARE nor the AOA operates programs in conflict zones; furthermore the AOA's policy of non-discrimination applies by extension to the programs it supports.

ACTION TAKEN **APPROVED (for sunset)**

DATE **July 22, 2017**
RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED:

H415-A/12  ANTIMICROBIAL – JUDICIOUS USE OF

The American Osteopathic Association supports the education for proper use of antimicrobial agents in order to decrease drug-resistant organisms. 2002; revised 2007; reaffirmed 2012

ACTION TAKEN  **APPROVED (for reaffirmation)**

DATE  **July 22, 2017**
RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED:

H416-A/12 ANTI-BULLYING LAW

The American Osteopathic Association supports anti-bullying policies enabling students to go to school in a peaceful manner without fear of tormenting or intimidating acts to themselves or others and supports a policy to prevent bullying in schools and provide treatment for those involved, thus furthering the cause of a peaceful education. 2002; reaffirmed 2007; 2012

ACTION TAKEN  **APPROVED (for reaffirmation)**

DATE  **July 22, 2017**
RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be SUNSET:

H417-A/12 BREASTFEEDING – FRIENDLY WORKPLACE

The American Osteopathic Association urges its membership to take a role in providing a breastfeeding friendly workplace in their offices and hospitals. 2002; reaffirmed 2007; 2012

Explanatory Statement:
H417-A/12 will be combined with H418-A/12 to form a single policy.

ACTION TAKEN  APPROVED (for sunset)

DATE  July 22, 2017
RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED as AMENDED:

H418-A/12 BREASTFEEDING-PROMOTION – PROTECTION AND SUPPORT OF

The American Osteopathic Association urges its membership to take a role in the protection, promotion and support of breastfeeding AND IN PROVIDING TO ENCOURAGE THE PROVISION OF BREASTFEEDING FRIENDLY ENVIRONMENTS IN THEIR PLACES OF STUDY AND WORK, INCLUDING BUT NOT LIMITED TO COLLEGES, HOSPITALS, AND OFFICES OTHER HEALTHCARE FACILITIES. 2002; reaffirmed 2007; 2012

Explanatory Statement:
Language from H417-A/12 combined with H418-A/12 to form a single policy

ACTION TAKEN APPROVED as AMENDED

DATE July 22, 2017
SUBJECT: H420-A/12 EMERGENCY MEDICAL IDENTIFICATION – PROTOCOL AND GUIDELINES

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED:

H420-A/12 EMERGENCY MEDICAL IDENTIFICATION – PROTOCOL AND GUIDELINES


ACTION TAKEN _APPROVED (for reaffirmation)_

DATE _July 22, 2017_
SUBJECT: H422-A/12 ORGAN DONATION – OPPOSITION TO FINANCIAL INCENTIVES FOR ORGAN DONORS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED as AMENDED:

H422-A/12 ORGAN DONATION – OPPOSITION TO FINANCIAL INCENTIVES FOR ORGAN DONORS

The American Osteopathic Association states its opposition to direct payment or other financial reimbursement in exchange for donation of human organs and tissue and urges the osteopathic medical profession investigate other, more ethical alternatives to raising organ donor identification rates while preserving its first duty to protecting patient interests. 2002; 2007, 2012

Explanatory Statement:
Reimbursement of expenses that would be incurred by an individual in connection with organ donation does not create inappropriate incentive for organ donation. There is, however, ethical concern from payments of cash or other financial incentives or inducements that may take unfair advantage of people facing financial hardships.

ACTION TAKEN _APPROVED (as amended)_

DATE _July 22, 2017_
RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be SUNSET:

H423-A/12  ORGAN DONOR IDENTIFICATION

The American Osteopathic Association encourages osteopathic physicians to discuss organ donation options with their outpatients as well as their inpatients and asks that all physicians honor the policies of their designated Organ Procurement Organization in achieving optimal organ donor identification goals. 2002; 2007, 2012

Explanatory Statement:
This language is covered under current policy H411-A/16.

ACTION TAKEN  APPROVED (for sunset)  

DATE  July 22, 2017
RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED:

**H427-A/12 VIOLENCE IN THE ENTERTAINMENT MEDIA**


ACTION TAKEN **APPROVED (for reaffirmation)**

DATE **July 22, 2017**
RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the
following policy be REAFFIRMED:

H430-A/12 STEM CELL RESEARCH
The American Osteopathic Association supports biomedical research on stem cells and will
continue to monitor developments in stem cell research and sources of stem cell funding. 2007;
reaffirmed 2012

ACTION TAKEN  **APPROVED (for reaffirmation)**

DATE  **July 22, 2017**
RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED:

**H434-A/12  HUMAN PAPILLOMAVIRUS VACCINATION – EDUCATION ON**

The American Osteopathic Association supports efforts to educate the general public regarding the human papillomavirus (HPV) and its relationship to certain cancers and genital warts; urges osteopathic physicians to educate themselves and their patients regarding the availability and benefits of administering HPV vaccine to patients as recommended by the Centers for Disease Control and Prevention’s Advisory Committee on Immunization Practices; and urges adequate public and private insurance coverage for HPV vaccines in patient populations as recommended by the Advisory Committee on Immunization Practices (ACIP); and supports ongoing research to determine whether HPV vaccine is beneficial to other groups in the general population. 2007; reaffirmed as amended 2012

**ACTION TAKEN**  **APPROVED (for reaffirmation)**

**DATE**  **July 22, 2017**
RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED:

H436-A/12 PHYSICAL EDUCATION FOR GRADES K-12 – DAILY

ACTION TAKEN **APPROVED** (for reaffirmation)

DATE  **July 22, 2017**
SUBJECT: H442-A/12  SMOKING – USE TOBACCO PRODUCTS

SUBMITTED BY: Bureau on Scientific Affairs and Public Health

REFERRED TO: Committee on Public Affairs

RESOLVED, that the Bureau on Scientific Affairs and Public Health recommend that the following policy be REAFFIRMED as AMENDED:

H442-A/12  SMOKING – USE OF TOBACCO PRODUCTS

The American Osteopathic Association: (1) supports education on the hazards of smoking TOBACCO PRODUCTS beginning at the elementary school level; (2) encourages physicians to inquire into tobacco use and exposure as part of both prenatal visits and every appropriate health supervision visit; (3) strongly recommends that all federal and state health agencies continue to take positive action to discourage the American public from using cigarettes and other tobacco products; (4) encourages its members to discuss the hazards of tobacco use with their patients; (5) encourages the elimination of federal subsidies and encourages increased taxation of tobacco products at both federal and state levels suggesting that monies from the additional taxation could be earmarked for smoking-reduction programs and research for prevention of tobacco-related diseases; that municipal, state and federal executive agencies and lawmakers enact clean-indoor air acts, a total ban on tobacco product advertising, opposes cigarette vending machines in general and supports federal legislation to limit access to cigarette machines to minors, and the elimination of free distribution of cigarettes OR TOBACCO PRODUCTS in the United States; and that grades K -12 should be encouraged to incorporate a curricular component that has been proven effective in preventing tobacco usage in its health education curriculum; and, (6) urges the development of anti-tobacco educational programs targeted to all members of society, with the ultimate goal of achieving a tobacco-free nation.


ACTION TAKEN  APPROVED (as amended)

DATE  July 22, 2017
RESOLVED, that the Bureau of Socioeconomic Affairs, the Bureau of State Government Affairs, and the Bureau on Federal Health Programs recommend that the following policy be SUNSET:

H623-A/12  OVERWEIGHT AND OBESITY – RECOGNITION AS BILLABLE DIAGNOSES

The American Osteopathic Association will work with insurers, the CMS and other third-party payers to recognize obesity as a growing threat to the health and security of our nation; and work so that physicians may be appropriately paid for the treatment and prevention of both overweight and obesity as a primary or secondary diagnoses. 2007; reaffirmed as amended 2012

Explanatory Statement:
Combined under H440-A/12 OBESITY -- TREATMENT OF

ACTION TAKEN  APPROVED (for sunset)

DATE  July 22, 2017
SUBJECT: END OF LIFE CARE

SUBMITTED BY: Bureau on Federal Health Programs / Bureau on State Government Affairs / Bureau on Socioeconomic Affairs

REFERRED TO: Committee on Public Affairs

WHEREAS, The American Osteopathic Association (AOA) has several policies on end of life care; and

WHEREAS, it is in the interest of the AOA to consolidate these policies while maintaining substantive intent of them; now, therefore be it

RESOLVED, that H431-A/15 END OF LIFE CARE – POLICY STATEMENT ON be amended to include substantive elements from H431-A/12 End Of Life Care – Cultural Sensitivity; H218-A/12 End Of Life Care – For Children; H205-A/13 Geriatric End Of Life Healthcare; H413-A/12 Do Not Resuscitate (DNR) Orders On Elder Adults In Long Term Or Extended-Care Facilities; and H411-A/12 End Of Life Care For The Developmentally Disabled; and, be it further

RESOLVED, that H431 – A/15 END OF LIFE CARE – POLICY STATEMENT ON be amended as follows:

The American Osteopathic Association approves the attached white paper on end of life care and (1) encourages all osteopathic physicians to maintain competency in end of life care through educational programs such as the web-based osteopathic Education for Professionals on End of Life Care (Osteopathic EPEC) modules; (2) SUPPORTS THE DEVELOPMENT, DISTRIBUTION AND IMPLEMENTATION OF COMPREHENSIVE CURRICULA TO TRAIN MEDICAL STUDENTS, INTERNS, RESIDENTS AND PHYSICIANS IN END-OF-LIFE ISSUES; (3) URGES OSTEOPATHIC MEDICAL SCHOOLS, AND APPROPRIATE TRAINING PROGRAMS TO SUPPORT INNOVATIVE APPROACHES TO INSTRUCTION IN GERIATRIC MEDICINE AND END-OF-LIFE CARE; (4) encourages all osteopathic physicians to stay current with their individual state statutes on end of life care; (5) SUPPORTS PUBLIC POLICIES WHICH UPHOLDS A PATIENT’S RIGHT TO A “DO NOT ATTEMPT RESUSCITATION” (DNAR) AND/OR ALLOW NATURAL DEATH (AND), DESIGNATION, DETERMINED BY THE PATIENT OR, IF THE PATIENT IS INCOMPETENT, BY THE FAMILY, ATTENDING PHYSICIANS, PATIENT ADVOCATE, AND/OR DURABLE POWER OF HEALTH CARE ATTORNEY (DPOA); (6) encourages all osteopathic physicians to engage patients and their families in discussion and documentation of advance care planning regarding end of life decisions; (7) WILL WORK TO IMPLEMENT POLICIES TO ENSURE HOSPICE AND PALLIATIVE SERVICES FOR ALL INDIVIDUALS, INCLUDING THE DEVELOPMENTALLY CHALLENGED, CHILDREN, AND OTHER SPECIAL POPULATIONS; AND (8) URGES THAT OSTEOPATHIC PHYSICIANS...
RECOGNIZE THE IMPORTANCE OF CULTURAL DIVERSITY IN
PERSPECTIVES ON DEATH, SUFFERING, BEREAVEMENT AND RITUALS
AT THE END OF LIFE, AND INCORPORATE CULTURAL ASSESSMENT
INTO THEIR COMPREHENSIVE EVALUATION OF THE PATIENT AND
FAMILY; THE AOA WILL WORK TO IDENTIFY SOURCES OF CULTURALLY
APPROPRIATE INFORMATION ON ADVANCE DIRECTIVES, PALLIATIVE;
CARE, AND END OF LIFE ETHICAL ISSUES IN POPULATIONS SERVED BY
OSTEOPATHIC PHYSICIANS.
(White Paper to follow as currently drafted in H431-A/15); and, be it further

RESOLVED, that upon the approval of this resolution the American Osteopathic Association
(AOA) policies H431-A/12 End Of Life Care -- Cultural Sensitivity; H218-A/12 End
Of Life Care -- For Children; H205-A/13 Geriatric End Of Life Healthcare; H413-
A/12 Do Not Resuscitate (DNR) Orders On Elder Adults In Long Term Or
Extended-Care Facilities; and H411-A/12 End Of Life Care For The Developmentally
Disabled be deleted from the policy compendium.

Explanatory Statement:
Need to streamline policy compendium.

ACTION TAKEN _APPROVED (as amended)_

DATE _July 22, 2017_
WHEREAS, powdered caffeine has been available in the United States for several years. It is sold as a supplement so the Food and Drug Administration (FDA) does not regulate this product. The federal substance abuse administration reported that powdered caffeine caused deaths; and

WHEREAS, the number of emergency department visits involving energy drinks doubled — from 10,068 visits in 2007 to 20,783 visits in 2011, according to the federal Substance Abuse and Mental Health Services Administration. Most of the cases involved teens or young adults. The top selling canned or bottled caffeinated energy drinks have between 50 and 250mg of caffeine, with an average of 110mg caffeine. A teaspoon of caffeine powder could contain 3,200 milligrams of caffeine or near an equivalent of 28 energy drinks. In that concentrated amount, a person can experience adverse effects in a matter of minutes. Agitation, confusion, tachycardia, arrhythmia, emesis, and seizures are side effects of caffeine overdose; and

WHEREAS, the FDA released a safety alert in 2015, FDA Consumer Advice on Pure Powdered Caffeine. The first two sentences are: “The FDA is warning about pure powdered caffeine being marketed directly to consumers, and recommends avoiding these products. In particular, FDA is concerned about pure powdered caffeine sold in bulk bags over the internet; now, therefore be it

RESOLVED, that the American Osteopathic Association oppose the use of pure CONCENTRATED powdered caffeine for non-medical uses.

Explanatory Statement:
- [https://thenypost.files.wordpress.com/2014/07/5544661711_f2717a6f93_o.jpg?quality=90&strip=all&w=664&h=441&crop=1](https://thenypost.files.wordpress.com/2014/07/5544661711_f2717a6f93_o.jpg?quality=90&strip=all&w=664&h=441&crop=1)

ACTION TAKEN **APPROVED as AMENDED**

DATE **July 22, 2017**
WHEREAS, eating disorders are the third most common chronic condition affecting adolescent females with estimated prevalence of anorexia nervosa, bulimia nervosa, and binge eating disorder among adolescents in the United States is 0.3 percent, 0.9 percent and 1.6 percent respectively; and

WHEREAS, individuals with anorexia nervosa had a six-fold increase in mortality when compared to the general population and crude mortality rates for anorexia nervosa, bulimia nervosa, and eating disorders not otherwise specified are 4.0 percent, 3.9 percent, and 5.2 percent, respectively; and

WHEREAS, the Society of Adolescent Health and Medicine suggest weight restoration, resumption of spontaneous menses, and improved bone mineral density are important goals of treatment; and may require inpatient refeeding and nutritional rehabilitation based on the patient’s physical and emotional health, rapidity of weight loss, availability of outpatient resources, and family circumstances; and

WHEREAS, patients with less severe eating disorders at baseline were more likely to abstain from eating disorder behavior after family-based outpatient treatment, leaving patients with severe eating concerns needing inpatient therapy; and

WHEREAS, the estimated prevalence of adolescents and children with eating disorders of inpatient psychiatric admissions is 13.3 percent; and

WHEREAS, research studies have shown a 24 percent drop out rate of hospitalizations among patients suffering with eating disorders; and

WHEREAS, the Mental Health Parity and Addiction Equity Act of 2008 requires doctors and insurers to treat and cover mental illness in the same manner as physical illness; and

WHEREAS, reimbursement by insurance companies remains inadequate for patients with eating disorders hospitalized on medical units; and

WHEREAS, 96.7 percent of eating disorder specialists believe that health insurance companies’ refusal to cover treatment puts patients with anorexia nervosa in life threatening situations; and

WHEREAS, research evaluating effective treatment of eating disorders have found competing events, for example, termination of insurance coverage competes with patient outcome; now, therefore be it
RESOLVED, that the American Osteopathic Association (AOA) support improved access to
treatment in residential and inpatient facilities, and efforts to reduce the financial
barriers of intensive treatment for patients suffering from eating disorders; and, be it
further

RESOLVED, that the AOA encourage residential and inpatient treatment facilities caring for
patients suffering from eating disorders, to manage care in consideration of the patient's
overall medical and mental health needs, and to continue treatment until goals of weight
restoration and physiologic status are obtained; and, be it further.

RESOLVED, that the AOA support continued care for individuals suffering from eating
disorders staying in residential and inpatient facilities, regardless of insurance criteria
requiring termination of treatment.

Explanatory Statement:
The goal of this resolution is for the Student Osteopathic Medical Association and the American
Osteopathic Association to support health benefit plans that cover diagnosis and treatment of eating
disorders on the basis of the medical necessities of an individual patient as judged by their healthcare
provider - as opposed to predetermined biometric benchmarks. Some states have passed bills in
support of this, for example Missouri 2015 Senate Bill 145; however, it is not a uniform ruling across
the United States. The authors of this resolution would like to see progress to move forward with this
nationally.

Missouri 2015 Senate Bill 145
Requires health benefit plans cover diagnosis and treatment of eating disorders

Summary: requires health insurance to provide coverage for the diagnosis and treatment of eating
disorders. The act further requires that the provided coverage include a broad array of specialist
services as prescribed as necessary by the patient's treatment team. Coverage under this act is limited to
medically necessary treatment and the treatment plan must include all elements necessary for a health
benefit plan to pay claims. Under the act medical necessity determinations and care management for the
treatment of eating disorders shall consider the overall medical and mental health needs of the
individual with the eating disorder and shall not be based solely on weight. Coverage may be subject to
other general exclusions and limitations of the contract or benefit plan not in conflict with the act

REFERENCES:
3. Fotios C Papadopoulos, Anders Ekbom, Lena Brandt, Lisa Ekselius. Excess mortality, causes of death and
prognostic factors in anorexia nervosa. The British Journal of Psychiatry 2009, 194 (1) 10-17; DOI:
10.1192/bjp.bp.108.054742

ACTION TAKEN APPROVED

DATE July 22, 2017
WHEREAS, the House of Delegates referred H-400-A/16 to the Bureau of Scientific Affairs and Public Health to craft language combining H200-A/11; H414-A/12; and H417-A/15; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) urge its members as well as government agencies to continue to develop, expand, and participate in programs targeted at: reducing, preventing, and managing violence, abuse, and neglect of all kinds; educating medical students, residents, and practicing physicians to improve their knowledge, attitudes, and skills in addressing violence, abuse and neglect; treating, assisting, and advocating for victims; rehabilitating abusers; and any other domain related to the welfare of victims of violence, abuse, and/or neglect.

ACTION TAKEN  APPROVED

DATE  July 22, 2017
RESOLVED, that the Bureau of Scientific Affairs and Public Health (BSAPH) recommend
that the following policy be REFERRED to (BSAPH):

**H200-A/11 VIOLENCE AND ABUSE PREVENTION AND EDUCATION**

The American Osteopathic Association urges its members as well as government agencies to continue to develop and expand educational and preventative programs to reduce violence and abuse of all kinds; supports the promotion, distribution and implementation of curricula and other educational resources focused on medical students, residents and practicing physicians to improve their knowledge, attitudes and skills in addressing violence and abuse; this effort will include, but not be limited to, pre and post doctoral education, continuing medical education, community education, demonstration projects and efforts for dissemination of “best practices” in preventing and addressing violence and abuse across the lifespan. 2001; revised 2006; revised 2011.

Explanatory Statement:

**ACTION TAKEN** REFERRED **(to Bureau of Scientific Affairs and Public Health)**

**DATE** July 23, 2016
WHEREAS, the Ohio Osteopathic Association (OOA) submitted two resolutions in 2014 to
the House of Delegates regarding recreational marijuana’s impact on patients (H428–
A/14) and osteopathic physicians and students’ use of recreational marijuana (H-434 –
A/2014); and

WHEREAS, both resolutions were referred to the AOA Bureau of Scientific Affairs and Public
Health (BSAPH); and

WHEREAS, the BSAPH presented its response in House Resolution H-436 – A/2016 which
recommended against the AOA adopting H-428 and H-434; and

WHEREAS, H-436 – A/2016 was referred back to BSAPH to craft a “statement that addresses
the potential risks and benefits of recreational marijuana, the potential risks and benefits
of medical cannabis, and general policy guidelines for the use of these substances by
Osteopathic Medical Students, Physicians, and patients;” now, therefore be it

RESOLVED, that the House of Delegates adopt the attached white paper entitled,
“Recreational Marijuana Use by Physicians, Students, and Patients”.

Explanatory Statement:
See attached Bureau of Scientific Affairs and Public Health White Paper “Recreational Marijuana Use
by Physicians, Students, and Patients.”

ACTION TAKEN  APPROVED

DATE  July 22, 2017
Recreational Marijuana Use by Physicians, Students, and Patients

I. Purpose
This policy paper addresses the potential risks and benefits of recreational marijuana, the potential risks and benefits of medical cannabis, and policy guidelines for the use of these substances by Osteopathic medical students, physicians, and patients. The policy paper provides the following:

1. Summary of current literature regarding risks and benefits of cannabis as a foundation for policy development around both medical and recreational marijuana use.
2. Discussion of the driving forces in the legalization/decriminalization of marijuana use at the state level.
3. Policy recommendations around risk/benefit of marijuana use and its potential impact on osteopathic physicians and students as well as patients.

II. Background
Approximately 22.2 million Americans aged 12 and over reported using marijuana within the last 30 days. This is an increase from 6.2 percent in 2002 to 8.3 percent in 2015.

As of May 2017, twenty-nine states, the District of Columbia, Guam and Puerto Rico have legalized marijuana use for medicinal purposes. Eight of these states and the District of Columbia have also legalized cannabis for recreational use. The trend of legalizing marijuana illuminates two, often competing, forces which are: (1) a greater public acceptance of use of cannabis for both medicinal and recreational purposes; and (2) a concern for the impact of existing laws governing cannabis possession and use on the societal as well as personal level. As states continue to legalize medicinal and recreational cannabis use, it is important to take into consideration the potential public health threat cannabis use represents. Similar to alcohol consumption and tobacco use, osteopathic physicians must guide the care of patients as marijuana use moves from a criminal act to an acceptable behavior, albeit a behavior that may pose a public health threat.

Risks and Benefits of Cannabis
A systematic review of cannabis was commissioned by the National Academy of Science, Engineering and Medicine (the Academies) in April 2016 and published on January 17, 2017.

The commissioned report is the first comprehensive review of published literature since the 1999 Institute of Medicine (IOM) Report marijuana and medicine: Assessing the science base. The Academies’ report is entitled, The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research. This 395-page report represents the best current knowledge regarding the risks and benefits of cannabis synthesized by leading national researchers. In addition, the report describes gaps in the literature, identifies future research opportunities, and summarizes policy issues regarding the laws and uses of cannabis across the various states that have decriminalized marijuana. The report also discusses current federal activities such as the enforcement of the Controlled Substance Act.

The committee commissioned by the Academies conducted an extensive search of relevant databases which included Medline, Embase, the Cochrane Database of Systematic Reviews, and
PsycINFO. The committee identified more than 24,000 abstracts of articles published since the 1999 IOM report. Only articles published in English were eligible for the study. Case reports, editorials, studies by “anonymous” authors, conference abstracts, and commentaries were excluded. Ultimately, the committee conducted an in-depth review of more than 10,700 abstracts in determining their relevance to the final report.

Summary of Major Findings

**Therapeutic Benefits.** Research has demonstrated that cannabis use has therapeutic effects for patients. Oral cannabinoids are an effective antiemetic in treating nausea and vomiting resulting from chemotherapy treatment. With respect to chronic pain, cannabis and/or cannabinoids can significantly reduce pain symptoms for chronic pain (e.g., fibromyalgia) patients. For multiple sclerosis patients, short-term use of oral cannabinoids improves patient-reported spasticity symptoms. Other therapeutic benefits of cannabis may be seen in patients that suffer from Tourette syndrome, Posttraumatic Stress Disease (PTSD) and social anxiety disorders. More research, however, is needed for the effects of cannabinoids on other conditions such as epilepsy, Parkinson’s disease, and schizophrenia.

**Cancer Risks.** Cannabis use poses health risks for various diseases and conditions as well as injury and death. There is modest evidence that marijuana use is associated with an increased incidence of a specific type of testicular cancer. There is insufficient evidence that marijuana use increases the risk of other cancers (e.g., esophageal, prostate, cervical, leukemia, or cancer in children whose mother used marijuana during her pregnancy), and there is no evidence that smoking marijuana increases the risk of such cancers as lung cancer or head and neck cancer.

**Pulmonary & Cardiometabolic Concerns.** Cannabis use and its growing popularity raise questions regarding pulmonary and cardiometabolic issues. Evidence has shown that regular use of marijuana is associated with chronic cough and phlegm production. More research, however, is needed to determine whether smoking marijuana is associated with Chronic Obstructive Pulmonary Disease (COPD), asthma, and/or a decline in lung function. More research is also needed to determine the exact association of marijuana use with heart attack, stroke and diabetes.

**Effect on Infectious Diseases.** There is a lack of evidence regarding the effects of marijuana on the human immune system. There has been some belief that marijuana use has adverse effects on the immune system of HIV patients. More research is needed to determine a statistical association. According to the limited evidence that does exist, smoking marijuana on a regular basis may have anti-inflammatory benefits. However, more research is needed.

**Effect on Cognitive Impairment.** Marijuana use is associated with cognitive impairment which affects a person’s performance. This altered state of mind can lead to injury that may, ultimately, result in death. Studies have found that marijuana use immediately prior to operating a vehicle increases the risk of getting into a motor vehicle accident.

Cognitive performance (i.e., learning, memory and attention) can be impaired up to 24 hours after the use of marijuana. A few studies have found that impairments in cognitive domains may continue even after a person has stopped smoking marijuana. The lingering effects of marijuana are especially concerning for adolescents. The evidence purports that the use of marijuana during
adolescence can have lasting effects on a young person’s academic achievement, future employment, and social interactions and productivity. ³

**Additional Concerns Regarding Children.** In states where recreational marijuana has been legalized, the evidence indicates that children have an increased risk of unintentional adverse effects (e.g., respiratory distress). There are other concerns such as low birth weight. Studies have found that maternal recreational marijuana use during pregnancy is associated with low birthweight babies. More research is necessary to determine the association of marijuana use and other pregnancy and childhood outcomes.³

**Mental Health Issues.** Studies have found that the use of marijuana increases the risk of developing schizophrenia and other psychoses. The risk of developing a mental health issue increases with the dosage. Conversely, individuals with schizophrenia and other psychoses prior to using cannabis may experience better performance on learning and memory tasks when they use marijuana. Studies have found bipolar disorder is an exception to this observation. Individuals diagnosed with bipolar disorder that use marijuana daily may experience intensified symptoms than those diagnosed with bipolar disorder do not use marijuana.³

Other mental health illness studies include depression, anxiety, suicide and posttraumatic stress disorder (PTSD). There is evidence that heavy marijuana users are more likely to report thoughts of suicide than non-users, and individuals that use marijuana regularly have an increased risk of developing social anxiety disorder. There is a lack of evidence that marijuana use increases the likelihood of developing other types of anxiety disorders, depression, or PTSD.³

**Cannabis Addiction and Abuse of Other Substances.** As individuals increase their frequency of cannabis consumption, there is a corresponding increased risk of becoming addicted to the substance. Additionally, it has been found that individuals that begin using marijuana at a young age are at an increased risk of developing an addiction to cannabis. Cannabis use has also been linked to an increased risk of an individual abusing other substances.³

**Clinical Features of Cannabis Intoxication**

Regardless of the positive and negative aspects of cannabis use, it is important to understand and recognize the clinical manifestations of cannabis intoxication. Similar to alcohol intoxication, cannabis intoxication can influence an individual’s behaviors, perceptions and interaction with others. For example, a person experiencing cannabis intoxication may have a heightened sociability and sensitivity to certain stimuli (e.g., colors, music), altered perception of time, and an intensified appetite for sweet and fatty foods. Some users report feeling relaxed or experiencing a sensation described as a “rush” or “buzz” after smoking cannabis.⁴ Such effects may be accompanied by decreased short-term memory, dry mouth, and impaired perception and motor skills. Other concerns regarding cannabis use focus on public safety. In light of the current trend in legalizing medical and recreational cannabis, the potential for impaired driving due to acute intoxication is a genuine threat to public safety.

Acute cannabis intoxication has several major contributors. One of the key contributors is tetrahydrocannabinol (THC), a compound found in the marijuana plant that stimulates cells in the brain and cause psychological effects.⁵ In incidents where a person using cannabis may have high blood levels of THC, the person may experience panic attacks, paranoid thoughts and
hallucinations. In addition to the dosage of THC in a person’s system, two other key factors that impact the intensity and duration of intoxication due to cannabis use are (1) individual differences in the rate of absorption and metabolism of THC, and (2) the loss of sensitivity to THC’s effects.3,6 Studies as synthesized in the Academies’ report have found that “prolonged CB1 receptor occupation as a consequence of the sustained use of cannabis can trigger a process of desensitization, rendering subjects tolerant to the central and peripheral effects of THC and other cannabinoid agonists.”3,7 In studies conducted with animals, recurrent exposure to THC resulted in decreased CB1 receptor levels and connections between CB1 and its transducing G-proteins were compromised. Similar results were found in humans. In one study, researchers used imaging to study the brain of humans who were considered chronic cannabis users and found a down-regulation of CB1 receptors in the cortical regions of the brain.3,8

III. Decriminalization of Marijuana Use

There has been a recent trend in states legalizing cannabis use for medical as well as recreational purposes. What once was criminalized is now becoming legal and acceptable in society. As noted in the Academies report, public opinion appears to be the primary influence for many of the policy changes.

The Gallup Poll began surveying Americans on the legalization of cannabis in the late 1960s when marijuana use began having a wider and more mainstream appeal.3 Over the span of approximately 50 years, support for the legalization of cannabis use increased to 28 percent in 1977, 31 percent in 2000, and 58 percent in 2015.

The support for legalizing marijuana use can be differentiated by medicinal use versus recreational use. As reflected in the polls, medicinal use, as prescribed by a physician, has received overwhelming support from the public. Results from national surveys conducted by ProCon have shown that since 1998, 60 to 85 percent of Americans are supportive of the use of medical cannabis.9 Quinnipiac also conducted a poll where it was found that 89 percent of respondents supported medical cannabis.10 It is clear that public perception of cannabis use has changed over the years and many support medicinal use.

Legalization of recreational marijuana use appears to have a different plight in the landscape of public opinion. Support has been slow, but has recently increased with the legalization of marijuana in several states. In 2016, the Pew Research Center which has conduct various surveys on the topic of legalizing marijuana found that 57 percent of Americans believe marijuana should be legalized compared to 12 percent in 1969.10 While the 2016 percentage is lower than that in support of legalizing marijuana for medicinal purposes, based on trending data, the legalization for recreational use is becoming increasingly popular.

State and National Policies

Currently, states are the main players in changing policy regarding the medical and recreational use of marijuana. As indicated in the Academies’ report, a large portion of the states have used the popular referendum approach as opposed to the deliberative legislative process to modify their cannabis use laws. States have adopted a variety of approaches in how they regulate marijuana use.2 Some states have broad laws regarding medicinal use, others have stricter laws that limit access, and
then there are those states that still criminalize marijuana use, but may allow for a legal defense under specific circumstances.

**State Broad Policies.** In states with broad policies, access to medical cannabis is restricted to a specific population or condition/illness. Patients may access medical cannabis as their physician deems necessary. Many people may view this approach as de facto legalization of marijuana for recreational use.3

**State Restrictive Policies.** States that have implemented restrictions to access typically require patients to meet certain qualifying criteria before permitting them access. The states may also restrict the types of medical products available to patients. Such states like New York do not allow patients to smoke cannabis, but they may have access to tinctures, oils, concentrates, and other similar products.3

Other states may have non-THC policies which require products to have no-THC or low-THC/high-CBD such as CBD oil. Oftentimes, the states that have no-THC policies have exceptions to the law that can be used as a legal defense.3

**State Policies - Production & Distribution.** Not only do states have different policies on the prescription of cannabis products, but also, different policies on the production and distribution of products. For example, some states regulate the establishment and operation of dispensaries (storefronts). Patients with prescriptions may visit these dispensaries to obtain a wide array of cannabis products. Some dispensaries are allowed to advertise their products and services to patients, while others may promote their services to the broader general public. In other states, only patients and caregivers may cultivate cannabis solely for the purpose of using it as prescribed within their homes. Yet, there are other states that strictly prohibit the supply and distribution of any cannabis products.3

**Federal Law.** Unlike the states, the federal government has not implemented any national laws legalizing marijuana use nor have they challenged any laws implemented by the states. However, the federal government under the Obama Administration issued guidelines regarding the topic. Through the guidelines, the federal government has indicated it will not seek to prosecute individuals who are in compliance with their state laws; however, states are charged with implementing additional policies to ensure the health and safety of the general public. Additionally, the guidelines prescribe specific incidents wherein the federal government reserved the right to take action against an individual or group under the Controlled Substances Act.12 The federal government is encouraging research on cannabis use by allowing universities and state departments to grow industrial marijuana to conduct research on its benefits and risks.13

**IV. Existing AOA Policy and Previous Considerations**

Currently, the AOA has adopted a policy of “support[ing] well-controlled clinical studies on the use of cannabis, commonly referred to as marijuana, and related cannabinoids for patients who have significant medical conditions for which current evidence suggests possible efficacy; and encourage[ing] the National Institutes of Health (NIH) to facilitate the development of well-designed clinical research studies into the medical use of cannabis” (H-419 - A/2016).

The AOA also has policies governing the impaired behaviors of practicing physicians (H-316 - A/2014; H-407 - A/2016; and H-334 - A/2013). These policies broadly apply to physicians and non-
physicians who are experiencing impairment resulting from use of any mind-altering substance, including marijuana.

V. AOA Policy

As marijuana decriminalization moves forward, there is a greater need to educate health professionals about the evidence-based benefits and risks of marijuana use for both medicinal and recreational purposes. All policies should focus on assuring that the public health threat of marijuana is minimalized and that the benefit of the drug, where indicated by evidence, is available to patients in need.

Physicians and students using cannabis for medical or recreational purposes will suffer cognitive impairment. Critical thinking, key to the ability to diagnose and treat patients, will be affected and patient safety will be jeopardized. Furthermore, though studies suggest cognitive dysfunction associated with cannabis use continues even after cessation of cannabis use, the duration of the impairment cannot be known. More empirical research is needed to clarify and quantify the overall impact of cannabis use and develop recommendations for use.

After review of the recently released report by the Academies regarding cannabis use, the AOA adopts the following policies:

1. The American Osteopathic Association does not recommend any use of cannabis by physicians and medical students because of patient safety concerns. This statement is supported by the following evidence from the Academies’ report:
   
   a. “During acute cannabis intoxication, the user’s sociability and sensitivity to certain stimuli (e.g., colors, music) may be enhanced, the perception of time is altered, and the appetite for sweet and fatty foods is heightened. Some users report feeling relaxed or experiencing a pleasurable “rush” or buzz” after smoking cannabis (Agrawal et al., 2014). These subjective effects are often associated with decreased short-term memory, dry mouth, and impaired perception and motor skills. When very high blood levels of THC are attained, the person may experience panic attacks, paranoid thoughts, and hallucinations (Li et al., 2014). Furthermore, as legalized medical and recreational cannabis availability increase nationwide, the impairment of driving abilities during acute intoxication has become a public safety issue.”

   b. “Psychosocial
      
      i. Recent cannabis use impairs the performance in cognitive domains of learning, memory, and attention. Recent use may be defined as cannabis use within 24 hours of evaluation.
      
      ii. A limited number of studies suggest that there are impairments in cognitive domains of learning, memory, and attention in individuals who have stopped smoking cannabis.
      
      iii. Cannabis use during adolescence is related to impairments in subsequent academic achievement and education, employment and income, and social relationships and social roles.”
2. The American Osteopathic Association does not support recreational use of marijuana by patients due to uncertainties in properties, dosing, and potential for impairment. Recreational marijuana use is legal only as determined by specific state law.

3. The American Osteopathic Association recognizes that the use of marijuana is an evolving field of research, and thus, encourages the NIH and other research entities to conduct research on the effects of cannabis use on cognition as well as the public health implications of marijuana use.

4. The American Osteopathic Association shall review its policy in light of any new evidence that will be generated by research entities and update this policy as necessary.

VI. References


WHEREAS, the House of Delegates referred H-430 - A/2016 AOA SUPPORT FOR NEEDLE EXCHANGE PROGRAMS and H-432 - A/2016 INCREASED HARM REDUCTION MODALITIES FOR PEOPLE WITH SUBSTANCE USE DISORDERS to Bureau of Scientific Affairs and Public Health (BSAPH) to conduct research and determine the public health advantages and disadvantages of harm reduction programs; and

WHEREAS, BSAPH has reviewed referred resolutions H-430 - A/2016 and H-432 - A/2016 and conducted research on harm reduction strategies; now, therefore be it

RESOLVED, that the House of Delegates adopt the attached white paper entitled, “Harm Reduction Modalities for People Who Inject Drugs.”

Explanatory Statement:

ACTION TAKEN  APPROVED

DATE  July 22, 2017
AOA SUPPORT OF HARM REDUCTION MODALITIES FOR PEOPLE WHO INJECT DRUGS

INTRODUCTION

Though the annual number of new HIV infection diagnoses has declined significantly over the past 10 years, this trend is not consistent across all groups. Behaviors such as sharing needles, syringes, and other injection equipment cause people who inject drugs (PWID) to be at high risk for contracting and transmitting HIV, viral hepatitis and other infections. In 2013, as many as 3,096 of the estimated 47,352 diagnoses of HIV infection in the United States were attributable to injection drug use (IDU).

The recent epidemic of prescription opioid abuse has led to increased numbers of PWID, creating new populations of people at increased risk for infections such as HIV. Specifically, suburban and rural areas, which have historically been areas at low risk for HIV, have been disparately impacted. This epidemic is one of the most significant public health problems that the United States has seen in decades.

Not only does the current opioid crisis place a new group at risk for infectious diseases, but it has created an epidemic of overdoses as well. Fatal drug overdoses are now the number one leading cause of injury death in the United States. In 2015, there were 33,091 opioid-related deaths, and since 1999, the number of opioid overdoses has quadrupled.

To mitigate the impact of injection drug use and its associated consequences, communities across the United States and abroad are considering harm reduction approaches, such as needle exchange programs and safe injection facilities. The goal of this paper is to discuss the benefits and risks of implementing such interventions, and to present the AOA’s position on harm reduction as an approach for impacting the consequences of substance abuse among PWID.

PUBLIC HEALTH SIGNIFICANCE

According to the CDC, 1.2 million people in the US are living with HIV, and 1 in 8 (161,200) are not aware of their infection. PWID represent a significant percentage (13.8%) of persons living with HIV (PLWH) as well as those newly diagnosed with HIV (7%). HIV-negative persons who inject drugs have a 1 in 160 chance of contracting HIV each time they share a needle with an HIV-positive person.

5 Ibid. 
7 “HIV in the United States: At A Glance.” 
8 Ibid. 
9 “Office of the Associate Director of Policy: Health Impact in 5 Years.”
Overall, HIV diagnoses among PWID declined 48% from 2008 to 2014. However, this downward trend varied by race/ethnicity. HIV incidence among Black and Hispanic/Latino PWID declined by nearly half, in both urban and nonurban areas. Among urban White PWID, however, there was a decrease of 28% during 2008–2012, but there was no change in incidence from 2012–2014. Similar trends were noted among nonurban Whites. Although there was some decline in HIV diagnoses among Whites since 2008, the CDC reports that heroin use and injection drug use among Whites is increasing.\\(^{10}\)

In addition to HIV, there is significant hepatitis C (HCV) burden among PWID. As HCV is approximately ten times more infectious than HIV, 50% to 90% of HIV-positive PWID are co-infected with HCV. Recent increases in acute HCV infections suggest that progress made toward lowering rates of HIV infection over the years may be jeopardized by rising use of opioids and heroin.\\(^{11}\)

The costs associated with treating HIV and HCV over a lifetime require significant investment. In 2010 dollars, the cost of HIV treatment is approximately $379,668, and in 2014 the initial market prices of HCV treatment ranged from $84,000 to $96,000. Fortunately, the cost of HCV medications has dropped to approximately $40,000 for Medicaid programs since 2014. Reportedly, HCV treatment can save $14.3 billion in health care expenses, but it costs $69.5 billion to initiate.\\(^{12}\)

Addressing the burden of HIV and HCV requires facilitation of multiple public health strategies aimed at interrupting disease transmission and reducing risk of acquiring and transmitting HIV, HBV, HCV, and other blood-borne infections. Strategies to interrupt disease transmission for PWID include evidence-based practices of promoting the use of sterile needles or syringes for every injection, as well as ensuring access to medical treatment, behavior-change counseling and addiction treatment services.\\(^{13}\)

Injection drug use carries the consequence of inflicting considerable harm on PWID themselves and to society. As communities develop methods of reversing increasing mortality trends, public health officials, as well as federal, state, and local organizations are exploring harm reduction interventions aimed at preventing overdose deaths, interrupting disease transmission, and alleviating harm to people misusing drugs and their families.

**HARM REDUCTION PHILOSOPHY AND APPROACHES**

With respect to illicit drug use, harm reduction refers to a public health approach consisting of policies, programs, and practices directed at reducing the harms associated with the use of mind altering drugs. The defining element is prevention of harm, rather than abstinence or prevention of drug use, and its targets are people who continue to use drugs and are at elevated risk for contracting and spreading diseases.\\(^{14}\)

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\\(^{11}\) “Office of the Associate Director of Policy: Health impact in 5 Years.”
\\(^{12}\) Ibid.
\\(^{13}\) Ibid.
Though components of it can be traced back to the early 1930’s, the term ‘harm reduction’ gained popularity in the mid-1980s. As awareness grew about high incidences of HIV among PWID in many countries, European cities began pioneering interventions such as needle and syringe programs. During the 90’s, harm reduction strategies gained acceptance around the world, and by 2000 they were vital components of drug policy guidance from the European Union. By 2009, 31 European countries provided needle/ syringe programs (NEP, NSP) and opioid substitution therapy (OST), or at least supported them by policy. Harm reduction in prisons was also established during this period with 6 countries offering needle and syringe exchange programs, and 23 providing OST. Europe was also a pioneer in establishing drug consumption rooms (DCR), opening nearly all of the DCRs in the world. Due in part to the efforts of Europe, harm reduction is now official policy of the United Nations.  

Rooted in the concept of harm reduction is the principle that drug use for some people is inevitable because they are either unable or unwilling to abstain. In the 2010 National Survey on Drug Use and Health, for example, 30% of illicit drug users who had not entered treatment responded that they simply were not ready to commit to stopping their drug use, regardless of the consequences. 

To effectively serve people in different phases of addiction and abuse, harm reduction ideally involves multiple simultaneous interventions customized for locality and need. For example, a harm reduction package may be comprised of opioid substitution therapy, needle and syringe programs, drug consumption rooms and counseling services. They may also include peer interventions and advocacy for funding or policy change. Needle and syringe programs are generally at the center of harm reduction interventions targeting PWID. 

**NEEDLE-SYRINGE SERVICE PROGRAMS**

The Centers for Disease Control and Prevention define Syringe Service Programs (SSPs), also referred to as syringe exchange programs (SEPs), needle exchange programs (NEPs) and needle-syringe programs (NSPs), as “…community-based programs that provide access to sterile needles and syringes free of cost and facilitate safe disposal of used needles and syringes.”

The first NEP was established in Amsterdam in 1983 in an attempt to quell a hepatitis B outbreak. Other European countries followed suit after the presentation of HIV/AIDS. In 2014, there were 158 countries around the world with documented PWID; however, only 90 countries were operating NSPs. 

The first SSP in the United States was in New Haven, Connecticut in 1987. The program operated underground because of laws which made possession of drug paraphernalia illegal. In many states this is still the case. The first SSP to receive public funds opened in 1988 in Tacoma, Washington. Just 2 years later,

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17 “Harm reduction among injecting drug users — evidence of effectiveness.”
in Hawaii, the first state-approved SSP was signed into law. According to the North American Syringe Exchange Network, more than 200 syringe services programs operate in 36 states, Washington, D.C., and the territories.\(^{21}\)

In addition to providing sterile needles, syringes, other drug preparation equipment, and disposal services, syringe service programs offer clients a range of other services. Many programs provide health education and counseling, immunizations, access to substance abuse and mental health treatment, screening for tuberculosis, hepatitis, HIV and other STIs, and condom distribution, as well as referrals for social services and medical programs. Programs may also be equipped with naloxone to reverse opioid overdoses.\(^{22}\)

Within the past 10 years, the United States has experienced an increase in drug injection. Of particular concern are persons who escalated to injecting prescription opioids and heroin after using oral analgesics. Much of this activity has been identified in suburban and rural areas. HCV and HIV infection in these nonurban areas correlate with noted injection patterns and trends. The 2015 HIV outbreak in Scott County, Indiana, and documented HCV epidemics in multiple locations around the country underscores the continued need for SSPs and highlights the limited coverage of prevention services for HIV and HCV among PWID in rural and suburban areas.\(^{23}\)

**HISTORY OF THE BAN ON FUNDING NEEDLE EXCHANGE PROGRAMS**

With the advent of the “War on Drugs” in 1988, the United States Congress implemented a ban on the use of federal funds to support syringe exchange. During the 1990s, however, an Institute of Medicine panel recommended that the federal prohibition of needle and syringe exchange programs be revoked. The idea was supported by findings that needle and syringe exchange programs contributed to lowered HIV incidence and did not amplify injection drug use. The Centers for Disease Control and Prevention also assessed needle and syringe exchange programs and concluded that they were effective in halting the spread of HIV among PWID. Based on these endorsements, it was anticipated that the ban would be repealed, but President Clinton chose not to pursue changes to the federal law.\(^{24}\)

In December 2009, President Obama signed the Consolidated Appropriations Act of 2010. Though this act gave states permission to fund syringe services programs with federal dollars, there was no money specifically earmarked. One year later, however, in December of 2011, Congress restored the ban, reversing 2009 decision.\(^{25}\)

Precipitated by the HIV outbreak in Indiana, along with sharp increases in rates of injection drug use across the country, Kentucky and West Virginia legislators championed the addition of language into an omnibus spending bill to revoke the ban. The bill was passed by Congress at the end of December 2015. The modified law is theoretically a partial repeal. Through the Consolidated Appropriations Act of 2016, states were given the ability to use federal dollars to finance syringe service program operations, including staffing, automobiles, gas, leases, and other

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\(^{22}\) Ibid.


\(^{25}\) Ibid.
operating expenses. The purchase of sterile needles and syringes is still prohibited, but funds may be used to support comprehensive services for PWID.  

**Perceived Risks of Needle-Syringe Exchange Programs**

Antagonists of needle and syringe exchange programs in the United States have primarily focused on three ideological and moral arguments for justifying prohibition. The first argument is that federal funding of needle and syringe exchange programs would signal governmental acceptance of illegal drug use, conflicting with law enforcement efforts. The second argument is that federal funding of needle and syringe exchange programs could encourage drug abuse and jeopardize public health and safety by facilitating IDU, increasing the circulation of contaminated needles, and increasing crime. The third argument is that federal approval of needle and syringe exchange programs could cause children to believe that drug use is acceptable. However, studies have shown these concerns to be largely unfounded.

The US government authorized several reports to evaluate outcomes of needle and syringe exchange programs. Key report authors were: 1) the National Commission on AIDS; 2) the U.S. General Accounting Office; 3) the Centers for Disease Control/University of California; and 4) the National Academy of Sciences. The reports reinforced the advantages of needle and syringe exchange programs and did not indicate any negative outcomes. The studies affirmed that when barriers such as criminalization laws regarding the purchase and possession of IDU equipment are eliminated, PWID are less likely to share needles. The reports further concluded that needle and syringe exchange programs do not increase drug use among program participants, nor do they lead to the recruitment of new drug users.  

As a potential threat to public safety, the concern of improper disposal of needles has been widely studied. This perspective assumes that PWID will not return needles to distribution sites, and will, therefore, potentially endanger the health of the surrounding community by exposing residents to contaminated needles. However, successful rates of return of used needles have been documented. In her meta-analysis, study author Kate Ksobiech reviewed needle return data from 8 studies, comprised of 26 articles. Ksobiech calculated an overall worldwide return rate of 90%, though there was great variability at individual sites. Return rates for U.S. needle and syringe exchange programs were comparable to those of international programs. One limitation noted in the study, however, is that researchers could not confirm where the needles originated, nor could they ascertain if people returned their own needles or those of their social network.  

Additionally, the World Health Organization has concluded that there is no evidence that needle and syringe programs negatively impact PWID, their communities, or society at large. “Studies have searched for and found no convincing evidence of the following unintended complications associated with needle and syringe exchange programs: greater injection frequency, increased illicit drug use, a rise in syringe lending to other IDUs, recruitment of new IDUs, social network

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26 Ibid.  
27 Ibid.  
formation, greater numbers of discarded used needles, less motivation to change, i.e. reduce, drug use and increased transition from non-injecting drug use to IDU.30

Needle and syringe exchange sites are not always accessible to people when they need them. As a result, some PWID collect and exchange high volumes of used needles and then sell the clean ones to their peers. This black market has been identified as an unintended consequence of needle and syringe exchange programs in some rural and scarcely resourced areas, and underscores the need for more substance abuse services and IDU resources in these communities.31 Little if any research has been conducted on the effects of black market needles on injection drug use and HIV transmission. Also of note, while needle and syringe exchange programs are found to be effective in reducing HIV transmission and injecting risk behaviors among PWID, evidence regarding their impact on reducing HCV infection has been inconclusive.32

**BENEFITS OF NEEDLE-SYRINGE EXCHANGE PROGRAMS**

The most notable benefit of needle and syringe exchange programs is that they lead to a reduction of morbidity and disease transmission, which translates to a reduction in associated health care costs. However, there are many other documented benefits. Needle and syringe exchange programs also promote public health and safety, connect PWID to substance abuse treatment programs, and provide an entry point into other health services, such as HIV and STD testing and care and treatment programs.33

- **Interruption of Disease transmission**

In their systematic review, Bramson, Des Jarlais et al found positive associations between publicly funded syringe exchange programs, low HIV incidence, low absolute numbers of new HIV diagnoses, and greater service provision. The study concluded that the distribution of large numbers of needles and syringes was causal, indicating that public funding of Syringe exchange programs leads to lower HIV incidence. When Syringe exchange programs and over the counter sales of syringes are consistently funded, they are impactful in reducing HIV transmission.34

- **Linkage to Care and Services**

Many SSPs link PWID to key services and programs, such as HIV care and treatment, pre-exposure prophylaxis (PrEP), and post-exposure prophylaxis (PEP) services; hepatitis C treatment, hepatitis A and B vaccinations; screening for STI’s and TB; partner services; prevention of mother-to-child HIV transmission; and other medical, social, and mental health services.35 Given the availability of

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35 “HIV and Injection Drug Use.”
new treatments that effectively cure HCV, linking PWID to HCV and HIV testing and referring those diagnosed to care and treatment may be the most significant services offered.36

However, access to substance abuse counseling and treatment is also an important component. Study results indicate that new SEP participants are five times more likely to enter a drug treatment program than nonparticipants. Findings also showed that PWID who participated in needle exchange were more likely than those who did not to reduce or stop injecting.37

- **Reduction in Health Care Costs**

International studies have concluded that harm reduction programs reduce health-related expenses by decreasing the number of emergency room visits, as well as the number of infected persons needing treatment and care. From 2000 to 2009, the Australian Centre in HIV Epidemiology and Clinical Research spent approximately $27 million annually on its NSP. During the same period, net cost savings of $1.28 billion were realized as a result of preventing new HCV and HIV infections. Similarly, analyses of Vancouver’s harm reduction and SIF revealed over $6 million in savings, due to prevention of overdose deaths and HIV infections in Vancouver. While these savings are due in part to the accessibility of sterile injecting equipment, a significant portion can be attributed to prevention of downstream emergency care costs.

When compared to non-drug users, chronic drug users, such as PWID, are more likely to seek inpatient and emergency care than non-drug users, and less likely to use outpatient/primary care services. PWID are prone to soft-tissue infections and other preventable IDU-related complications that lead them to utilize the emergency room for care. Data analyses of consecutive admissions of PWID to emergency care for late stage treatment of these conditions indicate that harm reduction methods, including skin-cleaning practices, effectively diminish preventable incidents and acute care expenses.38

- **Promotion of Public Health and Safety**

In communities where IDU is prevalent, residents are understandably concerned about unsafe disposal and circulation of potentially contaminated needles and syringes because inadvertent contact could lead to infection. Syringe exchange programs address this issue by removing used needles from circulation and educating their clients about safe disposal of used syringes. In fact, many Syringe exchange programs urge participants to return as many needles and syringes as possible. Consequently, most syringes issued by Syringe exchange programs are returned. In Baltimore, for example, evaluation of Syringe exchange programs confirmed that Syringe exchange programs contributed significantly in reducing the number of improperly discarded syringes by approximately 50 percent. Similarly, studies in Portland, Oregon, revealed a two-thirds reduction in the number of improperly discarded syringes after the implementation of a SEP, and in 2000, nearly 3.5 million syringes were returned in San Francisco.39

- **Protection of Law Enforcement Personnel from Needle Stick Injuries**

In the course of duty, police officers are in danger of needle stick injuries, placing them at risk of becoming infected with hepatitis B, hepatitis C and HIV. Risk factors include working evening shifts, performing pat-down searches, being on patrol duties, and being a less experienced officer. Findings from a study of police officers in San Diego revealed that nearly 30 percent had

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36 “Syringe Service Programs for Persons Who Inject Drugs in Urban, Suburban, and Rural Areas — United States, 2013.”

37 “Public Safety, Law Enforcement, and Syringe Exchange: Fact Sheet.”


39 “Public Safety, Law Enforcement, and Syringe Exchange: Fact Sheet.”
experienced a needle stick at some point, and more than 27 percent of those injured been stuck at least 2 times. By contrast, only 1 in 50,000 officers in the United States are killed by a firearm during the course of duty. Syringe exchange programs decrease the number of contaminated needles in circulation, which may in turn decrease law enforcement personnel’s risk of exposure to contaminated needles. In a study of Connecticut police officers, needle stick injuries declined by nearly two-thirds after implementing Syringe exchange programs.40

SAFE INJECTING FACILITIES

Safe injection facilities (SIF) are known by many names, including Safe(r) injection Sites (SIS), drug consumption facilities (DCF), Medically Supervised Injection Centers (MSIC), and Safer or Supervised Injection Facilities (SIF). They are part of a harm reduction approach to IDU. At these sites, users of illicit drugs have access to disinfecting agents and clean needles, as well as medical professionals. These legally sanctioned facilities provide a safe environment without the threat of arrest, and it provides them with access to professionals that can offer advice and refer them for rehabilitation services.41 SIFs are not “shooting galleries”, which are illegal injecting facilities run by drug dealers.42 SIFs are managed by medical professionals, such as nurses and social workers, and drug sales are prohibited.43

Government sanctioned SIFs came into operation in Europe in the mid-1980s; the first of these facilities was established in Switzerland in 1984. Other SIFs existed in the Netherlands prior to this era, but they were not government sanctioned. In Germany, government sanctioned SIFs came into operation in the early 1990s, but government funding and approval was not obtained until later in 2000. Australia was attempted to open three non-government sanctioned SIFs in the late 1990s; one facility was legally approved in 2001. Currently, the only government approved SIF in North America is located in Vancouver, Canada, and it was implemented in 2003.44

There are various models of SIFs, however, the core services are generally the same:

- Provision of sterile injecting equipment;
- Medical supervision of injections, including emergency response to drug overdoses;
- Injection-related first aid (such as wound and abscess care); and
- Assessment and referral to primary health care, drug treatment and social services.45

Despite demonstrated efficacy and the presence of these facilities in Europe, there is still apprehension in North America. There are nearly 100 SIFs in operation outside of the United States, yet none have been established within the U.S. However, King County in Seattle is attempting to open at least two public SIFs after a unanimous vote in January to endorse these sites by the county’s Board of Health. In September of 2016, a task force of heroin and opioid abuse

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40“Public Safety, Law Enforcement, and Syringe Exchange: Fact Sheet.”
42“A critical review of the effectiveness of safe injection facilities as a harm reduction strategy.”
44“A critical review of the effectiveness of safe injection facilities as a harm reduction strategy.”
experts recommended that the sites be opened in Seattle to reduce the surge of overdose deaths in recent years.\textsuperscript{46}

**ADVANTAGES OF SAFE INJECTING FACILITIES**

There are many benefits associated with this kind of intervention. These benefits include allowing PWID to inject in a clean environment without having to rush, allowing PWID to have access to medical staff that are able to respond to overdoses and prevent deaths, and easy access to clean IDU equipment. The success rate of reduction of overdose deaths in safe injecting facilities is very high. SIFs aid public health by controlling the spread of disease and improving the quality of life for PWID.\textsuperscript{47}

Additionally, SIFs lower the costs of public health and emergency room visits by providing PWID with supervision by medical professionals who can help reduce the risk of overdose. On average, an emergency ambulance costs $1,000 per trip, with additional costs if medical supplies are used. This expense is absorbed by taxpayers for the uninsured.\textsuperscript{48}

A systematic literature review performed via PubMed, ScienceDirect, and Web of Science databases found seventy five articles whose study results converged to find that SIFs were most effective in attracting marginalized PWID, providing access to primary health care, reducing the frequency of overdoses, and providing safer conditions for injection. There was no evidence indicating an increase in drug trafficking, drug use, nor crime in the areas surrounding the SIFs. There was a positive correlation between the presence of SIFs, reduced amounts of abandoned syringes, and reduced levels of public drug injections. The majority of the referenced articles originated in Vancouver and Sydney.\textsuperscript{49}

**OPPOSITION TO SAFE INJECTING FACILITIES**

Common objections to the establishment of facilities such as SIFs, SISs, DCRs, and other harm reduction programs include the fear that these facilities would attract more drug users to that area, encourage youths to use drugs, and increase drug use rates. Even though the evidence previously presented along with other evidence has not supported these beliefs, these views still have a large influence on the public’s beliefs about the effects of these facilities on their communities. The large amount of evidence thwarting this view indicates that objections to these programs often originate from speculation rather than concrete evidence. SISs have also been accused of fostering drug use and drug trafficking, though no substantial evidence has been found to support this claim.\textsuperscript{50}

**CONCLUSION**

There are approximately 3000 new HIV infections among PWID per year in the US. HIV, HCV, overdose, STIs, soft tissue infections, tuberculosis, and substance use disorders are among the many health problems facing PWID. Harm reduction interventions such as needle and syringe exchange programs, opioid substitution therapy, and SIFs have demonstrated potential to reduce morbidity,


\textsuperscript{50} “Alternatives to Public Injection.”; “Supervised injection services: what has been demonstrated? A systematic literature review.”
mortality and disparities among vulnerable individuals, decrease costs associated with injection drug use, and diminish harm sustained by PWID and their communities. However, public funding is necessary to provide effective, comprehensive services for this population. State and local funding is only possible in areas with favorable syringe exchange policies. Fully repealing the ban on the use of federal funds for harm reduction interventions would provide additional funding to programs and enhance overall impact. IDU has been an important factor of HIV transmission in the US. Public funding of NSP is strongly associated with both reducing HIV transmission among PWID in states that experienced high HIV incidence, and with maintaining low HIV in other states. Increased, consistent state and local public funding of syringe exchange and other harm reduction strategies, in addition to federal funding, would be a significant step forward.51

AOA POLICY

Given the research demonstrating the effectiveness of harm reduction strategies, such as syringe service programs and supervised injection facilities, in reducing HIV transmission, along with endorsements of the American Medical Association (AMA) (H-95.958),52 World Health Organization (WHO), U.S Centers for Disease Control and Prevention (CDC), and the Institute of Medicine (IOM), the AOA adopts the following policy statements as its official position on the use of harm reduction strategies to combat the consequences of injection drug use:

1. The American Osteopathic Association (AOA) supports harm reduction strategies, such as syringe service programs and supervised injection facilities, particularly when they include comprehensive services, such as substance abuse and mental health counseling and treatment.

2. The American Osteopathic Association (AOA) shall advocate for the increased availability of harm reduction modalities including safe injecting facilities and supervised injection facilities at the local, state, and federal level.

3. The American Osteopathic Association (AOA) strongly encourages state medical associations to initiate state legislation that decriminalizes drug paraphernalia possession and procurement so that injection drug users can obtain needles and syringes without a prescription and needle exchange program employees are protected from prosecution for disseminating syringes.

4. The American Osteopathic Association (AOA) is in favor of complete repeal of the ban on federal funding for syringe exchange programs.

5. The American Osteopathic Association (AOA) is in favor of syringe service programs and encourages physicians to provide patients with education on such programs.

References


http://www.drugpolicy.org/supervised-injection-facilities


RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be REAFFIRMED as AMENDED:

H405-A/11  MEDICATION FOR INDIGENT PATIENTS

The American Osteopathic Association supports those pharmaceutical companies that donate near-expired maintenance medication to volunteer distribution centers. THE DONATION OF NON-EXPIRED MEDICATIONS for distribution to indigent patients on the basis of financial need. 2001; revised 2006; reaffirmed 2011

ACTION TAKEN  APPROVED (as amended)

DATE  July 22, 2017
Mr. Speaker, I present for consideration Resolution No. H-500, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

**Line 4 of Resolution No. H-500**
**Page 1 - Line 6 of Resolution No. H-500**
their professional lives. The standards presented are designed to address the OSTEOPATHIC AND ALLOPATHIC osteopathic physician's

**Explanatory Statement:** The editorial change is intended to clarify that the Code of Ethics is being amended to be applicable to osteopathic and allopathic physicians. Because this is the American Osteopathic Association, it is important to retain the word “osteopathic” in the AOA’s Code of Ethics.

And I so move. APPROVED

**H-501 AMENDMENTS TO THE AMERICAN OSTEOPATHIC ASSOCIATION INTERPRETS SECTIONS OF CODE OF ETHICS**

Mr. Speaker, I present for consideration Resolution No. H-501, and the Committee recommends that it be REFERRED back to the Committee on AOA Governance & Organizational Structure and its Subcommittee on Constitution & Bylaws to: (1) change references from “osteopathic physicians” to “osteopathic and allopathic physicians”; (2) change references to specialty board certification in the Guide to Interpretation of Section 8 from “Physicians who are not certified by the AOA” and “Physicians who are certified by the AOA” to “Physicians who are not certified by the AOA OR ABMS”; and (3) review of the language in Part V of the Guide to Section 8, parts 4 and 5.

**Explanatory Statement:** Substantive changes to the proposed amendment to the Guides to Interpretation of the Code of Ethics and other sections of the Guides to Interpretation are required.

And I so move. APPROVED *(for Referral to CAGOS – C&B Subcommittee)*
H-502 AMENDMENT TO THE AMERICAN OSTEOPATHIC ASSOCIATION CONSTITUTION & BYLAWS TO ALLOW FOR NATIONAL HEALTH CARE ASSOCIATION REPRESENTATION

Mr. Speaker, I present for consideration Resolution No. H-502, and the Committee recommends that it be REFERRED back to the Committee on AOA Governance & Organizational Structure for review of the proposed change with respect to: (1) defining “National Health Care Association”; (2) clarifying whether the amendment is intended to allow for representation of a “National Health Care Association” (as described in the proposed amendment to the AOA Constitution) or a “National Health Care Association for Physicians” (as described in the proposed amendments to the AOA Bylaws); and (3) providing an opportunity for the House of Delegates to approve the organization (just as the House of Delegates has authority to approve recognition of an affiliated organization in Article I, Section 3 of the AOA Bylaws).

Explanatory Statement: Substantive changes to the proposed amendments to the AOA Constitution and Bylaws are required.

And I so move. APPROVED (for Referral to CAGOS)

H-503 AMENDMENT TO THE AMERICAN OSTEOPATHIC ASSOCIATION CONSTITUTION & BYLAWS TO ALLOW FOR REGULAR MEMBERSHIP OF MEDICAL DOCTORS

Mr. Speaker, I present for consideration Resolution No. H-503, and the Committee recommends that it be REFERRED back to the Committee on AOA Governance & Organizational Structure for review of the proposed change with respect to: (1) clarifying the mechanism and criteria for developing the official list of international medical schools recognized by the AOA as described in the proposed amendment to Article II, Section 2 of the AOA Bylaws; and (2) changing references from “osteopathic physicians” to “osteopathic and allopathic physicians.”

Explanatory Statement: Substantive changes to the proposed amendments to the AOA Constitution and Bylaws are required. The additional time will also allow the AOA time to investigate and consider the impact of these proposed changes to the AOA’s Constitution and Bylaws. The Committee also suggests that the title for this Resolution be changed as follows:

AMENDMENT TO THE AMERICAN OSTEOPATHIC ASSOCIATION CONSTITUTION & BYLAWS TO ALLOW FOR REGULAR MEMBERSHIP OF MEDICAL DOCTORS ALLOPATHIC PHYSICIANS TO BE REGULAR MEMBERS

And I so move. APPROVED (for Referral to CAGOS)
H-504  STUDENT DELEGATES

Mr. Speaker, I present for consideration Resolution No. H-504, a proposed amendment to Article VI of the AOA Constitution, which is being presented to the House of Delegates for a first reading, and a proposed amendment to Article V of the AOA Bylaws:

Article VI - House of Delegates
Section 1 - Composition
A. OSTEOPATHIC MEDICAL Student Council Representation in Divisional Societies
STATE DIVISIONAL societies shall be awarded one additional delegate as an OSTEOPATHIC student council representative, for each college of osteopathic medicine accredited by this Association and located in the state represented by that divisional society. Such student delegateS SHALL to be elected according to the Bylaws of the American Osteopathic Association and THE STATE DIVISIONAL SOCIETY.

Mr. Speaker, the Committee recommends that the proposed amendments be REFERRED to the Committee on AOA Governance & Organizational Structure for review and comment.

Explanatory Statement: The Committee on AOA Governance & Organizational Structure (CAGOS) has been charged by the Board of Trustees as part of Strategic Plan Phase II to review the current governance structure, including Bureaus/Councils/Committees, the Board of Trustees and the House of Delegates. Changes to the mechanism for student representation in the House of Delegates suggested in this proposed amendment should be considered by the CAGOS as part of its review process.

And I so move. APPROVED (for Referral to CAGOS)

H-505  AMENDMENT TO THE AMERICAN OSTEOPATHIC ASSOCIATION CONSTITUTION & BYLAWS – BUREAU OF EMERGING LEADERS AND NEW PHYSICIAN IN PRACTICE

Mr. Speaker, I present for consideration Resolution No. H-505, a proposed amendment to Article VIII, Section 1, part D of the AOA Constitution, which are being presented to the House of Delegates for a first reading, and a proposed amendment to Article V, Section 11 of the AOA Bylaws:

AOA Constitution
Article VIII – Board of Trustees and Executive Committee - Section 1 D
Page 3 - Lines 4-5
D. One intern/resident member elected by the house of delegate to serve for one year. Candidates for the intern/resident position shall be enrolled in an AOA-approved internship or residency or, if enrolled in an ACGME-approved residency shall have applied for an AOA approval of the ACGME-approved residency. Candidates for the intern/resident position shall be nominated by the council of interns and residents, BUREAU OF EMERGING LEADERS.
Mr. Speaker, the Committee recommends that the proposed amendments be REFERRED to the Bureau of Emerging Leaders.

Explanatory Statement: The current proposed bylaw amendment for Article V, Section 11 should be revised from “and THESE DELEGATES shall not also be members of a divisional society or specialty college delegation to the AOA’s House of Delegates” to “Individuals serving as an Emerging Leader delegate shall not concurrently serve as a delegate for any other group at the AOA House of Delegates.” Similarly, in Bylaws, Article V, Section 1, part b, the language should be revised from “No specialty college delegate or alternate shall also be a member of the divisional society's delegation to the AOA's House of Delegates” to “No specialty college delegate or alternate shall concurrently serve as a delegate for a divisional society at the AOA’s House of Delegates.” Consideration should also be given to changing the title of the section heading for Article V, Section 11 to: “Representation of Osteopathic AND ALLOPATHIC Physicians in Postdoctoral Training AND/OR NEW PHYSICIANS IN PRACTICE, at such time as the amendments proposed in H-503 to allow for regular membership status of allopathic physicians is approved.

And I so move. APPROVED (for Referral to BEL)

Mr. Speaker, this concludes the Committee’s report. I would like to thank the members of the Committee.

Committee Members:

1. Linda Delo, DO – CHAIR
2. Valerie DeLuca, DO – VICE CHAIR
3. Andrew Adair, DO
4. Gene M. Battistella, DO
5. David Bollard, DO
6. Paul Emmans, DO
7. Mike Jaczko, DO
8. Susan Moore-Riesbeck, DO
9. Elizabeth Palmarozzi, DO
10. David Park, DO
11. Steven Sherman DO
12. John F. Uslick, DO

STAFF
Josh Prober, JD
RESOLVED, that the AOA House of Delegates approve the following amendment to the AOA Code of Ethics:

Page 1 - Line 6:
their professional lives. The standards presented are designed to address the osteopathic OSTEOPATHIC AND ALLOPATHIC physician's

Page 2 - Lines 3-5:
licensure to practice the healing arts unless SHE/he is actually licensed on the basis of that degree in the state in which she/he practices. A physician shall designate her/his osteopathic OR ALLOPATHIC CREDENTIALS school of practice in all professional uses of her/his name.

Reference Committee Explanatory Statement:
The editorial change is intended to clarify that the Code of Ethics is being amended to be applicable to osteopathic and allopathic physicians. Because this is the American Osteopathic Association, it is important to retain the word “osteopathic” in the AOA’s Code of Ethics.

ACTION TAKEN  APPROVED as AMENDED

DATE  July 22, 2017

______________
The American Osteopathic Association has formulated this Code to guide its member physicians in their professional lives. The standards presented are designed to address the osteopathic physician's ethical and professional responsibilities to patients, to society, to the AOA, to others involved in healthcare and to self.

Further, the American Osteopathic Association has adopted the position that physicians should play a major role in the development and instruction of medical ethics.

Section 1
The physician shall keep in confidence whatever she/he may learn about a patient in the discharge of professional duties. Information shall be divulged by the physician when required by law or when authorized by the patient.

Section 2
The physician shall give a candid account of the patient's condition to the patient or to those responsible for the patient's care.

Section 3
A physician-patient relationship must be founded on mutual trust, cooperation, and respect. The patient, therefore, must have complete freedom to choose her/his physician. The physician must have complete freedom to choose patients whom she/he will serve. However, the physician should not refuse to accept patients for reasons of discrimination, including, but not limited to, the patient's race, creed, color, sex, national origin sexual orientation, gender identity or handicap. In emergencies, a physician should make her/his services available.

Section 4
A physician is never justified in abandoning a patient. The physician shall give due notice to a patient or to those responsible for the patient's care when she/he withdraws from the case so that another physician may be engaged.

Section 5
A physician shall practice in accordance with the body of systematized and scientific knowledge related to the healing arts. A physician shall maintain competence in such systematized and scientific knowledge through study and clinical applications.

Section 6
The osteopathic medical profession has an obligation to society to maintain its high standards and, therefore, to continuously regulate itself. A substantial part of such regulation is due to the efforts and influence of the recognized local, state and national associations representing the osteopathic medical profession. A physician should maintain membership in and actively support such associations and abide by their rules and regulations.

Section 7
Under the law a physician may advertise, but no physician shall advertise or solicit patients directly or indirectly through the use of matters or activities which are false or misleading.
Section 8
A physician shall not hold forth or indicate possession of any degree recognized as the basis for licensure to practice the healing arts unless she/he is actually licensed on the basis of that degree in the state in which she/he practices. A physician shall designate her/his osteopathic OR ALLOPATHIC CREDENTIALS school of practice in all professional uses of her/his name. Indications of specialty practice, membership in professional societies, and related matters shall be governed by rules promulgated by the American Osteopathic Association.

Section 9
A physician should not hesitate to seek consultation whenever she/he believes it advisable for the care of the patient.

Section 10
In any dispute between or among physicians involving ethical or organizational matters, the matter in controversy should first be referred to the appropriate arbitrating bodies of the profession.

Section 11
In any dispute between or among physicians regarding the diagnosis and treatment of a patient, the attending physician has the responsibility for final decisions, consistent with any applicable hospital rules or regulations.

Section 12
Any fee charged by a physician shall compensate the physician for services actually rendered. There shall be no division of professional fees for referrals of patients.

Section 13
A physician shall respect the law. When necessary a physician shall attempt to help to formulate the law by all proper means in order to improve patient care and public health.

Section 14
In addition to adhering to the foregoing ethical standards, a physician shall recognize a responsibility to participate in community activities and services.

Section 15
It is considered sexual misconduct for a physician to have sexual contact with any current patient whom the physician has interviewed and/or upon whom a medical or surgical procedure has been performed.

Section 16
Sexual harassment by a physician is considered unethical. Sexual harassment is defined as physical or verbal intimation of a sexual nature involving a colleague or subordinate in the workplace or academic setting, when such conduct creates an unreasonable, intimidating, hostile or offensive workplace or academic setting.

Section 17
From time to time, industry may provide some AOA members with gifts as an inducement to use their products or services. Members who use these products and services as a result of these gifts, rather than simply for the betterment or their patients and the improvement of the care rendered in their practices, shall be considered to have acted in an unethical manner.
Section 18
A physician shall not intentionally misrepresent himself/herself or his/her research work in any way.

Section 19
When participating in research, a physician shall follow the current laws, regulations and standards of the United States or, if the research is conducted outside the United States, the laws, regulations and standards applicable to research in the nation where the research is conducted. This standard shall apply for physician involvement in research at any level and degree of responsibility, including, but not limited to, research, design, funding, participation either as examining and/or treating provider, supervision of other staff in their research, analysis of data and publication of results in any form for any purpose.
RESOLVED, that the AOA House of Delegates approve the following amendments to the American Osteopathic Association Interprets Sections of the Code of Ethics:

Interpretation of Section 3
Page 1 - Lines 10 - 11:
Therefore, the AOA interprets section 3 of its code of ethics to permit but not require an osteopathic physician to treat a patient when the physician reasonably believes the patient is

Interpretation of Section 7
Page 1 - Lines 20:
osteopathic physicians, the types of practices in which they engage, their office hours, place of their

Guide to Section 8 - Part I-Indications of Specialty Practice
Page 2 - Lines 1 and 10:
1. Osteopathic Physicians who are not certified by the AOA or who do not devote their
2. Osteopathic Physicians who are certified by the AOA or who devote themselves

Page 3 - Lines 2, 3, and 15:
Part IV-Degrees (other than DO OR MD)
It is strongly recommended that only the degree DO OR MD appear on professional stationery.

Part V-Telephone Directory Listings FOR OSTEOPATHIC PHYSICIANS

Interpretation of Section 17
Page 4 - Line 9
2. It is ethical and in the best interest of their patients for osteopathic physicians to meet

Explanatory Statement
Substantive changes to the proposed amendment to the Guides to Interpretation of the Code of Ethics and other sections of the Guides to Interpretation are required.

ACTION TAKEN REFERRED (to Subcommittee on Constitution & Bylaws)

DATE July 22, 2017
AOA INTERPRETS SECTIONS OF CODE OF ETHICS

Interpretation of Section 3
This section notes that a physician-patient relationship must be founded on mutual trust, cooperation and respect—a patient must have complete freedom to choose his or her physician, and a physician must have complete freedom to choose patients whom he or she will serve.

Section 3 does not address a patient's discriminating against a physician based on the physician's race, creed, color, sex, national origin, sexual orientation, gender identity or disability; and a patient may express a desire to not be treated by a particular physician or by a physician with certain characteristics.

Therefore, the AOA interprets section 3 of its code of ethics to permit but not require an osteopathic physician to treat a patient when the physician reasonably believes the patient is experiencing a life- or limb-threatening event, even though the patient may have previously expressed a desire to not be treated by a physician based on the physician's race, creed, color, sex, national origin, sexual orientation, gender identity or disability.

Interpretation of Section 7
This section is designed to discourage practices, which would lead to false, misleading or deceptive information being promulgated.

Section 7 does not prohibit advertising, so long as advertising is designed as making proper factual information available to the public. People seeking healthcare are entitled to know the names of osteopathic physicians, the types of practices in which they engage, their office hours, place of their offices, and other pertinent factual information. On the other hand, the public should be protected from subjective advertising material designed to solicit patients, which is essentially misleading. Such material would include attempts to obtain patients by influence or persuasion, employing statements that are self-laudatory and deceptive; the result of which is likely to lead a patient to a misinformed choice and unjustified expectations. (July 1985)
AOA Code of Ethics & Interpretation

Guide to Section 8

This guide applies to AOA members' professional (as opposed to organizational) stationery, office signs, 2 telephone directories, and to other listings referred to by the general public. (July 1985)

Part I-Indications of Specialty Practice

1. Osteopathic Physicians who are not certified by the AOA or who do not devote their time exclusively to a specialty should not indicate any area of practice specialization. They may designate the nature of their practice in one of the following ways: General Practice, General Practice of Osteopathic Medicine, and Surgery.

2. Osteopathic Physicians who are certified by the AOA or who devote themselves exclusively to a specialty may designate such specialty in one of the following ways: Practice Limited to Internal Medicine (or other practice area), or Internal Medicine.

The listing of terms in each of the two categories is illustrative and should act as a guideline.

Part II-Membership in Professional Organizations

The public has little or no knowledge of what membership in various professional organizations entails. Accordingly, use of the names or initials of such organizations tends to indicate unusual professional competence, which is usually not justified. Professional stationery should contain no indication whatever of membership in professional organizations or of any present or past office held in any professional organization.

Designation of membership in various professional organizations is permissible on organizational stationery (AOA, divisional and district society, practice organizations, etc.) provided the organizational stationery is not used in practice correspondence.

The above guidelines apply with respect to written signatures of physicians. For example, a physician should not use FACOI or other appropriate fellowship designation in signing a letter or other communications that will go to a patient. The physician may use such designation in correspondence with other physicians or third parties.

Part III-Osteopathic Identification

The following, in order of preference, are considered proper on practice stationery and office signs:

1. John Doe, DO
2. John Doe, Osteopathic Physician & Surgeon
3. John Doe, Doctor of Osteopathy

The following are not considered proper on practice stationery or office signs:

1. Dr. John Doe (this is considered improper even if the doctor signs his name John Doe, DO). The osteopathic identification should be printed.
2. Dr. John Doe, Specialist in Osteopathic Medicine. The term specialist should be avoided in this circumstance.
Part IV-Degrees (other than DO OR MD)

It is strongly recommended that only the degree DO OR MD appear on professional stationery. However, the following additional guides are offered: No undergraduate degree (BA, BS, etc.) should be used.

Graduate degrees (MA, MS, PhD, etc.) should not be used unless the degree recognizes work in a scientific field directly related to the healing arts. Therefore, advanced degrees in scientific fields such as public health, physiology, anatomy, and chemistry may be used but their use is not recommended.

Honorary degrees relating to scientific achievement in the healing arts or other achievements within the osteopathic profession (such as administrative excellence or educational achievement) may be used if the honorary nature of the degree is indicated by use after the degree of the abbreviation "Hon."

Law degrees may be used if the physician carries on medical-legal activities.

Part V-Telephone Directory Listings FOR OSTEOPATHIC PHYSICIANS

1. It is desirable for divisional societies to have an established program to implement these guidelines and, where necessary, to meet with representatives of the telephone companies in furtherance of that objective.

2. In classified directories, it is recommended that DOs be listed under the heading "Physicians and Surgeons-(DO)" and that there be a cross-reference to that heading from the heading "Physicians and Surgeons-Osteopathic." This letter heading is also acceptable as the main listing if it has long been the heading customarily used in the community.

3. In telephone directory listings of doctors, it is recommended that the doctor's name be followed by the abbreviation DO.

4. The abbreviation "Dr" is not recommended because it is misleading. "Dr" can refer to dentists, doctors of medicine, etc. "Phys" is also misleading because it can refer to MDs.

5. In telephone directories, no indication of certification or membership in any osteopathic professional organization should appear by initials or abbreviations, because such would generally be confusing.

6. In classified telephone directories it is not improper to indicate "Practice limited to" or simply to name the field of specialty.

Only specialties or practice interests recognized as such by the American Osteopathic Association should be indicated.

Only physicians who are certified in or who limit their practice exclusively to a specialty should list themselves in a particular field.
Interpretation of Section 17

Section 17 relates to the interaction of physicians with pharmaceutical companies.

1. Physicians’ responsibility is to provide appropriate care to patients. This includes determining the best pharmaceuticals to treat their condition. This requires that physicians educate themselves as to the available alternatives and their appropriateness so they can determine the most appropriate treatment for an individual patient. Appropriate sources of information may include journal articles, continuing medical education programs, and interactions with pharmaceutical representatives.

2. It is ethical and in the best interest of their patients for osteopathic physicians to meet with pharmaceutical companies and their representatives for the purpose of product education, such as, side effects, clinical effectiveness and ongoing pharmaceutical research.

3. Pharmaceutical companies may offer gifts to physicians from time to time. These gifts should be of limited value and the appropriate to patient care or the practice of medicine. Gifts unrelated to patient care are generally inappropriate. The use of a product or service based solely on the receipt of a gift shall be deemed unethical.

4. When a physician provides services to a pharmaceutical company, it is appropriate to receive compensation. However, it is important that compensation be in proportion to the services rendered. Compensation should not have the substance or appearance of a relationship to the physician’s use of the employer’s products in patient care.

Position Papers/Ethical Content

Position papers adopted by the AOA House of Delegates define official AOA policy. Many of the position papers further clarify issues with ethical content.

Specific areas and papers related to them are:

A. Responsibilities to the patient:
---Confidentiality of patient records
---Counseling female patients on reproductive issues
---Death: Right to die
---Physician treating minors without parental consent
---Patient confidentiality
---Patient's bill of rights
---Patient-physician relations

B. Responsibilities to society:
---Abused persons
---Ethical and sociological consideration for medical care
---Healthcare institutional responsibilities
---Impaired physician, assistance
---Medicare and Medicaid Abuse
---Medicare and Medicaid - ethical physician arrangements
---Substance abuse
C. Responsibilities to the AOA:
--Active institutional membership--AOHA
--Dual degrees
--Industry gifts to physicians
--Professional association by DOs

D. Responsibilities to others involved in healthcare:
--Acupuncture
--Osteopathic medicine in foreign countries

E. Responsibilities to self:
--Medicare-physician coverage
--Osteopathic Manipulative Treatment (OMT) programs
--Physician administered OMT

1. "Stationery" includes letterheads, billheads, professional cards, checks, prescription blanks and any other stationery products used in practice.

2. The guide applies to door signs, listings in building lobbies, and outside signs.

3. DOs with limited licenses may obtain rulings on permissible designations on requests addressed to the AOA Committee on Ethics.
RESOLVED, that the AOA House of Delegates approve the following amendments to the American Osteopathic Association Constitution & Bylaws to allow for national health care associations that represent physicians to send delegates to the AOA’s House of Delegates:

**AOA Constitution**

Article VI - House of Delegates - Section 1 - Composition
Page 2 - Lines 4-7

D. NATIONAL HEALTH CARE ASSOCIATIONS. EACH AOA RECOGNIZED NATIONAL HEALTH CARE ASSOCIATION SHALL BE REPRESENTED BY ONE DELEGATE TO BE SELECTED AS PROVIDED IN THE BYLAWS OF THE AMERICAN OSTEOPATHIC ASSOCIATION.

**AOA Bylaws**

Article I - Divisional, District and Affiliated Societies
Page 4 - Lines 26-35

SECTION 4-NATIONAL HEALTH CARE ASSOCIATIONS FOR PHYSICIANS
UPON APPLICATION FROM A NATIONAL HEALTH CARE ASSOCIATION THAT REPRESENTS THE INTERESTS OF PHYSICIANS FOR REPRESENTATION IN THE AOA HOUSE OF DELEGATES, THE BOARD OF TRUSTEES AND THE CHIEF EXECUTIVE OFFICER SHALL INVESTIGATE SUCH ORGANIZATION AND, UPON SATISFACTORY PROOF OF A GENERAL AGREEMENT IN POLICY WITH THOSE OF THIS ASSOCIATION, SHALL AUTHORIZE THE ISSUANCE OF CREDENTIALS FOR THAT NATIONAL HEALTH CARE ASSOCIATION TO BE REPRESENTED IN THE AOA’S HOUSE OF DELEGATES BY ONE DELEGATE AND ONE ALTERNATE DELEGATE.

Section 45-Amendments to Governing Documents

Article V - House of Delegates - Section 1 - Certification of Delegates and Alternates
Page 10 - Lines 12-25

C. NATIONAL HEALTH CARE ASSOCIATIONS FOR PHYSICIANS.
EACH AOA RECOGNIZED NATIONAL HEALTH CARE ASSOCIATION SHALL SELECT ONE DELEGATE AND AT LEAST ONE ALTERNATE TO THE AOA HOUSE OF DELEGATES IN A MANNER PRESCRIBED BY ITS ORGANIZATION’S GOVERNING BOARD, PROVIDED THAT SUCH DELEGATE AND ALTERNATE SHALL ALSO BE MEMBERS IN GOOD STANDING OF THE AOA. NO NATIONAL
HEALTH CARE ASSOCIATION DELEGATE OR ALTERNATE SHALL ALSO BE A MEMBER OF A DIVISIONAL SOCIETY'S OR SPECIALTY COLLEGE'S DELEGATION TO THE AOA'S HOUSE OF DELEGATES. THE SECRETARY OF EACH NATIONAL HEALTH CARE ASSOCIATION SHALL CERTIFY THE NAME OF ITS DELEGATE AND ALTERNATE TO THE CHIEF EXECUTIVE OFFICER OF THE AOA AT LEAST 30 DAYS PRIOR TO THE FIRST DAY OF THE ANNUAL MEETING OF THE AOA HOUSE OF DELEGATES. DELEGATES AND ALTERNATES MUST BE MEMBERS IN GOOD STANDING OF THE ASSOCIATION THEY REPRESENT.

Article V - House of Delegates - Section 3 - Committee on Credentials

Page 10 - Lines 42-46

society is entitled AND A LIST OF EACH SPECIALTY COLLEGE AND NATIONAL HEALTH CARE ASSOCIATION AUTHORIZED TO SEND DELEGATES TO THE AOA HOUSE. In case any organization has selected more than its legal representation, the Chief Executive Officer shall drop surplus names from the list, beginning at the bottom, and shall notify the divisional society of This action.

Article V - House of Delegates - Section 11 - Representation of Osteopathic Physicians In Postdoctoral Training

Page 12 - Lines 1-9

Section 11-Representation of Osteopathic Physicians In Postdoctoral Training

Osteopathic Physicians in postdoctoral training may be represented in the House of Delegates by two individuals who, at the time of the annual meeting, shall be enrolled in postdoctoral training programs. The two individuals and their alternates shall be selected by vote of the AOA's Council of Interns and Residents BUREAU OF EMERGING LEADERS. The delegates (and alternate delegates) selected by the Council of Interns and Residents BUREAU OF EMERGING LEADERS shall serve as the representatives of osteopathic physicians in postdoctoral training and shall not also be members of a divisional society or specialty college delegation to the AOA's House of Delegates. The chair of the Council of Interns and Residents BUREAU OF EMERGING LEADERS shall certify the name of its

Reference Committee Explanatory Statement:
Substantive changes to the proposed amendments to the AOA Constitution and Bylaws are required.

ACTION TAKEN REFERRED (to Committee on AOA Governance & Organizational Structure for)

DATE July 22, 2017
AMERICAN OSTEOPATHIC ASSOCIATION

CONSTITUTION & BYLAWS

CONSTITUTION

Article I - Name
The name of this Association shall be the American Osteopathic Association.

Article II - Objectives
The objectives of this Association shall be to promote the public health, to encourage scientific research, and to maintain and improve high standards of Osteopathic medical education.

Article III - Divisional Societies
This Association shall be a federation of divisional societies organized within state or foreign country boundaries, or within the uniformed services of the United States, which may be chartered by this Association as provided by the Bylaws, and all such organizations or divisions now a constituent part of the American Osteopathic Association are declared to be chartered as federated units of this Association.

Article IV - Affiliated Organizations
Affiliated organizations may be organized in conformity with the Bylaws of the Association.

Article V - Membership
The membership of this Association shall consist of Osteopathic physicians and of such others as have met the requirements prescribed by the Bylaws of the American Osteopathic Association.

Article VI - House of Delegates
The House of Delegates shall be the legislative body of the Association, shall exercise the delegated powers of the divisional societies in the affairs of this Association, and shall perform such other functions as are set forth in the Bylaws.

Section 1 - Composition
The House of Delegates shall consist of delegates elected by the divisional societies and other authorized units, the elected officers and trustees of the Association and of such other members as may be provided for in the Bylaws.

A. Divisional Societies and Uniformed Services Society
Four hundred seventy-three delegate positions shall be allocated among the divisional societies for each of the states and the District of Columbia and the affiliated organization that represents osteopathic physicians serving in the uniformed services as follows: each divisional society and the uniformed services affiliate shall be entitled to one delegate and one alternate delegate. The remaining delegate positions shall be allocated among divisional societies and the uniformed services affiliate based on the proportion of members of this association who are located in the state represented by that divisional society or, in the case of the uniformed services divisional society, the proportion of members of this association currently serving on active duty in the uniformed services of the United States. The allocation of additional delegates shall be recalculated each year.

B. Student Council Representation in Divisional Societies
Divisional societies shall be awarded one additional delegate as a student council representative for each college of osteopathic medicine accredited by this Association and located in the state represented by that divisional society, such
student delegate to be elected according to the Bylaws of the American Osteopathic Association.

C. **Specialty Affiliates** Each AOA recognized Specialty College shall be represented by one delegate to be selected as provided in the bylaws of the American Osteopathic Association.

D. **NATIONAL HEALTH CARE ASSOCIATIONS** EACH AOA RECOGNIZED NATIONAL HEALTH CARE ASSOCIATION SHALL BE REPRESENTED BY ONE DELEGATE TO BE SELECTED AS PROVIDED IN THE BYLAWS OF THE AMERICAN OSTEOPATHIC ASSOCIATION.

**Section 2-Presiding Officer**

The presiding officer of the House of Delegates shall be the Speaker and, in his absence or at his request, the Vice Speaker shall preside.

**Article VII – Officers**

**Section 1-Elected Officers**

The elected officers of this Association shall be the President, President-Elect, First Vice-President, Second Vice-President and Third Vice-President. The First Vice-President shall be a person who has had previous experience as a member of the Board of Trustees. The officers shall be elected annually by the House of Delegates for a term of one year, or until their successors are elected and installed. The President-Elect shall automatically succeed to the presidency upon his installation, during the annual meeting of the House of Delegates following his election to the office of President-Elect. In the case of the inability upon the part of the president to serve during the term of office for which he/she has been elected, and therefore the office becomes vacant, the President-Elect shall become president for the unexpired portion of the term and continue in that office for the term in which the President-Elect was originally elected. In such case, if the President-Elect is unable to serve for the full unexpired term of the president's office, then the responsibility of filling the office of President shall devolve upon the Board of Trustees.

**Section 2-Administrative Officers**

The administrative officers shall be Chief Executive Officer, a Controller, a General Counsel, and an Editor who shall be appointed by the Board of Trustees and employed to serve for such term as the Board shall define. The duties of these officers shall be those usual to such officers in their respective offices and such others as are set forth in the Bylaws. The Chief Executive Officer shall be the Secretary of the Association.

**Article VIII - Board of Trustees and Executive Committee**

**Section 1-Board of Trustees**

The Board of Trustees shall be the administrative and executive body of the association and perform such other duties as are provided by the bylaws. The Board of Trustees of this association shall consist of twenty-nine members.

A. Seven elected officers: The President, President-Elect, The Past Presidents for the preceding two years, First Vice-President, Second Vice-President, and Third Vice-President;

B. Eighteen at-large trustees, six of whom shall be elected annually by the house of delegates to serve for three years;

C. One new physician in practice member elected by the House of Delegates to serve for one year. Candidates for the new physician in practice position shall be osteopathic physicians
who have completed their postdoctoral training within the past five years or received the
DO degree within the previous ten years shall be nominated by the council of new
physicians in practice;

D. One intern/resident member elected by the house of delegate to serve for one year.
Candidates for the intern/resident position shall be enrolled in an AOA-approved internship
or residency or, if enrolled in an ACGME-approved residency shall have applied for an
AOA approval of the ACGME-Approved residency. Candidates for the intern/resident
position shall be nominated by the council of interns and residents.

E. One student member elected by the House of Delegates to serve for one year. Candidates
for the student position shall be nominated, in altering years, by the Council of Osteopathic
Student Government Presidents (COSGP) and the Student Osteopathic Medical Association
(SOMA); and

F. One public member elected by the House of Delegates to serve for a three-year term, with a
one-term limit. Candidates for the public member position shall not be physicians and shall
be nominated by the committee on administrative personnel.

Section 2-Executive Committee
The Executive Committee of this Association shall consist of the President, President-elect, Past
Presidents for the preceding two years, the chairs of the Departments of Affiliate Affairs, Business
Affairs, Governmental Affairs, Professional Affairs, Research, Quality and Public Health, and the
Chair and Vice-Chair of the Department of Educational Affairs.

Section 3-Term Limit
For all trustees, with the exception of the President, President-Elect and the Past Presidents for the
preceding two years, the aggregate terms of Office of Trustees shall be limited to twelve (12) years,
with the exception that a trustee may complete the term in which twelve (12) years or more of
service is completed. Time served as a student member, intern/resident member, or as new
physician in practice member shall not be included in calculating the twelve years of service.

Article IX - Amendments
This Constitution may be amended by the House of Delegates at any annual meeting by a two-thirds
vote of the total number of delegates accredited for voting, provided that such amendments shall have
been presented to the House and filed with the Chief Executive Officer at a previous annual meeting,
who shall cause them to be distributed by first class mail, postage prepaid, to each divisional and
specialty society entitled to and voting representatives to the house of delegates, posted on the AOA’s
website, and published in the Journal of the American Osteopathic Association not less than two months or
more than four months prior to the meeting at which they are to be acted upon.

Article X - Gender Disclaimer
The American Osteopathic Association is open to persons of both sexes and does not discriminate
against any persons because of sex; therefore, the wording herein importing the masculine or feminine
gender includes the other gender and imports no such discrimination.
BYLAWS

Article I - Divisional, District and Affiliated Societies
Section 1 - Divisional Societies
Any state, territorial, provincial or foreign osteopathic organization, or an organization of osteopathic physicians serving in the uniformed services of the United States, which may desire to become a divisional society of the American Osteopathic Association and be chartered as a divisional society of this Association, shall apply on a prescribed form, submit evidence that its constitution, Bylaws, and Code of Ethics generally conform to those of this Association, and maintain an organizational structure which shall generally conform to that of this Association.

Upon such application, the Chief Executive Officer and the Board of Trustees shall investigate and, finding satisfactory proof, shall recommend to the House of Delegates that a charter be issued. The Association shall not issue such a charter to more than one divisional society in a given area.

Section 2 - District Societies
Divisional societies may, within their own areas, organize district societies whose relationship to the divisional society shall in all respects conform to that existing between the division and this Association.

Section 3 - Affiliated Organizations
Upon application from any organization for a charter as an affiliated organization, the Board of Trustees and the Chief Executive Officer shall investigate such organization and, upon satisfactory proof of a general agreement in policy and governing rules with those of this Association, shall recommend to the House of Delegates the issuance of such a charter. The Association shall not issue a charter to any organization, which duplicates the function or prerogatives of any presently affiliated organization. All organizations which have as their membership osteopathic physicians in good standing with the AOA, whether holding a current charter of affiliation or not, shall have as a medium of communication all publications of the AOA.

SECTION 4 - NATIONAL HEALTH CARE ASSOCIATIONS FOR PHYSICIANS
UPON APPLICATION FROM A NATIONAL HEALTH CARE ASSOCIATION THAT REPRESENTS THE INTERESTS OF PHYSICIANS FOR REPRESENTATION IN THE AOA HOUSE OF DELEGATES, THE BOARD OF TRUSTEES AND THE CHIEF EXECUTIVE OFFICER SHALL INVESTIGATE SUCH ORGANIZATION AND, UPON SATISFACTORY PROOF OF A GENERAL AGREEMENT IN POLICY WITH THOSE OF THIS ASSOCIATION, SHALL AUTHORIZE THE ISSUANCE OF CREDENTIALS FOR THAT NATIONAL HEALTH CARE ASSOCIATION TO BE REPRESENTED IN THE AOA'S HOUSE OF DELEGATES BY ONE DELEGATE AND ONE ALTERNATE DELEGATE.

Section 45 - Amendments to Governing Documents
Any amendments to the Constitution, Bylaws, Code of Ethics, and other governing documents, by whatever name called, of such a divisional society or affiliated organization shall be submitted to the Board of Trustees of the American Osteopathic Association, who shall review such amendments to determine whether, with the proposed amendments, the Constitution, Bylaws, Code of Ethics, or other governing documents would continue to conform generally to those of this Association and, with respect to the divisional society only, whether the organizational structure would continue to conform generally to those of this Association. Until such proposed amendments are given written approval of the Board of Trustees of the American Osteopathic Association, the divisional society or affiliated organization shall continue to operate under its previously approved Constitution, Bylaws, or other governing documents.
Article II – Membership

Section 1-Classification
The members of this Association shall be classified as follows:

a. Regular Members
b. Honorary Life Members
c. Life Members
d. Associate Members
e. Student Members
f. Honorary Members
g. International Physician Members
h. Allied Members

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.

b. Honorary Life Member
Honorary life membership shall be conferred on each president upon conclusion of his term of office.

Such honorary life membership shall not exempt the holder thereof from the maintenance of regular membership in his divisional society or from assessments levied by this Association.

Honorary life membership may also be conferred by the Board of Trustees on a regular member who has been in good standing for 25 consecutive years immediately preceding, and who has rendered outstanding service to the profession at either the state or national level, or who is recommended for such a membership by official action of his divisional society and the Committee on Membership.

Such honorary life members shall have the privileges and duties of regular members including the payment of assessments levied by the Association, but shall not be required to pay dues.
c. **Life Member**

Life membership may be granted to any regular member who has reached the age of 70 years, or who has completed 50 years of osteopathic practice, whichever comes first, and who has been in good standing for 25 consecutive years immediately preceding. The Committee on Membership may waive this requirement on individual consideration. Such members shall have the privileges and duties of regular members, but shall not be required to pay dues or assessments beginning the year in which the age of 70 is attained.

Life membership may also be granted by the Board of Trustees or its Executive Committee on recommendation of his divisional society, to any regular member who has become permanently totally disabled. Such members shall have the privileges and duties of regular members, but shall not be required to pay dues or assessments.

d. **Associate Member**

By specific action of the Board of Trustees, or its Executive Committee, associate memberships may be granted to the following:

Graduates of accredited schools of medicine, dentistry or podiatry holding teaching, research or administrative positions in AOA accredited healthcare facilities and colleges or who practice jointly with regular members of this Association;

Doctors of philosophy or education and other nondoctoral personnel holding teaching, research or administrative positions in AOA accredited healthcare facilities or colleges; administrative employees of this Association, affiliated organizations and divisional societies; and any other professionals as determined by the Board of Trustees, excepting osteopathic physicians and students in colleges of osteopathic medicine.

Such associate members shall be required to pay dues and assessments as determined by these Bylaws. They shall receive a complimentary online subscription to the Association's publications and shall be eligible for such benefits as are periodically established by the Board of Trustees.

Associate members shall not be eligible for membership in the House of Delegates or the Board of Trustees, or to hold any elective offices of this Association. Special listing in the *AOA Yearbook and Directory of the Osteopathic Profession* shall be provided.

e. **Student Member**

Student membership status shall be granted to each undergraduate student in an approved college of osteopathic medicine.

At such time as a student member graduates from his osteopathic college, he shall automatically become enrolled as a regular member of the Association. Each student member shall receive such publications and other literature, except the *AOA Yearbook and Directory*, as may be directed by the Board of Trustees or the House of Delegates.

f. **Honorary Member**

By specific action of the Board of Trustees, honorary membership may be granted to individuals, not eligible for any other category of membership, who support the goals and objectives of this Association. Such honorary members shall not be required to pay dues or assessments. They shall receive complimentary copies of the Association's publications and such other services as authorized by the Board of Trustees. Honorary members shall not be eligible for membership in the House of Delegates or the Board of Trustees, or hold any elective offices of this Association. Special listing in the *AOA Yearbook and Directory* shall be provided.
Such membership, when conferred, shall remain in full force and effect unless revoked by action of the Board of Trustees of the American Osteopathic Association.

g. **International Physician Members**

By specific action of the Board of Trustees, or its Executive Committee, international membership may be granted to the following allopathic physicians who are:

- Graduates of schools of medicine located outside of the United States on an official list of schools recognized by the AOA, and holding a license for unlimited scope of medical practice including the authority to prescribe without limitation in their country of practice, and these allopathic physicians reside and practice outside of the United States and who support the goals and objectives of the AOA and the AOA Code of Ethics.

Such International Physician Members will be required to pay dues and assessments as determined by these Bylaws. They shall receive a complimentary subscription to the Association’s publications and shall be eligible for such benefits as are periodically established by the Board of Trustees.

International Physician Members shall not be eligible for membership in the House of Delegates or the Board of Trustees, or to hold any elective offices of this Association. Special listing in the *AOA Yearbook and Directory* shall be provided.

h. **Allied Member**

By specific action of the Committee on Membership, allied membership may be granted to those licensed allied healthcare providers who are currently employed, with an active member of the AOA, contribute to the practice of that member, are not eligible for any other category of membership and who support the goals and objectives of this Association.

Such allied members shall be required to pay dues and assessments as determined by these Bylaws. They shall be eligible for such benefits as may periodically be determined by the Board of Trustees.

Allied members shall not be eligible for membership in the House of Delegates or the Board of Trustees, or to hold any elective offices of this Association. Special listing in the *AOA Yearbook and Directory* will be provided.

By specific action of the Committee on Membership, allied membership may be granted to allopathic physicians holding an MD degree and licensed to practice in the United States who support the AOA mission and subscribe to its Code of Ethics.

Individuals who have received their training and/or degree in osteopathic medicine from a school that is not accredited by the AOA Bureau of Professional Education are not eligible for membership in the AOA.

**Section 3-Disciplinary Action**

The membership of any member of the Association who, in the opinion of the Executive Committee of the Association, purposely and persistently violates the established policy of the Association or who seeks to undermine the unity of the osteopathic profession or of any of its divisional societies or affiliated organizations may be revoked, suspended, or placed on probation by action of the Executive Committee of the Association upon the recommendation of the Committee on Membership, after the member has been given notice and an opportunity to be heard before such action is taken. Any individual whose membership has been so revoked, suspended, or placed on probation shall have the right of appeal to the Board of Trustees of the AOA at its next regular meeting, requesting a review of the action of the Executive Committee, and the Board of Trustees, on review, may in its discretion take such action in regard thereto as it deems appropriate.
Section 4 - Continuing Medical Education
Regular members shall be required to satisfy Continuing Medical Education (CME) requirements. The CME requirements shall be determined and administered by the Board of Trustees. Members who do not meet the CME requirement are subject to such disciplinary action as is determined to be appropriate by the Board of Trustees, including revocation of membership, suspension, censure or probation.

Article III - Dues and Assessments

Section 1 - Payment of Dues
The annual dues of regular members of the Association shall be payable in advance on or before June, the beginning of the fiscal year.

A member whose dues shall remain unpaid for three months shall become suspended. He may be reinstated upon payment of dues and assessments provided such payments are received prior to the end of the current fiscal year, or, if later, by applying as a new member.

Section 2 - Dues Rates

a. Members
The annual dues of all members of the Association (except for allied members discussed in section 2c and student members discussed in section 2d, below) shall be determined by the House of Delegates and administered by the Board of Trustees.

b. Hardship Cases
Upon recommendation of the Committee on Membership, the Board of Trustees, or its Executive Committee, may remit a part or all of the annual dues of a member in good standing who, because of physical disability, maintain a limited practice or no practice. For just cause, properly authenticated, similar action may be taken by the Board of Trustees, or its Executive Committee, in regard to regular members not otherwise specifically covered by other provisions of this Article.

c. Allied Members
The annual dues rates for allied members shall be determined and administered by the Board of Trustees.

d. Student Rate
Student members shall not be liable for dues or any assessment.

e. International Physician Members
The annual dues rates for International Physician Members shall be determined and administered by the Board of Trustees.

Section 3 - Assessments
To meet emergencies the Board of Trustees may levy such assessments as may be necessary, provided that the total of such assessments in any one-year shall not exceed the amount of the annual dues. Failure to pay such assessments shall incur the same penalty as failure to pay dues. Those dropped from membership for nonpayment of dues during the fiscal year in which an assessment is levied shall be required to pay the assessment prior to reapplying for membership.

Section 4 - Refunding Dues
No dues will be refunded if a membership is terminated for cause or because of resignation.
Article IV - Code of Ethics

Section 1
The House of Delegates shall establish a Code of Ethics for the information and guidance of the members. Members of the Association, in their daily conduct, shall comply with the provisions of the Code of Ethics. The Code shall cover duties of physicians to patients, duties of physicians to other physicians and to the profession at large, and responsibilities of physicians to the public. The House of Delegates shall not adopt any provisions of the Code of Ethics, which may be in conflict with the Constitution or Bylaws of the Association.

Section 2
The Code of Ethics may be amended by the House of Delegates at any annual meeting by two-thirds vote of the total number of delegates accredited for voting, provided a copy of the proposed amendment is deposited with the Chief Executive Officer at least 90 days before the annual meeting at which it is to be voted upon.

It shall be the duty of the Chief Executive Officer to have the proposed amendment distributed by first class mail, postage prepaid, to each divisional and specialty society entitled to send voting representatives to the House of Delegates, posted on the AOA’s website, and published in *The Journal of the American Osteopathic Association* not later than one month before the annual meeting at which the amendment is scheduled for consideration.

The American Osteopathic Association has formulated this Code to guide its member physicians in their professional lives. The standards presented are designed to address the osteopathic physician’s ethical and professional responsibilities to patients, to society, to the AOA, to others involved in healthcare and to self.

Further, the American Osteopathic Association has adopted the position that physicians should play a major role in the development and instruction of medical ethics.

Article V - House of Delegates

Section 1-Certification of Delegates and Alternates

a. Divisional Societies
The Chief Executive Officer of this Association shall furnish to the secretary of each divisional society, 75 days before the first day of the annual meeting of the House of Delegates, a statement of the number of regular members of this Association located in the area represented by that divisional society or, in the case of the uniformed services divisional society, the number of regular members of this Association currently serving in the uniformed services of the United States.

Based on that statement, each divisional society shall select, in a manner prescribed by its Constitution and Bylaws, the number of delegates (and their alternates) to the House of Delegates of this Association to which it is entitled under the provisions of the Constitution of the American Osteopathic Association. Delegates and alternates must be regular or student members in good standing of this Association and of the divisional societies, which they represent. Delegates (and their alternates) shall serve during the annual meeting of the House of Delegates and during the interim between annual meetings or until their successors are elected. The secretary of each divisional society shall certify its delegates and alternates to the Chief Executive Officer of this Association in writing at least 30 days prior to the first day of the annual meeting of the House of Delegates.

In the event that any state, provincial or foreign osteopathic association does not become a
chartered divisional society, the regular members of this Association in that jurisdiction, at a
regularly called meeting, may elect or appoint one delegate (and alternate) as their representative in
the House, and such delegate (and alternate) shall be accredited in the same manner and have the
same privileges as those of a divisional society.

b. Specialty Colleges
Each AOA recognized specialty college shall select one delegate and at least one alternate to the AOA
House of Delegates in a manner prescribed in its constitution and Bylaws. No specialty college delegate
or alternate shall also be a member of the divisional society's delegation to the AOA's House of
Delegates. The Secretary of each specialty college shall certify the name of its delegate and alternate to
the Chief Executive Officer of the AOA at least 30 days prior to the first day of the annual meeting of
the AOA House of Delegates. Each delegate and alternate must be a member in good standing of this
association and his specialty college.

C. National Health Care Associations for Physicians.
Each AOA recognized national health care association shall select one delegate and at least one alternate to the AOA
House of Delegates in a manner prescribed by its organization's governing board, provided that such delegate and alternate shall also be
members in good standing of the AOA. No national health care association delegate or alternate shall also be a member of a
divisional society's or specialty college's delegation to the AOA's House of Delegates. The Secretary of each national health care
association shall certify the name of its delegate and alternate to the Chief Executive Officer of the AOA at least 30 days prior to the
first day of the annual meeting of the AOA House of Delegates. Delegates and alternates must be members in good standing of the
association they represent.

Section 2-Voting
Each delegate shall have one vote in the House, except when one-fourth of the members present shall
call for the yeas and nays on any question; the Chief Executive Officer shall, before any other motion
can be made, call the roll by divisional societies and enter the yeas and nays in the record. In recording
such vote each divisional society shall be given one vote for each 20 regular members of the American
Osteopathic Association located in the area represented by that divisional society (or in the case of the
uniformed services divisional society, one vote for each 20 regular members of the American
Osteopathic Association currently serving in the uniformed services of the United States), as certified
to 75 days before the annual meeting of the House of Delegates under the requirements of Section 1
of this Article, and such votes may be cast by any one of the delegation then seated or divided among
the various members of the delegation as the delegation in caucus shall decide.

Section 3-Committee on Credentials
The Committee on Credentials shall consist of three or more members appointed by the President and
it shall be the duty of the Committee to receive and validate the credentials of the delegates to the
House and to report all delegates entitled to be seated in the House. The Chief Executive Officer shall
furnish the Credentials Committee a list showing the number of delegates to which each divisional
society is entitled AND A LIST OF EACH SPECIALTY COLLEGE AND NATIONAL HEALTH
CARE ASSOCIATION AUTHORIZED TO SEND DELEGATES TO THE AOA HOUSE. In
case any organization has selected more than its legal representation, the Chief Executive Officer shall
drop surplus names from the list, beginning at the bottom, and shall notify the divisional society of
This action.

Section 4-Seating of Delegates
A delegate having been seated shall remain the accredited delegate throughout the meeting. In the event that an accredited delegate has failed to qualify and assume his seat when the House convenes on the second day of the meeting, his accredited alternate may be seated. If a delegate, having been seated, finds himself unable to be present on account of physical disability or other cause acceptable to the House, his alternate may be seated for that roll call period and shall continue as delegate until the previously seated delegate shall return for duty at a subsequent roll call. In that case the alternate delegate who has been seated may, by direction of the House, be dropped from the roll and the previously seated delegate shall return to his seat in the House.

Section 5-Annual Meeting
The annual meeting of the House of Delegates shall be held during June, July or August, and separate from the annual convention or clinical assembly of the Association, upon call of the President. Special sessions of the House of Delegates may be called by the President. The delegates shall be given at least two weeks notice and the object or objects shall be stated in the call of such special meeting.

Section 6-Presiding Officer
The Speaker of the House of Delegates shall be its presiding officer. The Vice Speaker shall preside over the House of Delegates in the absence of or at the request of the Speaker and assume all duties of the Speaker.

Section 7-New Business
No new business shall be introduced on the last day of the meeting of the House of Delegates except by a two-thirds consent of those members present, provided two-thirds of the seated delegates are in attendance.

Section 8-Quorum
One-half of the accredited delegates of the House shall constitute a quorum.

Section 9-Governing Rules
The meetings of the House of Delegates and of all other bodies of this Association shall be governed by Robert's Rules of Order Newly Revised, except in such instances as are specifically provided for in the Constitution and Bylaws of the Association or in the order of business which may be adopted from time to time. The order of business and any special rules adopted at the beginning of the meeting shall govern the procedure unless unanimously suspended.

Section 10-Representation of Student Councils
The student council of each accredited college of osteopathic medicine and each branch campus may be represented in the House of Delegates by its president (and such president’s alternate elected by such student council) as a member of the delegation of the divisional society representing the state in which such college of osteopathic medicine and branch campus is located. Each such student delegate shall be accredited in the same manner and have the same privileges as the other members of the divisional society delegation; however, the chief administrative officer of each accredited college of osteopathic medicine and each branch campus shall certify the student council president and alternate to the Chief Executive Officer of this Association in writing or by electronic communication at least 30 days prior to the first day of the annual meeting of the House of Delegates and such Chief Executive Officer shall forthwith similarly certify each student council president and alternate to the secretary of the appropriate divisional society.
Section 11—Representation of Osteopathic Physicians In Postdoctoral Training

Osteopathic Physicians in postdoctoral training may be represented in the House of Delegates by two individuals who, at the time of the annual meeting, shall be enrolled in postdoctoral training programs. The two individuals and their alternates shall be selected by vote of the AOA's Council of Interns and Residents BUREAU OF EMERGING LEADERS. The delegates (and alternate delegates) selected by the Council of Interns and Residents BUREAU OF EMERGING LEADERS shall serve as the representatives of osteopathic physicians in postdoctoral training and shall not also be members of a divisional society or specialty college delegation to the AOA's House of Delegates. The chair of the Council of Interns and Residents BUREAU OF EMERGING LEADERS shall certify the name of its delegates and alternate delegates to the Chief Executive Officer of the AOA in writing or by electronic communication at least 30 days prior to the first day of the annual meeting of the AOA House of Delegates. Each delegate and alternate must be a member in good standing of this Association.

Section 12—Representation of Student Osteopathic Medical Association

The Student Osteopathic Medical Association (SOMA) may be represented in the House of Delegates by one member of the SOMA Board selected by vote of the SOMA Board (or such SOMA member’s alternate, who shall also be a member of the SOMA Board selected by the SOMA Board). No SOMA delegate or alternate shall also be a member of a divisional society’s delegation representing the state in which such SOMA Board member's osteopathic college is located. The SOMA delegate shall be accredited in the same manner and have the same privileges as the other members of the divisional society delegation; however, the Chief Administrative Officer of SOMA shall certify the SOMA delegate and alternate to the Chief Executive Officer of this Association in writing or by electronic communication at least 30 days prior to the first day of the annual meeting of the House of Delegates.

Article VI—Elections

Section 1—Qualifications

Except where positions are designated as public members, membership in both the AOA and a divisional society shall be a requisite for qualification for any officer or for any member of any department, division, bureau or committee of the Association, however selected, if the incumbent shall be an osteopathic physician.

Section 2—Nominations

Nomination of all officers and trustees of this Association, and nomination of the Speaker and Vice Speaker of the House of Delegates, excepting nomination of those otherwise provided for in the Constitution, shall be a regular order of business in the House of Delegates at the annual meeting of the House. Nominations may be made from the floor immediately preceding the balloting. Nominating speeches shall not exceed two minutes.

Section 3—Method of Election

Election of such officers and trustees as are elected by the House of Delegates shall take place during the last day of the annual meeting. All elections shall be by ballot except as hereinafter provided in this section and a majority of all votes cast shall be necessary to elect. In recording such vote, each divisional society shall be given one vote for each 20 regular members of the American Osteopathic Association located in the area or serving in the uniformed services of the United States represented by that division, and such votes may be cast by any one of the delegation then seated or divided among the various members of the delegation as the delegation in caucus shall decide. If there shall be but one nominee for a given office or trusteeship it shall be the duty of the secretary to cast the elective ballot for that nominee. The Speaker and Vice Speaker of the House shall be elected to serve for one year or until their successors are elected and installed.
Section 4--Installation

The officers who have served throughout that meeting shall complete all business of the annual meeting so far as is practicable. The officers-elect shall be installed as the final order of business and shall assume the authority of their respective offices upon adjournment of the meeting.

Article VII--Board of Trustees

Section 1--Duties

The Board of Trustees shall:

a. Direct the management of the affairs of the Association between annual meetings. It shall meet coincident with the annual meeting of the House of Delegates and at other times on call of the President, shall make all arrangements for the annual meetings, shall appoint all standing and special committees not otherwise provided for in these Bylaws, and may fill by appointment any vacancy occurring in its own membership or any other elective office until the time of the next meeting of the House of Delegates. A quorum of the Board shall be a majority of the members thereof.

b. Appoint a Chief Executive Officer, a Controller, a General Counsel, and an Editor, and shall fix the amount of their salaries and the length of their terms of office. It shall fix the duties of the Chief Executive Officer, Controller, General Counsel, Editor and all other officials, committees, departments and bureaus necessary to the proper execution of the policies of the Association and not fixed by these Bylaws.

c. Have the responsibility of management of the finances of the Association and shall authorize and supervise, the House of Delegates concurring, all expenditures thereof. It shall appoint a certified public accountant to audit the financial records of the Association and certify to the accuracy of the statement of financial condition of the Association to be reported at the annual meetings.

No appropriation shall be made by the House of Delegates except upon recommendation of the Bureau of Finance approved by the Board of Trustees, and all resolutions, motions or otherwise, having for their purpose the appropriation of funds, shall first be referred without discussion to the Bureau of Finance of the Board of Trustees. An adverse ruling on such motions may be overruled by a three-fourths vote of the House of Delegates.

d. Provide for the publication of an official journal of the Association and such other publications as are deemed necessary or shall be directed by the House of Delegates.

e. Maintain and revise the Administrative Guide annually. The general purpose of this manual shall be to provide a handy reference book of concise statements of the duties of all officials, committees, departments, bureaus and employees of the Association, to the end that there shall be no conflict of jurisdiction or duplication of effort. Copies of such Guide shall be furnished to each divisional society and affiliated organization as well as officers of the American Osteopathic Association and other groups or individuals as directed by the Board of Trustees of the Association.

f. Establish such departments, committees, bureaus, councils, and commissions, and authorize the president’s creation of such task forces, as shall be necessary to further the policies of the Association and determined by the House of Delegates and shall determine the duties and powers of such departments, committees, bureaus, councils, commissions and task forces.

g. Approve from its own membership, based on the President’s appointment, the chairs of the
departments. The department chairs shall direct the activities of their respective
departments. However, the public member of the board shall not be eligible to serve as a
department chair. The Board shall also approve, based on the President’s appointment, the
members of the various committees, bureaus, councils, commissions and task forces under
the departments

h. Decide finally all questions of an ethical or judicial character. It shall haveinvestigated by the
Committee on Ethics all charges or complaints of violation of the Constitution, Bylaws, or of
grossly unprofessional conduct of any member. The Board shall have the power to censure,
place on probation for not exceeding a three-year period, suspend for not exceeding a three-
year period or expel a member, as the findings warrant. A member may be cited to appear
before it by the Board of Trustees or the Committee on Ethics to answer charges or
complaints of unethical or unprofessional conduct. Upon 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, his license to practice in a state on the grounds of having committed a
violation of a disciplinary provision of the licensing law by a duly constituted state licensing
agency, or the voluntary surrender of his license while under charges of having committed
said violation, such member shall automatically be deemed expelled from membership in this
Association; a conviction shall be deemed final for the purposes hereof when affirmed by an
appealable tribunal of final jurisdiction or upon expiration of the period allowed for appeal.
The Committee on Membership shall be granted the authority to restore to membership a
doctor whose license was revoked, and later retroactively reinstated by his licensing board.

If, because of a breach of the Code of Ethics, a member shall have been suspended, or
expelled from a divisional society or affiliated organization by proper action of such
divisional society or affiliated organization, the Board of Trustees of this Association shall
review the record of such decision. The decision may first be referred to the Committee on
Ethics for recommendations. If the Board shall concur in the action of the divisional society
or affiliated organization, such 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. The Board is authorized to adopt and amend from time to time, in
the manner directed by the Board, a Guide for Administrative Procedure regulating the
procedure applicable to matters involving violations of the Code of Ethics.

Section 2--Appeal
A minority of one-third or more members of the Board of Trustees present at any session may
appeal to the House of Delegates from the decision of the majority on any question at the current
meeting.

Section 3--Executive Committee
The Executive Committee shall transact the business of the Board of Trustees between meetings.

Section 4--By-Mail Vote
Between meetings of the Board of Trustees and of the Executive Committee, a by-mail vote, or vote
by other means of electronic communications, on any urgent matter may be taken of the members of
the Board of Trustees, or Executive Committee, if a consent in writing setting forth the action so
taken shall be signed by all of the trustees or members of the Executive Committee entitled to vote
with respect to the subject matter thereof, any such vote to be entered into the records at the next
meeting of the Board.

Section 5--Indemnification
Each trustee, officer, and employee of this Association now or hereafter in office and his heirs,
executors, and administrators, and each trustee, officer, and employee of this Association and his heirs, executors, and administrators who now acts, or shall hereafter act at the request of this Association as employee, trustee, director, or officer of another corporate entity controlled by this Association, shall be indemnified by this Association against all costs, expenses, judgments, fines, and amounts or liability therefore, including counsel fees, reasonably incurred by or imposed upon him in connection with or resulting from any action, suit, proceeding, or claim to which he may be made a party, or in which he may be or become involved by reason of his acts of omission or commission, or alleged acts of omission or commission as such trustee, officer, or employee, or, subject to the subsequent provisions of the section, any settlement thereof, whether or not he continues to be such trustee, officer, or employee at the time of incurring such costs, expenses, judgments, fines or amounts, provided that such indemnification shall not apply with respect to any matters as to which such trustee, officer, or employee shall be finally adjudged in such action, suit, or proceeding to have been individually guilty of misconduct, misfeasance, or malfeasance in the performance of his duty as such trustee, officer, or employee. The indemnification herein provided shall, with respect to any settlement of any such suit, action, proceeding, or claim, include reimbursement of any amounts paid and expenses reasonably incurred in settling any such suit, action, proceeding, or claim, when the Board of Trustees has determined that such settlement and reimbursement appear to be for the best interests of this Association. Such determination shall be made (1) by the Board of Trustees or by a majority vote of a quorum consisting of trustees who were not parties to such action, suit, or proceeding, or (2) if such a quorum is not obtainable (or, even if obtainable, a quorum of disinterested trustees so directs) by independent legal counsel in a written opinion. The foregoing right of indemnification shall be in addition to and not exclusive of any and all other rights as to which any such trustee, officer, or employee may be entitled under any bylaw, agreement, or otherwise.

Expenses incurred in defending a civil or criminal action, suit, or proceeding may be paid by the Association in advance of the final disposition of such action, suit, or proceeding as authorized by the Board of Trustees or Executive Committee in the manner heretofore provided, upon receipt of a written undertaking by or on behalf of the trustee, officer, or employee to repay such amount unless it shall ultimately be determined that he is entitled to be indemnified by the Association as authorized in this section.

The Board of Trustees may authorize the Association to purchase and maintain insurance on behalf of any person who is or was a trustee or employee of the Association or is or was serving at the request of the Association as a trustee, director, officer, employee, or agent of another corporate entity controlled by the Association against any liability asserted against him and incurred by him in any such capacity, or arising out of his status as such, whether or not the Association would have the authority or power to indemnify him against such liability under the provisions of this section.

Article VIII--Duties of Officers

Section 1--President

The President shall be the chairman of the Board of Trustees and of the Executive Committee and shall perform the duties usually pertaining to his office. He shall nominate, subject to approval by the Board of Trustees, all appointive officers, unless otherwise specified in the Bylaws and in accordance with the directives contained in the Administrative Guide or as established by the Board of Trustees or the House of Delegates.

Section 2--President-elect

The President-elect shall perform the duties of the office of the President in the absence of or at the request of the President.
Section 3--Vice-Presidents
The Vice-Presidents, in the order of their designation and in the absence or at the request of the President and President-elect, shall perform the duties of the office of the President.

Section 4--Speaker/Vice-Speaker of the House of Delegates
The Speaker or the Vice-Speaker of the House of Delegates shall perform such duties as custom and parliamentary usage require. The Speaker shall appoint reference committees of the House to perform functions for which they are created subject to the approval of the House. He shall have such other privileges and duties as may be assigned to him by the House of Delegates, which privileges and duties shall not be in conflict with the privileges and duties assigned by the Constitution and Bylaws to other officers of the Association. The Vice-Speaker of the House of Delegates shall assume the duties of the Speaker in his absence or at his request.

Section 5--Chief Executive Officer
The Chief Executive Officer shall:

a. Be the chief administrative officer of the Association and of the central office. He shall be the executive and recording secretary of the Association. He shall counsel with the other administrative officers and with the heads of departments in the central office to produce the greatest possible cooperation and efficiency in the conduct of the affairs of the Association under the President and the Board of Trustees. He shall cooperate with the chairmen of various agencies of the Association in the execution of the policies of the Association as outlined by the House of Delegates. It shall be his duty to coordinate the work performed by the various departments, bureaus, and committees of the Association.

b. Direct the joint activities of the Association and the divisional societies as provided by the Bylaws, and may select one or more of the trustees or like officers of the divisional societies, to assist him in this work in their respective areas.

c. Be responsible for the correspondence of the Association and shall keep accurate record of the proceedings of the House of Delegates and the Board of Trustees. d. Be responsible for the supervision of assistance to the divisional societies in all matters according to the policies laid down by the Association and for the supervision of the execution of plans of the Association with regard to colleges, affiliated organizations and campaigns.

d. Keep on file an accurate record of all transactions of his office, which shall at any time be subject to examination by the President or the Board of Trustees, shall make an annual report to the House of Delegates and Board, and shall perform such other duties as are prescribed by the Board not in conflict with the Constitution and Bylaws of this Association.

e. Be the statistical officer of the Association, and shall have charge of the archives, including legal, historical and scientific records of value to the Association.

f. Be authorized to provide such assistance as is necessary for the proper conduct of the central office, subject to the directives of the Board of Trustees, and at the expiration of his term shall deliver to his successor all property and papers pertaining to his office. He shall file bond with such surety company and in such amount as the Board of Trustees shall determine.

Section 6--Controller
The Controller shall:

a. Have charge of the funds and assets of the Association, cooperate with the Chief Executive Officer and Editor under the direction of the Board of Trustees, and disburse such funds only in the manner prescribed by the Board of Trustees.
b. Be responsible for the collection of dues and assessments as provided in these Bylaws; shall cooperate with like officers of the divisional societies and may delegate them to assist him in their respective societies.

c. Keep on file accurate records of the transactions of his office, which shall at all times be subject to examination by the Board of Trustees. He shall prepare reports quarterly for the Board of Trustees and annually for the House of Delegates and the Board, and at the expiration of his employment; he shall deliver to his successors or to the Board, or their assigned agent, all monies, records and other property of the Association subject to his jurisdiction. He shall perform such other duties as may be prescribed by the Board consistent with the Constitution and Bylaws of the Association.

d. Be provided with such assistance as is necessary to the proper conduct of his office, subject to the directives of the Board of Trustees through the Chief Executive Officer. He shall file bond with such surety company and in such sum as the Board of Trustees may determine.

Section 7--General Counsel
The General Counsel shall:

a. Be the chief legal officer of the Association, responsible for oversight and management of all legal services provided to the Association, its trustees, officers and staff to ensure protection of the Association’s legal rights and maintenance of its operations consistent with the limits established by law.

b. Provide legal advice and guidance to the trustees, officers, and staff, bureaus, councils, task forces, commissions and committees of the Association on the legal implications of matters relevant to the Association, including compliance with federal, state, and local laws and regulations applicable to a tax-exempt, not-for-profit membership organization and adherence to internal organizational policies and procedures.

c. Draft and review contracts and other legal documents, policies and procedures; research pertinent to legal issues; prepare written and oral opinions and position statements on issues identified by the Association’s trustees, officers, staff, bureaus, councils, task forces, commissions and committees;

d. Represent or coordinate the representation of the Association in judicial and administrative proceedings; and

c. Select and retain outside counsel, as required, to obtain legal opinions or to handle claims and litigation. Supervises legal work of other Association attorneys and outside counsel.

Section 8--Editor
The Editor shall:

a. Have the editorial direction, in accordance with the established policies of the Board of Trustees and House of Delegates, of The Journal of the American Osteopathic Association, other periodical publications of the Association and of the AOA Yearbook and Directory, under the general supervision of the Chief Executive Officer, and shall cooperate with all departments of the central office.

b. Be provided with such assistance as is necessary to the proper conduct of his office, subject to the directives of the Board of Trustees through the Chief Executive Officer.
Article IX—Departments, Bureaus, and Committees

The Board of Trustees and House of Delegates, consistent with the powers given to it by these Bylaws, shall establish and determine the duties of departments, bureaus, councils, commissions, committees, and task forces necessary to further the policies of the Association. The Association’s departments shall include the Departments of Affiliated Affairs, Business Affairs, Educational Affairs, Governmental Affairs, Professional Affairs, and Research, Quality & Public Health. The activities of all departments, bureaus and committees shall, so far as possible, be executed in close cooperation with the Chief Executive Officer. Upon the expiration of the terms of office of chairs and members of the departments, bureaus, or committees, all records of the same shall be delivered by the chairs to the Chief Executive Officer. All employed staff of departments, bureaus, and committees in the offices shall be under the jurisdiction of the Chief Executive Officer.

Article X—Conventions and Meetings

Whenever referred to in this Constitution and Bylaws, the words annual meeting shall refer to the annual meetings of the Board of Trustees or of the House of Delegates, respectively, and the words annual convention or clinical assembly shall refer to the annual clinical assembly of the Association.

Section 1—Annual Clinical Assembly

The annual clinical assembly shall be held at such time and place as may be determined by the Board of Trustees, provided, however, such action may be changed by the House of Delegates by a two-thirds vote of the total number of delegates accredited for voting.

Section 2—Annual Meetings

The annual meetings of the Board of Trustees shall be held at such time and place as may be determined by the Board of Trustees, provided, however, such action may be changed by the House of Delegates by a two-thirds vote of the total number of delegates accredited for voting.

Article XI—Amendments

Section 1—Bylaws

These Bylaws may be amended at any annual or special meeting of the House of Delegates by a two-thirds vote of the total number of delegates accredited for voting, provided that the amendment shall have been filed with the Chief Executive Officer at least two months before the meeting at which the amendment is to be voted upon. Upon receiving a copy of the amendment, it shall be the duty of the Chief Executive Officer to cause it to be distributed by first class mail, postage paid, to each divisional and specialty society entitled to send voting representatives to the House of Delegates, posted on the AOA’s website, and published in The Journal of the American Osteopathic Association at least one month before the meeting. The Board of Trustees may revise the proposed amendment if necessary to secure conformity to this Constitution and Bylaws and shall then refer it to the House for final action not later than the day prior to the end of the meeting.

Section 2—Articles of Incorporation

The Articles of Incorporation of this Association may be amended by the adoption of a resolution by the Board of Trustees setting forth the proposed amendment and directing that the amendment be submitted to a vote at a meeting of the House of Delegates, which may be either an annual or a special meeting. Written or printed notice setting forth the proposed amendment or a summary of the changes to be effected thereby shall be posted on the AOA’s website and delivered not less than five nor more than 40 days before the date of the meeting, either personally or by mail, by or at the direction of the President, or the Chief Executive Officer, or the officers or persons calling the meeting, to each delegate entitled to vote at such meeting.
Written or printed notice shall include the printing of the amendment in the electronic and/or printed issue of The Journal of the American Osteopathic Association published not less than five days or more than 40 days before the date of the meeting. The proposed amendment shall be adopted upon receiving at least two-thirds of the votes entitled to be cast by the total number of delegates accredited for voting.

**Article XII--Gender Disclaimer**

The American Osteopathic Association is open to persons of both sexes and does not discriminate against any person because of sex; therefore, the wording herein importing the masculine or feminine gender includes the other gender and imports no such discrimination.
RESOLVED, that the AOA House of Delegates approve the following amendments to the American Osteopathic Association Constitution & Bylaws to allow for Medical Doctors (MD) membership in the American Osteopathic Association as regular members:

**AOA Constitution**

Article V - Membership

The membership of this Association shall consist of Osteopathic physicians and of such others as have met WHO MEET the requirements prescribed by the Bylaws of the American Osteopathic

**AOA Bylaws**

Article II - Membership - Section 2 - Membership Requirements

An applicant for regular membership in this Association shall be a graduate of a college of osteopathic medicine approved by the American Osteopathic Association'S COMMISSION ON OSTEOPATHIC COLLEGE ACCREDITATION OR ALLOPATHIC MEDICAL SCHOOLS ACCREDITED BY THE LIAISON COMMITTEE ON MEDICAL EDUCATION OR GRADUATES OF SCHOOLS OF MEDICINE LOCATED OUTSIDE OF THE UNITED STATES ON AN OFFICIAL LIST OF SCHOOLS RECOGNIZED BY THE AOA, 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.

Reference Committee Explanatory Statement:

Substantive changes to the proposed amendments to the AOA Constitution and Bylaws are required. The additional time will also allow the AOA time to investigate and consider the impact of these proposed changes to the AOA’s Constitution and Bylaws. The Committee also suggests that the title for this Resolution be changed as follows:

AMENDMENT TO THE AMERICAN OSTEOPATHIC ASSOCIATION CONSTITUTION & BYLAWS TO ALLOW FOR REGULAR MEMBERSHIP OF MEDICAL DOCTORS ALLOPATHIC PHYSICIANS TO BE REGULAR MEMBERS
ACTION TAKEN  REFERRED (to Committee on AOA Governance & Organizational Structure for)

DATE  July 22, 2017
AMERICAN OSTEOPATHIC ASSOCIATION
CONSTITUTION & BYLAWS

CONSTITUTION

Article I - Name
The name of this Association shall be the American Osteopathic Association.

Article II - Objectives
The objectives of this Association shall be to promote the public health, to encourage scientific research, and to maintain and improve high standards of Osteopathic medical education.

Article III - Divisional Societies
This Association shall be a federation of divisional societies organized within state or foreign country boundaries, or within the uniformed services of the United States, which may be chartered by this Association as provided by the Bylaws, and all such organizations or divisions now a constituent part of the American Osteopathic Association are declared to be chartered as federated units of this Association.

Article IV - Affiliated Organizations
Affiliated organizations may be organized in conformity with the Bylaws of the Association.

Article V - Membership
The membership of this Association shall consist of Osteopathic physicians and of such others as have met the requirements prescribed by the Bylaws of the American Osteopathic Association.

Article VI - House of Delegates
The House of Delegates shall be the legislative body of the Association, shall exercise the delegated powers of the divisional societies in the affairs of this Association, and shall perform such other functions as are set forth in the Bylaws.

Section 1 - Composition
The House of Delegates shall consist of delegates elected by the divisional societies and other authorized units, the elected officers and trustees of the Association and of such other members as may be provided for in the Bylaws.

A. Divisional Societies and Uniformed Services Society
Four hundred seventy-three delegate positions shall be allocated among the divisional societies for each of the states and the District of Columbia and the affiliated organization that represents osteopathic physicians serving in the uniformed services as follows: each divisional society and the uniformed services affiliate shall be entitled to one delegate and one alternate delegate. The remaining delegate positions shall be allocated among divisional societies and the uniformed services affiliate based on the proportion of members of this association who are located in the state represented by that divisional society or, in the case of the uniformed services divisional society, the proportion of members of this association currently serving on active duty in the uniformed services of the United States. The
allocation of additional delegates shall be recalculated each year.

B. Student Council Representation in Divisional Societies. Divisional societies shall be awarded one additional delegate as a student council representative for each college of osteopathic medicine accredited by this Association and located in the state represented by that divisional society, such student delegate to be elected according to the Bylaws of the American Osteopathic Association.

C. Specialty Affiliates. Each AOA recognized Specialty College shall be represented by one delegate to be selected as provided in the bylaws of the American Osteopathic Association.

Section 2-Presiding Officer
The presiding officer of the House of Delegates shall be the Speaker and, in his absence or at his request, the Vice Speaker shall preside.

Article VII – Officers
Section 1-Elected Officers
The elected officers of this Association shall be the President, President-Elect, First Vice-President, Second Vice-President and Third Vice-President. The First Vice-President shall be a person who has had previous experience as a member of the Board of Trustees. The officers shall be elected annually by the House of Delegates for a term of one year, or until their successors are elected and installed. The President-Elect shall automatically succeed to the presidency upon his installation, during the annual meeting of the House of Delegates following his election to the office of President-Elect. In the case of the inability upon the part of the president to serve during the term of office for which he/she has been elected, and therefore the office becomes vacant, the President-Elect shall become president for the unexpired portion of the term and continue in that office for the term in which the President-Elect was originally elected. In such case, if the President-Elect is unable to serve for the full unexpired term of the president's office, then the responsibility of filling the office of President shall devolve upon the Board of Trustees.

Section 2-Administrative Officers
The administrative officers shall be Chief Executive Officer, a Controller, a General Counsel, and an Editor who shall be appointed by the Board of Trustees and employed to serve for such term as the Board shall define. The duties of these officers shall be those usual to such officers in their respective offices and such others as are set forth in the Bylaws. The Chief Executive Officer shall be the Secretary of the Association.

Article VIII - Board of Trustees and Executive Committee
Section 1-Board of Trustees
The Board of Trustees shall be the administrative and executive body of the association and perform such other duties as are provided by the bylaws. The Board of Trustees of this association shall consist of twenty-nine members.

A. Seven elected officers: The President, President-Elect, The Past Presidents for the preceding two years, First Vice-President, Second Vice-President, and Third Vice-President;

B. Eighteen at-large trustees, six of whom shall be elected annually by the house of delegates to serve for three years;

C. One new physician in practice member elected by the House of Delegates to serve for
one year. Candidates for the new physician in practice position shall be osteopathic
physicians who have completed their postdoctoral training within the past five years or
received the DO degree within the previous ten years shall be nominated by the council
of new physicians in practice;

D. One intern/resident member elected by the house of delegate to serve for one year.
Candidates for the intern/resident position shall be enrolled in an AOA-approved
internship or residency or, if enrolled in an ACGME-approved residency shall have
applied for an AOA approval of the ACGME-Approved residency. Candidates for the
intern/resident position shall be nominated by the council of interns and residents.

E. One student member elected by the House of Delegates to serve for one year. Candidates
for the student position shall be nominated, in altering years, by the Council of
Osteopathic Student Government Presidents (COSGP) and the Student Osteopathic
Medical Association (SOMA); and

F. One public member elected by the House of Delegates to serve for a three-year term,
with a one-term limit. Candidates for the public member position shall not be physicians
and shall be nominated by the committee on administrative personnel.

Section 2-Executive Committee
The Executive Committee of this Association shall consist of the President, President-elect, Past
Presidents for the preceding two years, the chairs of the Departments of Affiliate Affairs,
Business Affairs, Governmental Affairs, Professional Affairs, Research, Quality and Public
Health, and the Chair and Vice-Chair of the Department of Educational Affairs.

Section 3-Term Limit
For all trustees, with the exception of the President, President-Elect and the Past Presidents for
the preceding two years, the aggregate terms of Office of Trustees shall be limited to twelve (12)
years, with the exception that a trustee may complete the term in which twelve (12) years or more
of service is completed. Time served as a student member, intern/resident member, or as new
physician in practice member shall not be included in calculating the twelve years of service.

Article IX - Amendments
This Constitution may be amended by the House of Delegates at any annual meeting by a two-thirds
vote of the total number of delegates accredited for voting, provided that such amendments shall
have been presented to the House and filed with the Chief Executive Officer at a previous annual
meeting, who shall cause them to be distributed by first class mail, postage prepaid, to each
divisional and specialty society entitled to and voting representatives to the house of delegates,
posted on the AOA’s website, and published in the Journal of the American Osteopathic Association not
less than two months or more than four months prior to the meeting at which they are to be acted
upon.

Article X - Gender Disclaimer
The American Osteopathic Association is open to persons of both sexes and does not discriminate
against any persons because of sex; therefore, the wording herein importing the masculine or
feminine gender includes the other gender and imports no such discrimination.
BYLAWS

Article I - Divisional, District and Affiliated Societies

Section 1 - Divisional Societies
Any state, territorial, provincial or foreign osteopathic organization, or an organization of osteopathic physicians serving in the uniformed services of the United States, which may desire to become a divisional society of the American Osteopathic Association and be chartered as a divisional society of this Association, shall apply on a prescribed form, submit evidence that its constitution, Bylaws, and Code of Ethics generally conform to those of this Association, and maintain an organizational structure which shall generally conform to that of this Association.

Upon such application, the Chief Executive Officer and the Board of Trustees shall investigate and, finding satisfactory proof, shall recommend to the House of Delegates that a charter be issued. The Association shall not issue such a charter to more than one divisional society in a given area.

Section 2 - District Societies
Divisional societies may, within their own areas, organize district societies whose relationship to the divisional society shall in all respects conform to that existing between the division and this Association.

Section 3 - Affiliated Organizations
Upon application from any organization for a charter as an affiliated organization, the Board of Trustees and the Chief Executive Officer shall investigate such organization and, upon satisfactory proof of a general agreement in policy and governing rules with those of this Association, shall recommend to the House of Delegates the issuance of such a charter. The Association shall not issue a charter to any organization, which duplicates the function or prerogatives of any presently affiliated organization. All organizations which have as their membership osteopathic physicians in good standing with the AOA, whether holding a current charter of affiliation or not, shall have as a medium of communication all publications of the AOA.

Section 4 - Amendments to Governing Documents
Any amendments to the Constitution, Bylaws, Code of Ethics, and other governing documents, by whatever name called, of such a divisional society or affiliated organization shall be submitted to the Board of Trustees of the American Osteopathic Association, who shall review such amendments to determine whether, with the proposed amendments, the Constitution, Bylaws, Code of Ethics, or other governing documents would continue to conform generally to those of this Association and, with respect to the divisional society only, whether the organizational structure would continue to conform generally to those of this Association. Until such proposed amendments are given written approval of the Board of Trustees of the American Osteopathic Association, the divisional society or affiliated organization shall continue to operate under its previously approved Constitution, Bylaws, or other governing documents.

Article II - Membership

Section 1 - Classification
The members of this Association shall be classified as follows:

a. Regular Members
b. Honorary Life Members
c. Life Members
d. Associate Members
e. Student Members
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’s COMMISSION ON OSTEOPATHIC COLLEGE ACCREDITATION OR ALLOPATHIC MEDICAL SCHOOLS ACCREDITED BY THE LIAISON COMMITTEE ON MEDICAL EDUCATION OR GRADUATES OF SCHOOLS OF MEDICINE LOCATED OUTSIDE OF THE UNITED STATES ON AN OFFICIAL LIST OF SCHOOLS RECOGNIZED BY THE AOA, 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.

b. Honorary Life Member

Honorary life membership shall be conferred on each president upon conclusion of his term of office.

Such honorary life membership shall not exempt the holder thereof from the maintenance of regular membership in his divisional society or from assessments levied by this Association.

Honorary life membership may also be conferred by the Board of Trustees on a regular member who has been in good standing for 25 consecutive years immediately preceding, and who has rendered outstanding service to the profession at either the state or national level, or who is recommended for such a membership by official action of his divisional society and the Committee on Membership. Such honorary life members shall have the privileges and duties of regular members including the payment of assessments levied by the Association, but shall not be required to pay dues.
c. **Life Member**

Life membership may be granted to any regular member who has reached the age of 70 years, or who has completed 50 years of osteopathic practice, whichever comes first, and who has been in good standing for 25 consecutive years immediately preceding. The Committee on Membership may waive this requirement on individual consideration. Such members shall have the privileges and duties of regular members, but shall not be required to pay dues or assessments beginning the year in which the age of 70 is attained.

Life membership may also be granted by the Board of Trustees or its Executive Committee on recommendation of his divisional society, to any regular member who has become permanently totally disabled. Such members shall have the privileges and duties of regular members, but shall not be required to pay dues or assessments.

d. **Associate Member**

By specific action of the Board of Trustees, or its Executive Committee, associate memberships may be granted to the following:

- Graduates of accredited schools of medicine, dentistry or podiatry holding teaching, research or administrative positions in AOA accredited healthcare facilities and colleges or who practice jointly with regular members of this Association;
- Doctors of philosophy or education and other nondoctoral personnel holding teaching, research or administrative positions in AOA accredited healthcare facilities or colleges; administrative employees of this Association, affiliated organizations and divisional societies; and any other professionals as determined by the Board of Trustees, excepting osteopathic physicians and students in colleges of osteopathic medicine.

Such associate members shall be required to pay dues and assessments as determined by these Bylaws. They shall receive a complimentary online subscription to the Association's publications and shall be eligible for such benefits as are periodically established by the Board of Trustees.

Associate members shall not be eligible for membership in the House of Delegates or the Board of Trustees, or to hold any elective offices of this Association. Special listing in the *AOA Yearbook and Directory of the Osteopathic Profession* shall be provided.

e. **Student Member**

Student membership status shall be granted to each undergraduate student in an approved college of osteopathic medicine.

At such time as a student member graduates from his osteopathic college, he shall automatically become enrolled as a regular member of the Association. Each student member shall receive such publications and other literature, except the *AOA Yearbook and Directory*, as may be directed by the Board of Trustees or the House of Delegates.

f. **Honorary Member**

By specific action of the Board of Trustees, honorary membership may be granted to individuals, not eligible for any other category of membership, who support the goals and objectives of this Association. Such honorary members shall not be required to pay dues or assessments. They shall receive complimentary copies of the Association's publications and such other services as authorized by the Board of Trustees. Honorary members shall not be eligible for membership in the House of Delegates or the Board of Trustees, or hold any elective offices of this Association. Special listing in the *AOA Yearbook and Directory* shall be provided.
Such membership, when conferred, shall remain in full force and effect unless revoked by action of the Board of Trustees of the American Osteopathic Association.

g. **International Physician Members**

By specific action of the Board of Trustees, or its Executive Committee, international membership may be granted to the following allopathic physicians who are:

- Graduates of schools of medicine located outside of the United States on an official list of schools recognized by the AOA, and holding a license for unlimited scope of medical practice including the authority to prescribe without limitation in their country of practice, and these allopathic physicians reside and practice outside of the United States and who support the goals and objectives of the AOA and the AOA Code of Ethics

Such International Physician Members will be required to pay dues and assessments as determined by these Bylaws. They shall receive a complimentary subscription to the Association’s publications and shall be eligible for such benefits as are periodically established by the Board of Trustees.

International Physician Members shall not be eligible for membership in the House of Delegates or the Board of Trustees, or to hold any elective offices of this Association. Special listing in the *AOA Yearbook and Directory* shall be provided.

h. **Allied Member**

By specific action of the Committee on Membership, allied membership may be granted to those licensed allied healthcare providers who are currently employed, with an active member of the AOA, contribute to the practice of that member, are not eligible for any other category of membership and who support the goals and objectives of this Association.

Such allied members shall be required to pay dues and assessments as determined by these Bylaws. They shall be eligible for such benefits as may periodically be determined by the Board of Trustees.

Allied members shall not be eligible for membership in the House of Delegates or the Board of Trustees, or to hold any elective offices of this Association. Special listing in the *AOA Yearbook and Directory* will be provided.

By specific action of the Committee on Membership, allied membership may be granted to allopathic physicians holding an MD degree and licensed to practice in the United States who support the AOA mission and subscribe to its Code of Ethics.

Individuals who have received their training and/or degree in osteopathic medicine from a school that is not accredited by the AOA Bureau of Professional Education are not eligible for membership in the AOA.

### Section 3-Disciplinary Action

The membership of any member of the Association who, in the opinion of the Executive Committee of the Association, purposely and persistently violates the established policy of the Association or who seeks to undermine the unity of the osteopathic profession or of any of its divisional societies or affiliated organizations may be revoked, suspended, or placed on probation by action of the Executive Committee of the Association upon the recommendation of the Committee on Membership, after the member has been given notice and an opportunity to be heard before such action is taken. Any individual whose membership has been so revoked, suspended, or placed on probation shall have the right of appeal to the Board of Trustees of the AOA at its next regular meeting, requesting a review of the action of the Executive Committee, and the Board of Trustees, on review, may in its discretion take such action in regard thereto as it deems appropriate.
Section 4-Continuing Medical Education
Regular members shall be required to satisfy Continuing Medical Education (CME) requirements. The CME requirements shall be determined and administered by the Board of Trustees. Members who do not meet the CME requirement are subject to such disciplinary action as is determined to be appropriate by the Board of Trustees, including revocation of membership, suspension, censure or probation.

Article III - Dues and Assessments

Section 1-Payment of Dues
The annual dues of regular members of the Association shall be payable in advance on or before 1 June, the beginning of the fiscal year. A member whose dues shall remain unpaid for three months shall become suspended. He may be reinstated upon payment of dues and assessments provided such payments are received prior to the end of the current fiscal year, or, if later, by applying as a new member.

Section 2-Dues Rates
a. Members
The annual dues of all members of the Association (except for allied members discussed in section 2c and student members discussed in section 2d, below) shall be determined by the House of Delegates and administered by the Board of Trustees.

b. Hardship Cases
Upon recommendation of the Committee on Membership, the Board of Trustees, or its Executive Committee, may remit a part or all of the annual dues of a member in good standing who, because of physical disability, maintain a limited practice or no practice. For just cause, properly authenticated, similar action may be taken by the Board of Trustees, or its Executive Committee, in regard to regular members not otherwise specifically covered by other provisions of this Article.

c. Allied Members
The annual dues rates for allied members shall be determined and administered by the Board of Trustees.
d. Student Rate
Student members shall not be liable for dues or any assessment.
e. International Physician Members
The annual dues rates for International Physician Members shall be determined and administered by the Board of Trustees.

Section 3-Assessments
To meet emergencies the Board of Trustees may levy such assessments as may be necessary, provided that the total of such assessments in any one-year shall not exceed the amount of the annual dues. Failure to pay such assessments shall incur the same penalty as failure to pay dues. Those dropped from membership for nonpayment of dues during the fiscal year in which an assessment is levied shall be required to pay the assessment prior to reapplying for membership.

Section 4-Refunding Dues
No dues will be refunded if a membership is terminated for cause or because of resignation.
Article IV - Code of Ethics

Section 1
The House of Delegates shall establish a Code of Ethics for the information and guidance of the members. Members of the Association, in their daily conduct, shall comply with the provisions of the Code of Ethics. The Code shall cover duties of physicians to patients, duties of physicians to other physicians and to the profession at large, and responsibilities of physicians to the public. The House of Delegates shall not adopt any provisions of the Code of Ethics, which may be in conflict with the Constitution or Bylaws of the Association.

Section 2
The Code of Ethics may be amended by the House of Delegates at any annual meeting by two-thirds vote of the total number of delegates accredited for voting, provided a copy of the proposed amendment is deposited with the Chief Executive Officer at least 90 days before the annual meeting at which it is to be voted upon.

It shall be the duty of the Chief Executive Officer to have the proposed amendment distributed by first class mail, postage prepaid, to each divisional and specialty society entitled to send voting representatives to the House of Delegates, posted on the AOA’s website, and published in The Journal of the American Osteopathic Association not later than one month before the annual meeting at which the amendment is scheduled for consideration.

The American Osteopathic Association has formulated this Code to guide its member physicians in their professional lives. The standards presented are designed to address the osteopathic physician’s ethical and professional responsibilities to patients, to society, to the AOA, to others involved in healthcare and to self.

Further, the American Osteopathic Association has adopted the position that physicians should play a major role in the development and instruction of medical ethics.

Article V - House of Delegates

Section 1-Certification of Delegates and Alternates

a. Divisional Societies
The Chief Executive Officer of this Association shall furnish to the secretary of each divisional society, 75 days before the first day of the annual meeting of the House of Delegates, a statement of the number of regular members of this Association located in the area represented by that divisional society or, in the case of the uniformed services divisional society, the number of regular members of this Association currently serving in the uniformed services of the United States.

Based on that statement, each divisional society shall select, in a manner prescribed by its Constitution and Bylaws, the number of delegates (and their alternates) to the House of Delegates of this Association to which it is entitled under the provisions of the Constitution of the American Osteopathic Association. Delegates and alternates must be regular or student members in good standing of this Association and of the divisional societies, which they represent. Delegates (and their alternates) shall serve during the annual meeting of the House of Delegates and during the interim between annual meetings or until their successors are elected. The secretary of each divisional society shall certify its delegates and alternates to the Chief Executive Officer of this Association in writing at least 30 days prior to the first day of the annual meeting of the House of Delegates.
AOA Constitution & Bylaws

In the event that any state, provincial or foreign osteopathic association does not become a chartered divisional society, the regular members of this Association in that jurisdiction, at a regularly called meeting, may elect or appoint one delegate (and alternate) as their representative in the House, and such delegate (and alternate) shall be accredited in the same manner and have the same privileges as those of a divisional society.

b. Specialty Colleges

Each AOA recognized specialty college shall select one delegate and at least one alternate to the AOA House of Delegates in a manner prescribed in its constitution and Bylaws. No specialty college delegate or alternate shall also be a member of the divisional society's delegation to the AOA's House of Delegates. The Secretary of each specialty college shall certify the name of its delegate and alternate to the Chief Executive Officer of the AOA at least 30 days prior to the first day of the annual meeting of the AOA House of Delegates. Each delegate and alternate must be a member in good standing of this association and his specialty college.

Section 2-Voting

Each delegate shall have one vote in the House, except when one-fourth of the members present shall call for the yeas and nays on any question; the Chief Executive Officer shall, before any other motion can be made, call the roll by divisional societies and enter the yeas and nays in the record. In recording such vote each divisional society shall be given one vote for each 20 regular members of the American Osteopathic Association located in the area represented by that divisional society (or in the case of the uniformed services divisional society, one vote for each 20 regular members of the American Osteopathic Association currently serving in the uniformed services of the United States), as certified to 75 days before the annual meeting of the House of Delegates under the requirements of Section 1 of this Article, and such votes may be cast by any one of the delegation then seated or divided among the various members of the delegation as the delegation in caucus shall decide.

Section 3-Committee on Credentials

The Committee on Credentials shall consist of three or more members appointed by the President and it shall be the duty of the Committee to receive and validate the credentials of the delegates to the House and to report all delegates entitled to be seated in the House. The Chief Executive Officer shall furnish the Credentials Committee a list showing the number of delegates to which each divisional society is entitled. In case any organization has selected more than its legal representation, the Chief Executive Officer shall drop surplus names from the list, beginning at the bottom, and shall notify the divisional society of his action.

Section 4-Seating of Delegates

A delegate having been seated shall remain the accredited delegate throughout the meeting. In the event that an accredited delegate has failed to qualify and assume his seat when the House convenes on the second day of the meeting, his accredited alternate may be seated. If a delegate, having been seated, finds himself unable to be present on account of physical disability or other cause acceptable to the House, his alternate may be seated for that roll call period and shall continue as delegate until the previously seated delegate shall return for duty at a subsequent roll call. In that case the alternate delegate who has been seated may, by direction of the House, be dropped from the roll and the previously seated delegate shall return to his seat in the House.

Section 5-Annual Meeting

The annual meeting of the House of Delegates shall be held during June, July or August, and separate from the annual convention or clinical assembly of the Association, upon call of the President. Special sessions of the House of Delegates may be called by the President. The
Section 6-Presiding Officer
The Speaker of the House of Delegates shall be its presiding officer. The Vice Speaker shall preside over the House of Delegates in the absence of or at the request of the Speaker and assume all duties of the Speaker.

Section 7-New Business
No new business shall be introduced on the last day of the meeting of the House of Delegates except by a two-thirds consent of those members present, provided two-thirds of the seated delegates are in attendance.

Section 8-Quorum
One-half of the accredited delegates of the House shall constitute a quorum.

Section 9-Governing Rules
The meetings of the House of Delegates and of all other bodies of this Association shall be governed by Robert's Rules of Order Newly Revised, except in such instances as are specifically provided for in the Constitution and Bylaws of the Association or in the order of business which may be adopted from time to time. The order of business and any special rules adopted at the beginning of the meeting shall govern the procedure unless unanimously suspended.

Section 10-Representation of Student Councils
The student council of each accredited college of osteopathic medicine and each branch campus may be represented in the House of Delegates by its president (and such president’s alternate elected by such student council) as a member of the delegation of the divisional society representing the state in which such college of osteopathic medicine and branch campus is located. Each such student delegate shall be accredited in the same manner and have the same privileges as the other members of the divisional society delegation; however, the chief administrative officer of each accredited college of osteopathic medicine and each branch campus shall certify the student council president and alternate to the Chief Executive Officer of this Association in writing or by electronic communication at least 30 days prior to the first day of the annual meeting of the House of Delegates and such Chief Executive Officer shall forthwith similarly certify each student council president and alternate to the secretary of the appropriate divisional society.

Section 11-Representation of Osteopathic Physicians In Postdoctoral Training
Osteopathic physicians in postdoctoral training may be represented in the House of Delegates by two individuals who, at the time of the annual meeting, shall be enrolled in postdoctoral training programs. The two individuals and their alternates shall be selected by vote of the AOA's Council of Interns and Residents. The delegates (and alternate delegates) selected by the Council of Interns and Residents shall serve as the representatives of osteopathic physicians in postdoctoral training and shall not also be members of a divisional society or specialty college delegation to the AOA's House of Delegates. The chair of the Council of Interns and Residents shall certify the name of its delegates and alternate delegates to the Chief Executive Officer of the AOA in writing or by electronic communication at least 30 days prior to the first day of the annual meeting of the AOA House of Delegates. Each delegate and alternate must be a member in good standing of this Association.
Section 12–Representation of Student Osteopathic Medical Association

The Student Osteopathic Medical Association (SOMA) may be represented in the House of Delegates by one member of the SOMA Board selected by vote of the SOMA Board (or such SOMA member’s alternate, who shall also be a member of the SOMA Board selected by the SOMA Board). No SOMA delegate or alternate shall also be a member of a divisional society’s delegation representing the state in which such SOMA Board member’s osteopathic college is located. The SOMA delegate shall be accredited in the same manner and have the same privileges as the other members of the divisional society delegation; however, the Chief Administrative Officer of SOMA shall certify the SOMA delegate and alternate to the Chief Executive Officer of this Association in writing or by electronic communication at least 30 days prior to the first day of the annual meeting of the House of Delegates.

Article VI—Elections

Section 1–Qualifications

Except where positions are designated as public members, membership in both the AOA and a divisional society shall be a requisite for qualification for any officer or for any member of any department, division, bureau or committee of the Association, however selected, if the incumbent shall be an osteopathic physician.

Section 2–Nominations

Nomination of all officers and trustees of this Association, and nomination of the Speaker and Vice Speaker of the House of Delegates, excepting nomination of those otherwise provided for in the Constitution, shall be a regular order of business in the House of Delegates at the annual meeting of the House. Nominations may be made from the floor immediately preceding the balloting. Nominating speeches shall not exceed two minutes.

Section 3–Method of Election

Election of such officers and trustees as are elected by the House of Delegates shall take place during the last day of the annual meeting. All elections shall be by ballot except as hereinafter provided in this section and a majority of all votes cast shall be necessary to elect. In recording such vote, each divisional society shall be given one vote for each 20 regular members of the American Osteopathic Association located in the area or serving in the uniformed services of the United States represented by that division, and such votes may be cast by any one of the delegation then seated or divided among the various members of the delegation as the delegation in caucus shall decide. If there shall be but one nominee for a given office or trusteeship it shall be the duty of the secretary to cast the elective ballot for that nominee. The Speaker and Vice Speaker of the House shall be elected to serve for one year or until their successors are elected and installed.

Section 4–Installation

The officers who have served throughout that meeting shall complete all business of the annual meeting so far as is practicable. The officers-elect shall be installed as the final order of business and shall assume the authority of their respective offices upon adjournment of the meeting.
Article VII--Board of Trustees

1  **Section 1--Duties**

The Board of Trustees shall:

1. Direct the management of the affairs of the Association between annual meetings. It shall meet coincident with the annual meeting of the House of Delegates and at other times on call of the President, shall make all arrangements for the annual meetings, shall appoint all standing and special committees not otherwise provided for in these Bylaws, and may fill by appointment any vacancy occurring in its own membership or any other elective office until the time of the next meeting of the House of Delegates. A quorum of the Board shall be a majority of the members thereof.

2. Appoint a Chief Executive Officer, a Controller, a General Counsel, and an Editor, and shall fix the amount of their salaries and the length of their terms of office. It shall fix the duties of the Chief Executive Officer, Controller, General Counsel, Editor and all other officials, committees, departments and bureaus necessary to the proper execution of the policies of the Association and not fixed by these Bylaws.

3. Have the responsibility of management of the finances of the Association and shall authorize and supervise, the House of Delegates concurring, all expenditures thereof. It shall appoint a certified public accountant to audit the financial records of the Association and certify to the accuracy of the statement of financial condition of the Association to be reported at the annual meetings.

4. No appropriation shall be made by the House of Delegates except upon recommendation of the Bureau of Finance approved by the Board of Trustees, and all resolutions, motions or otherwise, having for their purpose the appropriation of funds, shall first be referred without discussion to the Bureau of Finance of the Board of Trustees. An adverse ruling on such motions may be overruled by a three-fourths vote of the House of Delegates.

5. Provide for the publication of an official journal of the Association and such other publications as are deemed necessary or shall be directed by the House of Delegates

6. Maintain and revise the Administrative Guide annually. The general purpose of this manual shall be to provide a handy reference book of concise statements of the duties of all officials, committees, departments, bureaus and employees of the Association, to the end that there shall be no conflict of jurisdiction or duplication of effort. Copies of such Guide shall be furnished to each divisional society and affiliated organization as well as officers of the American Osteopathic Association and other groups or individuals as directed by the Board of Trustees of the Association.

7. Establish such departments, committees, bureaus, councils, and commissions, and authorize the president’s creation of such task forces, as shall be necessary to further the policies of the Association and determined by the House of Delegates and shall determine the duties and powers of such departments, committees, bureaus, councils, commissions and task forces.

8. Approve from its own membership, based on the President’s appointment, the chairs of the departments. The department chairs shall direct the activities of their respective departments. However, the public member of the board shall not be eligible to serve as a department chair. The Board shall also approve, based on the President’s appointment, the members of the various committees, bureaus, councils, commissions and task forces.
h. Decide finally all questions of an ethical or judicial character. It shall have investigated by
the Committee on Ethics all charges or complaints of violation of the Constitution,
Bylaws, or of grossly unprofessional conduct of any member. The Board shall have the
power to censure, place on probation for not exceeding a three-year period, suspend for
not exceeding a three-year period or expel a member, as the findings warrant. A member
may be cited to appear before it by the Board of Trustees or the Committee on Ethics to
answer charges or complaints of unethical or unprofessional conduct. Upon 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, his license to practice in a state on the
grounds of having committed a violation of a disciplinary provision of the licensing law by
a duly constituted state licensing agency, or the voluntary surrender of his license while
under charges of having committed said violation, such member shall automatically be
deemed expelled from membership in this Association; a conviction shall be deemed final
for the purposes hereof when affirmed by an appellate tribunal of final jurisdiction or
upon expiration of the period allowed for appeal. The Committee on Membership shall
be granted the authority to restore to membership a doctor whose license was revoked,
and later retroactively reinstated by his licensing board.

If, because of a breach of the Code of Ethics, a member shall have been suspended, or
expelled from a divisional society or affiliated organization by proper action of such
divisional society or affiliated organization, the Board of Trustees of this Association shall
review the record of such decision. The decision may first be referred to the Committee
on Ethics for recommendations. If the Board shall concur in the action of the divisional
society or affiliated organization, such 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. The Board is authorized to adopt and amend
Procedure regulating the procedure applicable to matters involving violations of the Code
of Ethics.

Section 2--Appeal
A minority of one-third or more members of the Board of Trustees present at any session may
appeal to the House of Delegates from the decision of the majority on any question at the
current meeting.

Section 3--Executive Committee
The Executive Committee shall transact the business of the Board of Trustees between meetings.

Section 4--By-Mail Vote
Between meetings of the Board of Trustees and of the Executive Committee, a by-mail vote, or
vote by other means of electronic communications, on any urgent matter may be taken of the
members of the Board of Trustees, or Executive Committee, if a consent in writing setting forth
the action so taken shall be signed by all of the trustees or members of the Executive Committee
entitled to vote with respect to the subject matter thereof, any such vote to be entered into the
records at the next meeting of the Board.

Section 5--Indemnification
Each trustee, officer, and employee of this Association now or hereafter in office and his heirs,
executors, and administrators, and each trustee, officer, and employee of this Association and his
heirs, executors, and administrators who now acts, or shall hereafter act at the request of this
Association as employee, trustee, director, or officer of another corporate entity controlled by this Association, shall be indemnified by this Association against all costs, expenses, judgments, fines, and amounts or liability therefore, including counsel fees, reasonably incurred by or imposed upon him in connection with or resulting from any action, suit, proceeding, or claim to which he may be made a party, or in which he may be or become involved by reason of his acts of omission or commission, or alleged acts of omission or commission as such trustee, officer, or employee, or, subject to the subsequent provisions of the section, any settlement thereof, whether or not he continues to be such trustee, officer, or employee at the time of incurring such costs, expenses, judgments, fines or amounts, provided that such indemnification shall not apply with respect to any matters as to which such trustee, officer, or employee shall be finally adjudged in such action, suit, or proceeding to have been individually guilty of misconduct, misfeasance, or malfeasance in the performance of his duty as such trustee, officer, or employee. The indemnification herein provided shall, with respect to any settlement of any such suit, action, proceeding, or claim, include reimbursement of any amounts paid and expenses reasonably incurred in settling any such suit, action, proceeding, or claim, when the Board of Trustees has determined that such settlement and reimbursement appear to be for the best interests of this Association. Such determination shall be made (1) by the Board of Trustees or by a majority vote of a quorum consisting of trustees who were not parties to such action, suit, or proceeding, or (2) if such a quorum is not obtainable (or, even if obtainable, a quorum of disinterested trustees so directs) by independent legal counsel in a written opinion. The foregoing right of indemnification shall be in addition to and not exclusive of any and all other rights as to which any such trustee, officer, or employee may be entitled under any bylaw, agreement, or otherwise.

Expenses incurred in defending a civil or criminal action, suit, or proceeding may be paid by the Association in advance of the final disposition of such action, suit, or proceeding as authorized by the Board of Trustees or Executive Committee in the manner heretofore provided, upon receipt of a written undertaking by or on behalf of the trustee, officer, or employee to repay such amount unless it shall ultimately be determined that he is entitled to be indemnified by the Association as authorized in this section.

The Board of Trustees may authorize the Association to purchase and maintain insurance on behalf of any person who is or was a trustee or employee of the Association or is or was serving at the request of the Association as a trustee, director, officer, employee, or agent of another corporate entity controlled by the Association against any liability asserted against him and incurred by him in any such capacity, or arising out of his status as such, whether or not the Association would have the authority or power to indemnify him against such liability under the provisions of this section.

### Article VIII--Duties of Officers

#### Section 1--President

The President shall be the chairman of the Board of Trustees and of the Executive Committee and shall perform the duties usually pertaining to his office. He shall nominate, subject to approval by the Board of Trustees, all appointive officers, unless otherwise specified in the Bylaws and in accordance with the directives contained in the Administrative Guide or as established by the Board of Trustees or the House of Delegates.

#### Section 2--President-elect

The President-elect shall perform the duties of the office of the President in the absence of or at the request of the President.
Section 3--Vice-Presidents

The Vice-Presidents, in the order of their designation and in the absence or at the request of the President and President-elect, shall perform the duties of the office of the President.

Section 4--Speaker/Vice-Speaker of the House of Delegates

The Speaker or the Vice-Speaker of the House of Delegates shall perform such duties as custom and parliamentary usage require. The Speaker shall appoint reference committees of the House to perform functions for which they are created subject to the approval of the House. He shall have such other privileges and duties as may be assigned to him by the House of Delegates, which privileges and duties shall not be in conflict with the privileges and duties assigned by the Constitution and Bylaws to other officers of the Association. The Vice-Speaker of the House of Delegates shall assume the duties of the Speaker in his absence or at his request.

Section 5--Chief Executive Officer

The Chief Executive Officer shall:

a. Be the chief administrative officer of the Association and of the central office. He shall be the executive and recording secretary of the Association. He shall counsel with the other administrative officers and with the heads of departments in the central office to produce the greatest possible cooperation and efficiency in the conduct of the affairs of the Association under the President and the Board of Trustees. He shall cooperate with the chairmen of various agencies of the Association in the execution of the policies of the Association as outlined by the House of Delegates. It shall be his duty to coordinate the work performed by the various departments, bureaus, and committees of the Association.

b. Direct the joint activities of the Association and the divisional societies as provided by the Bylaws, and may select one or more of the trustees or like officers of the divisional societies, to assist him in this work in their respective areas.

c. Be responsible for the correspondence of the Association and shall keep accurate record of the proceedings of the House of Delegates and the Board of Trustees.

d. Be responsible for the supervision of assistance to the divisional societies in all matters according to the policies laid down by the Association and for the supervision of the execution of plans of the Association with regard to colleges, affiliated organizations and campaigns.

d. Keep on file an accurate record of all transactions of his office, which shall at any time be subject to examination by the President or the Board of Trustees, shall make an annual report to the House of Delegates and Board, and shall perform such other duties as are prescribed by the Board not in conflict with the Constitution and Bylaws of this Association.

e. Be the statistical officer of the Association, and shall have charge of the archives, including legal, historical and scientific records of value to the Association.

f. Be authorized to provide such assistance as is necessary for the proper conduct of the central office, subject to the directives of the Board of Trustees, and at the expiration of his term shall deliver to his successor all property and papers pertaining to his office. He shall file bond with such surety company and in such amount as the Board of Trustees shall determine.
Section 6—Controller

The Controller shall:

a. Have charge of the funds and assets of the Association, cooperate with the Chief Executive Officer and Editor under the direction of the Board of Trustees, and disburse such funds only in the manner prescribed by the Board of Trustees.

b. Be responsible for the collection of dues and assessments as provided in these Bylaws; shall cooperate with like officers of the divisional societies and may delegate them to assist him in their respective societies.

c. Keep on file accurate records of the transactions of his office, which shall at all times be subject to examination by the Board of Trustees. He shall prepare reports quarterly for the Board of Trustees and annually for the House of Delegates and the Board, and at the expiration of his employment; he shall deliver to his successors or to the Board, or their assigned agent, all monies, records and other property of the Association subject to his jurisdiction. He shall perform such other duties as may be prescribed by the Board consistent with the Constitution and Bylaws of the Association.

d. Be provided with such assistance as is necessary to the proper conduct of his office, subject to the directives of the Board of Trustees through the Chief Executive Officer. He shall file bond with such surety company and in such sum as the Board of Trustees may determine.

Section 7—General Counsel

The General Counsel shall:

a. Be the chief legal officer of the Association, responsible for oversight and management of all legal services provided to the Association, its trustees, officers and staff to ensure protection of the Association’s legal rights and maintenance of its operations consistent with the limits established by law.

b. Provide legal advice and guidance to the trustees, officers, and staff, bureaus, councils, task forces, commissions and committees of the Association on the legal implications of matters relevant to the Association, including compliance with federal, state, and local laws and regulations applicable to a tax-exempt, not-for-profit membership organization and adherence to internal organizational policies and procedures.

c. Draft and review contracts and other legal documents, policies and procedures; research pertinent to legal issues; prepare written and oral opinions and position statements on issues identified by the Association’s trustees, officers, staff, bureaus, councils, task forces, commissions and committees;

d. Represent or coordinate the representation of the Association in judicial and administrative proceedings; and

e. Select and retain outside counsel, as required, to obtain legal opinions or to handle claims and litigation. Supervises legal work of other Association attorneys and outside counsel.

Section 8—Editor

The Editor shall:

a. Have the editorial direction, in accordance with the established policies of the Board of Trustees and House of Delegates, of The Journal of the American Osteopathic Association, other periodical publications of the Association and of the AOA Yearbook and Directory, under the general supervision of the Chief Executive Officer, and shall cooperate with all departments of the central office.
b. Be provided with such assistance as is necessary to the proper conduct of his office, subject to the directives of the Board of Trustees through the Chief Executive Officer.

Article IX—Departments, Bureaus, and Committees

The Board of Trustees and House of Delegates, consistent with the powers given to it by these Bylaws, shall establish and determine the duties of departments, bureaus, councils, commissions, committees, and task forces necessary to further the policies of the Association. The Association’s departments shall include the Departments of Affiliated Affairs, Business Affairs, Educational Affairs, Governmental Affairs, Professional Affairs, and Research, Quality & Public Health. The activities of all departments, bureaus and committees shall, so far as possible, be executed in close cooperation with the Chief Executive Officer. Upon the expiration of the terms of office of chairs and members of the departments, bureaus, or committees, all records of the same shall be delivered by the chairs to the Chief Executive Officer. All employed staff of departments, bureaus, and committees in the offices shall be under the jurisdiction of the Chief Executive Officer.

Article X—Conventions and Meetings

Whenever referred to in this Constitution and Bylaws, the words annual meeting shall refer to the annual meetings of the Board of Trustees or of the House of Delegates, respectively, and the words annual convention or clinical assembly shall refer to the annual clinical assembly of the Association.

Section 1—Annual Clinical Assembly

The annual clinical assembly shall be held at such time and place as may be determined by the Board of Trustees, provided, however, such action may be changed by the House of Delegates by a two-thirds vote of the total number of delegates accredited for voting.

Section 2—Annual Meetings

The annual meetings of the Board of Trustees shall be held at such time and place as may be determined by the Board of Trustees, provided, however, such action may be changed by the House of Delegates by a two-thirds vote of the total number of delegates accredited for voting.

Article XI—Amendments

Section 1—Bylaws

These Bylaws may be amended at any annual or special meeting of the House of Delegates by a two-thirds vote of the total number of delegates accredited for voting, provided that the amendment shall have been filed with the Chief Executive Officer at least two months before the meeting at which the amendment is to be voted upon. Upon receiving a copy of the amendment, it shall be the duty of the Chief Executive Officer to cause it to be distributed by first class mail, postage paid, to each divisional and specialty society entitled to send voting representatives to the House of Delegates, posted on the AOA’s website, and published in The Journal of the American Osteopathic Association at least one month before the meeting. The Board of Trustees may revise the proposed amendment if necessary to secure conformity to this Constitution and Bylaws and shall then refer it to the House for final action not later than the day prior to the end of the meeting.

Section 2—Articles of Incorporation

The Articles of Incorporation of this Association may be amended by the adoption of a resolution by the Board of Trustees setting forth the proposed amendment and directing that the amendment be submitted to a vote at a meeting of the House of Delegates, which may be either an annual or a special meeting. Written or printed notice setting forth the proposed amendment or a summary of
the changes to be effected thereby shall be posted on the AOA’s website and delivered not less than five
nor more than 40 days before the date of the meeting, either personally or by mail, by or at the
direction of the President, or the Chief Executive Officer, or the officers or persons calling the
meeting, to each delegate entitled to vote at such meeting.

Written or printed notice shall include the printing of the amendment in the electronic and/or
printed issue of The Journal of the American Osteopathic Association published not less than five days or
more than 40 days before the date of the meeting. The proposed amendment shall be adopted upon
receiving at least two-thirds of the votes entitled to be cast by the total number of delegates
accredited for voting.

**Article XII--Gender Disclaimer**

The American Osteopathic Association is open to persons of both sexes and does not
discriminate against any person because of sex; therefore, the wording herein importing the
masculine or feminine gender includes the other gender and imports no such discrimination.
WHEREAS, the AOA Constitution states that, “This Association shall be a federation of divisional societies organized within state or foreign country boundaries, or within the uniformed services of the United States”; and

WHEREAS, student delegates serve as members of the state divisional society; and

WHEREAS, while the AOA bylaws require the student delegate to serve as a member of the state divisional society, the student delegate may have no connection to the state divisional society in which they serve since the student delegates is required to be the student council president and alternate elected by the student council of the college of osteopathic medicine; and

WHEREAS, divisional societies are awarded with one additional delegate as a student representative for each accredited college of osteopathic medicine in their respective state; and

WHEREAS, divisional societies are awarded with one additional delegate as a student representative for each branch campus of an accredited college of osteopathic medicine in their respective state; and

WHEREAS, divisional societies that have a college of osteopathic medicine designated as an additional location are not awarded a student representative; and

WHEREAS, students who attend a college of osteopathic medicine have no opportunity to serve as a student delegate for their state divisional society if their state has no accredited college of osteopathic medicine; and

WHEREAS, opportunities for student involvement are vital to attracting and retaining young physicians as members for the continued success of the AOA and state divisional societies; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) House of Delegates approve the following amendments to the AOA Constitution and Bylaws to allow each state divisional society to be awarded one student delegate to serve as a student representative for his or her respective state.
AMERICAN OSTEOPATHIC ASSOCIATION JULY 2016 CONSTITUTION

Article VI - House of Delegates

The House of Delegates shall be the legislative body of the Association, shall exercise the delegated powers of the divisional societies in the affairs of this Association, and shall perform such other functions as are set forth in the Bylaws.

Section 1-Composition

The House of Delegates shall consist of delegates elected by the divisional societies and other authorized units, the elected officers and trustees of the Association and of such other members as may be provided for in the Bylaws.

A. Divisional Societies and Uniformed Services Society

Four hundred seventy-three delegate positions shall be allocated among the divisional societies for each of the states and the District of Columbia and the affiliated organization that represents osteopathic physicians serving in the uniformed services as follows: each divisional society and the uniformed services affiliate shall be entitled to one delegate and one alternate delegate. The remaining delegate positions shall be allocated among divisional societies and the uniformed services affiliate based on the proportion of members of this association who are located in the state represented by that divisional society or, in the case of the uniformed services divisional society, the proportion of members of this association currently serving on active duty in the uniformed services of the United States. The allocation of additional delegates shall be recalculated each year.

B. OSTEOPATHIC MEDICAL Student Council Representation in Divisional Societies

Each divisional society shall be awarded one additional delegate as a Student Council representative for each college of osteopathic medicine accredited by this Association and located in the state represented by that divisional society. Such student delegates shall be elected according to the Bylaws of the American Osteopathic Association and THE STATE DIVISIONAL SOCIETY.

AMERICAN OSTEOPATHIC ASSOCIATION JULY 2016 BYLAWS

Article V - House of Delegates

Section 10-Representation of OSTEOPATHIC MEDICAL Student Councils

The OSTEOPATHIC MEDICAL student council of each accredited college of osteopathic medicine, and each branch campus, may be represented in the House of Delegates by its president (and such president’s alternate elected by such student council) as a member of the delegation of the divisional society representing the state in which such college of osteopathic medicine and branch campus is located. Each such student delegate shall be accredited in the same manner and have the same privileges as the other members of the divisional society delegation; however, the chief administrative officer of each accredited college of osteopathic medicine and each branch campus shall certify the student council president and alternate to the Chief Executive Officer of this Association in writing or by electronic communication at least 30 days prior to the first day of the annual meeting of the House of Delegates and such Chief Executive Officer shall forthwith similarly certify each student council president and alternate to the Secretary.
Reference Committee Explanatory Statement:
The Committee on AOA Governance & Organizational Structure (CAGOS) has been charged by the Board of Trustees as part of Strategic Plan Phase II to review the current governance structure, including Bureaus/Councils/Committees, the Board of Trustees and the House of Delegates. Changes to the mechanism for student representation in the House of Delegates suggested in this proposed amendment should be considered by the CAGOS as part of its review process.

ACTION TAKEN  REFERRED (to Committee on AOA Governance & Organizational Structure)

DATE  July 22, 2017
RES. NO. H-505 - A/2017 – Page 1

First Read

SUBJECT: AMENDMENT TO THE AMERICAN OSTEOPATHIC ASSOCIATION CONSTITUTION & BYLAWS – BUREAU OF EMERGING LEADERS AND NEW PHYSICIAN IN PRACTICE

SUBMITTED BY: AOA Bureau of Emerging Leaders

REFERRED TO: Committee on Constitution & Bylaws

RESOLVED, that the AOA House of Delegates approve the following amendments to the American Osteopathic Association Constitution & Bylaws:

AOA Constitution

Article VIII – Board of Trustees and Executive Committee - Section 1 D
Page 3 - Lines 4-5
D. One intern/resident member elected by the house of delegate to serve for one year. Candidates for the intern/resident position shall be enrolled in an AOA-approved internship or residency or, if enrolled in an ACGME-approved residency shall have applied for an AOA approval of the ACGME-Approved residency. Candidates for the intern/resident position shall be nominated by the council of interns and residents BUREAU OF EMERGING LEADERS.

AOA Bylaws

Article V - House of Delegates - Section 11 - Representation of Osteopathic Physicians In Postdoctoral Training
Page 11 - Lines 19-33
Section 11-Representation of Osteopathic Physicians In Postdoctoral Training AND/OR NEW PHYSICIANS IN PRACTICE may be represented in the House of Delegates by two individuals who, at the time of the annual meeting, shall be enrolled in postdoctoral training programs OR CURRENTLY A NEW PHYSICIAN IN PRACTICE AS DEFINED BY THE ASSOCIATION. The two individuals and their alternates shall be selected by vote of the AOA’s Council of Interns and Residents BUREAU OF EMERGING LEADERS (BEL). The delegates (and alternate delegates) selected by the Council of Interns and Residents BEL shall serve as the representatives of osteopathic physicians in postdoctoral training AND NEW PHYSICIANS IN PRACTICE. AND THESE DELEGATES shall not also be members of a divisional society or specialty college delegation to the AOA’s House of Delegates. The chair of the Council of Interns and Residents CO-CHAIRS OF THE BEL shall certify the nameS of its delegates and alternate delegates to the Chief Executive Officer of the AOA in writing or by electronic communication at least 30 days prior to the first day of the annual meeting of the AOA House of Delegates. Each delegate and alternate must be a member in good standing of this Association.
Reference Committee Explanatory Statement:
The current proposed bylaw amendment for Article V, Section 11 should be revised from “and THESE DELEGATES shall not also be members of a divisional society or specialty college delegation to the AOA’s House of Delegates” to “Individuals serving as an Emerging Leader delegate shall not concurrently serve as a delegate for any other group at the AOA House of Delegates.” Similarly, in Bylaws, Article V, Section 1, part b, the language should be revised from “No specialty college delegate or alternate shall also be a member of the divisional society’s delegation to the AOA’s House of Delegates” to “No specialty college delegate or alternate shall concurrently serve as a delegate for a divisional society at the AOA’s House of Delegates.” Consideration should also be given to changing the title of the section heading for Article V, Section 11 to: “Representation of Osteopathic AND ALLOPATHIC Physicians in Postdoctoral Training AND/OR NEW PHYSICIANS IN PRACTICE, at such time as the amendments proposed in H-503 to allow for regular membership status of allopathic physicians is approved.

ACTION TAKEN  REFERRED (to AOA Bureau of Emerging Leaders)

DATE  July 22, 2017
CONSTITUTION

Article I - Name
The name of this Association shall be the American Osteopathic Association.

Article II - Objectives
The objectives of this Association shall be to promote the public health, to encourage scientific research, and to maintain and improve high standards of Osteopathic medical education.

Article III - Divisional Societies
This Association shall be a federation of divisional societies organized within state or foreign country boundaries, or within the uniformed services of the United States, which may be chartered by this Association as provided by the Bylaws, and all such organizations or divisions now a constituent part of the American Osteopathic Association are declared to be chartered as federated units of this Association.

Article IV - Affiliated Organizations
Affiliated organizations may be organized in conformity with the Bylaws of the Association.

Article V - Membership
The membership of this Association shall consist of Osteopathic physicians and of such others as have met the requirements prescribed by the Bylaws of the American Osteopathic Association.

Article VI - House of Delegates
The House of Delegates shall be the legislative body of the Association, shall exercise the delegated powers of the divisional societies in the affairs of this Association, and shall perform such other functions as are set forth in the Bylaws.

Section 1 - Composition
The House of Delegates shall consist of delegates elected by the divisional societies and other authorized units, the elected officers and trustees of the Association and of such other members as may be provided for in the Bylaws.

A. Divisional Societies and Uniformed Services Society. Four hundred seventy-three delegate positions shall be allocated among the divisional societies for each of the states and the District of Columbia and the affiliated organization that represents osteopathic physicians serving in the uniformed services as follows: each divisional society and the uniformed services affiliate shall be entitled to one delegate and one alternate delegate. The remaining delegate positions shall be allocated among divisional societies and the uniformed services affiliate based on the proportion of members of this association who are located in the state represented by that divisional society or, in the case of the uniformed services divisional society, the proportion of members of this association currently serving on active duty in the uniformed services of the United States. The allocation of additional delegates shall be recalculated each year.

B. Student Council Representation in Divisional Societies. Divisional societies shall be awarded one additional delegate as a student council representative for each college of osteopathic medicine accredited by this Association and located in the state represented by that divisional society, such
student delegate to be elected according to the Bylaws of the American Osteopathic Association.

C. **Specialty Affiliates** Each AOA recognized Specialty College shall be represented by one delegate to be selected as provided in the bylaws of the American Osteopathic Association.

**Section 2-Presiding Officer**

The presiding officer of the House of Delegates shall be the Speaker and, in his absence or at his request, the Vice Speaker shall preside.

**Article VII – Officers**

**Section 1-Elected Officers**

The elected officers of this Association shall be the President, President-Elect, First Vice-President, Second Vice-President and Third Vice-President. The First Vice-President shall be a person who has had previous experience as a member of the Board of Trustees. The officers shall be elected annually by the House of Delegates for a term of one year, or until their successors are elected and installed. The President-Elect shall automatically succeed to the presidency upon his installation, during the annual meeting of the House of Delegates following his election to the office of President-Elect. In the case of the inability upon the part of the president to serve during the term of office for which he/she has been elected, and therefore the office becomes vacant, the President-Elect shall become president for the unexpired portion of the term and continue in that office for the term in which the President-Elect was originally elected. In such case, if the President-Elect is unable to serve for the full unexpired term of the president's office, then the responsibility of filling the office of President shall devolve upon the Board of Trustees.

**Section 2-Administrative Officers**

The administrative officers shall be Chief Executive Officer, a Controller, a General Counsel, and an Editor who shall be appointed by the Board of Trustees and employed to serve for such term as the Board shall define. The duties of these officers shall be those usual to such officers in their respective offices and such others as are set forth in the Bylaws. The Chief Executive Officer shall be the Secretary of the Association.

**Article VIII - Board of Trustees and Executive Committee**

**Section 1-Board of Trustees**

The Board of Trustees shall be the administrative and executive body of the association and perform such other duties as are provided by the bylaws. The Board of Trustees of this association shall consist of twenty-nine members.

A. Seven elected officers: The President, President-Elect, The Past Presidents for the preceding two years, First Vice-President, Second Vice-President, and Third Vice-President;

B. Eighteen at-large trustees, six of whom shall be elected annually by the house of delegates to serve for three years;

C. One new physician in practice member elected by the House of Delegates to serve for one year. Candidates for the new physician in practice position shall be osteopathic physicians who have completed their postdoctoral training within the past five years or received the DO degree within the previous ten years shall be nominated by the council of new physicians in practice;

D. One intern/resident member elected by the house of delegate to serve for one year.
Candidates for the intern/resident position shall be enrolled in an AOA-approved internship or residency or, if enrolled in an ACGME-approved residency shall have applied for an AOA approval of the ACGME-Approved residency. Candidates for the intern/resident position shall be nominated by the council of interns and residents.

EMERGING LEADERS.

E. One student member elected by the House of Delegates to serve for one year. Candidates for the student position shall be nominated, in altering years, by the Council of Osteopathic Student Government Presidents (COSGP) and the Student Osteopathic Medical Association (SOMA); and

F. One public member elected by the House of Delegates to serve for a three-year term, with a one-term limit. Candidates for the public member position shall not be physicians and shall be nominated by the committee on administrative personnel.

Section 2 - Executive Committee

The Executive Committee of this Association shall consist of the President, President-elect, Past Presidents for the preceding two years, the chairs of the Departments of Affiliate Affairs, Business Affairs, Governmental Affairs, Professional Affairs, Research, Quality and Public Health, and the Chair and Vice-Chair of the Department of Educational Affairs.

Section 3 - Term Limit

For all trustees, with the exception of the President, President-Elect and the Past Presidents for the preceding two years, the aggregate terms of Office of Trustees shall be limited to twelve (12) years, with the exception that a trustee may complete the term in which twelve (12) years or more of service is completed. Time served as a student member, intern/resident member, or as new physician in practice member shall not be included in calculating the twelve years of service.

Article IX - Amendments

This Constitution may be amended by the House of Delegates at any annual meeting by a two-thirds vote of the total number of delegates accredited for voting, provided that such amendments shall have been presented to the House and filed with the Chief Executive Officer at a previous annual meeting, who shall cause them to be distributed by first class mail, postage prepaid, to each divisional and specialty society entitled to and voting representatives to the house of delegates, posted on the AOA’s website, and published in the Journal of the American Osteopathic Association not less than two months or more than four months prior to the meeting at which they are to be acted upon.

Article X - Gender Disclaimer

The American Osteopathic Association is open to persons of both sexes and does not discriminate against any persons because of sex; therefore, the wording herein importing the masculine or feminine gender includes the other gender and imports no such discrimination.
BYLAWS

Article I - Divisional, District and Affiliated Societies

Section 1- Divisional Societies

Any state, territorial, provincial or foreign osteopathic organization, or an organization of osteopathic physicians serving in the uniformed services of the United States, which may desire to become a divisional society of the American Osteopathic Association and be chartered as a divisional society of this Association, shall apply on a prescribed form, submit evidence that its constitution, Bylaws, and Code of Ethics generally conform to those of this Association, and maintain an organizational structure which shall generally conform to that of this Association.

Upon such application, the Chief Executive Officer and the Board of Trustees shall investigate and, finding satisfactory proof, shall recommend to the House of Delegates that a charter be issued. The Association shall not issue such a charter to more than one divisional society in a given area.

Section 2- District Societies

Divisional societies may, within their own areas, organize district societies whose relationship to the divisional society shall in all respects conform to that existing between the division and this Association.

Section 3- Affiliated Organizations

Upon application from any organization for a charter as an affiliated organization, the Board of Trustees and the Chief Executive Officer shall investigate such organization and, upon satisfactory proof of a general agreement in policy and governing rules with those of this Association, shall recommend to the House of Delegates the issuance of such a charter. The Association shall not issue a charter to any organization, which duplicates the function or prerogatives of any presently affiliated organization. All organizations which have as their membership osteopathic physicians in good standing with the AOA, whether holding a current charter of affiliation or not, shall have as a medium of communication all publications of the AOA.

Section 4- Amendments to Governing Documents

Any amendments to the Constitution, Bylaws, Code of Ethics, and other governing documents, by whatever name called, of such a divisional society or affiliated organization shall be submitted to the Board of Trustees of the American Osteopathic Association, who shall review such amendments to determine whether, with the proposed amendments, the Constitution, Bylaws, Code of Ethics, or other governing documents would continue to conform generally to those of this Association and, with respect to the divisional society only, whether the organizational structure would continue to conform generally to those of this Association. Until such proposed amendments are given written approval of the Board of Trustees of the American Osteopathic Association, the divisional society or affiliated organization shall continue to operate under its previously approved Constitution, Bylaws, or other governing documents.

Article II – Membership

Section 1-Classification

The members of this Association shall be classified as follows:

a. Regular Members
b. Honorary Life Members
c. Life Members
d. Associate Members
e. Student Members
f. Honorary Members
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.

b. Honorary Life Member

Honorary life membership shall be conferred on each president upon conclusion of his term of office.

Such honorary life membership shall not exempt the holder thereof from the maintenance of regular membership in his divisional society or from assessments levied by this Association.

Honorary life membership may also be conferred by the Board of Trustees on a regular member who has been in good standing for 25 consecutive years immediately preceding, and who has rendered outstanding service to the profession at either the state or national level, or who is recommended for such a membership by official action of his divisional society and the Committee on Membership.

Such honorary life members shall have the privileges and duties of regular members including the payment of assessments levied by the Association, but shall not be required to pay dues.

c. Life Member

Life membership may be granted to any regular member who has reached the age of 70 years, or who has completed 50 years of osteopathic practice, whichever comes first, and who has been in good standing for 25 consecutive years immediately preceding. The Committee on Membership may waive this requirement on individual consideration. Such members shall have the privileges and duties of regular members, but shall not be required to pay dues or assessments beginning the year in which the age of 70 is attained.

Life membership may also be granted by the Board of Trustees or its Executive Committee on
recommendation of his divisional society, to any regular member who has become permanently totally
disabled. Such members shall have the privileges and duties of regular members, but shall not be
required to pay dues or assessments.

d. Associate Member
By specific action of the Board of Trustees, or its Executive Committee, associate memberships may be
granted to the following:
Graduates of accredited schools of medicine, dentistry or podiatry holding teaching, research or
administrative positions in AOA accredited healthcare facilities and colleges or who practice jointly
with regular members of this Association;
Doctors of philosophy or education and other nondoctoral personnel holding teaching, research or
administrative positions in AOA accredited healthcare facilities or colleges; administrative employees of
this Association, affiliated organizations and divisional societies; and any other professionals as
determined by the Board of Trustees, excepting osteopathic physicians and students in colleges of
osteopathic medicine.

Such associate members shall be required to pay dues and assessments as determined by these Bylaws.
They shall receive a complimentary online subscription to the Association's publications and shall be
eligible for such benefits as are periodically established by the Board of Trustees.

Associate members shall not be eligible for membership in the House of Delegates or the Board of
Trustees, or to hold any elective offices of this Association. Special listing in the AOA Yearbook and
Directory of the Osteopathic Profession shall be provided.

e. Student Member
Student membership status shall be granted to each undergraduate student in an approved college of
osteopathic medicine.

At such time as a student member graduates from his osteopathic college, he shall automatically
become enrolled as a regular member of the Association. Each student member shall receive such
publications and other literature, except the AOA Yearbook and Directory, as may be directed by the
Board of Trustees or the House of Delegates.

f. Honorary Member
By specific action of the Board of Trustees, honorary membership may be granted to individuals, not
eligible for any other category of membership, who support the goals and objectives of this
Association. Such honorary members shall not be required to pay dues or assessments. They shall
receive complimentary copies of the Association's publications and such other services as authorized by
the Board of Trustees. Honorary members shall not be eligible for membership in the House of
Delegates or the Board of Trustees, or hold any elective offices of this Association. Special listing in the
AOA Yearbook and Directory shall be provided.

Such membership, when conferred, shall remain in full force and effect unless revoked by action of the
Board of Trustees of the American Osteopathic Association.

g. International Physician Members
By specific action of the Board of Trustees, or its Executive Committee, international membership
may be granted to the following allopathic physicians who are:
Graduates of schools of medicine located outside of the United States on an official list of schools
recognized by the AOA, and holding a license for unlimited scope of medical practice including the
authority to prescribe without limitation in their country of practice, and these allopathic physicians
reside and practice outside of the United States and who support the goals and objectives of the AOA and the AOA Code of Ethics.

Such International Physician Members will be required to pay dues and assessments as determined by these Bylaws. They shall receive a complimentary subscription to the Association’s publications and shall be eligible for such benefits as are periodically established by the Board of Trustees.

International Physician Members shall not be eligible for membership in the House of Delegates or the Board of Trustees, or to hold any elective offices of this Association. Special listing in the AOA Yearbook and Directory shall be provided.

b. Allied Member

By specific action of the Committee on Membership, allied membership may be granted to those licensed allied healthcare providers who are currently employed, with an active member of the AOA, contribute to the practice of that member, are not eligible for any other category of membership and who support the goals and objectives of this Association.

Such allied members shall be required to pay dues and assessments as determined by these Bylaws. They shall be eligible for such benefits as may periodically be determined by the Board of Trustees.

Allied members shall not be eligible for membership in the House of Delegates or the Board of Trustees, or to hold any elective offices of this Association. Special listing in the AOA Yearbook and Directory will be provided.

By specific action of the Committee on Membership, allied membership may be granted to allopathic physicians holding an MD degree and licensed to practice in the United States who support the AOA mission and subscribe to its Code of Ethics.

Individuals who have received their training and/or degree in osteopathic medicine from a school that is not accredited by the AOA Bureau of Professional Education are not eligible for membership in the AOA.

Section 3-Disciplinary Action

The membership of any member of the Association who, in the opinion of the Executive Committee of the Association, purposely and persistently violates the established policy of the Association or who seeks to undermine the unity of the osteopathic profession or of any of its divisional societies or affiliated organizations may be revoked, suspended, or placed on probation by action of the Executive Committee of the Association upon the recommendation of the Committee on Membership, after the member has been given notice and an opportunity to be heard before such action is taken. Any individual whose membership has been so revoked, suspended, or placed on probation shall have the right of appeal to the Board of Trustees of the AOA at its next regular meeting, requesting a review of the action of the Executive Committee, and the Board of Trustees, on review, may in its discretion take such action in regard thereto as it deems appropriate.

Section 4-Continuing Medical Education

Regular members shall be required to satisfy Continuing Medical Education (CME) requirements. The CME requirements shall be determined and administered by the Board of Trustees. Members who do not meet the CME requirement are subject to such disciplinary action as is determined to be appropriate by the Board of Trustees, including revocation of membership, suspension, censure or probation.

Article III - Dues and Assessments

Section 1-Payment of Dues
The annual dues of regular members of the Association shall be payable in advance on or before 1
June, the beginning of the fiscal year.

A member whose dues shall remain unpaid for three months shall become suspended. He may be
reinstated upon payment of dues and assessments provided such payments are received prior to the
end of the current fiscal year, or, if later, by applying as a new member.

Section 2-Dues Rates

a. Members
The annual dues of all members of the Association (except for allied members discussed in section 2c
and student members discussed in section 2d, below) shall be determined by the House of Delegates
and administered by the Board of Trustees.

b. Hardship Cases
Upon recommendation of the Committee on Membership, the Board of Trustees, or its Executive
Committee, may remit a part or all of the annual dues of a member in good standing who, because of
physical disability, maintain a limited practice or no practice. For just cause, properly authenticated,
similar action may be taken by the Board of Trustees, or its Executive Committee, in regard to regular
members not otherwise specifically covered by other provisions of this Article.

c. Allied Members
The annual dues rates for allied members shall be determined and administered by the Board of
Trustees.

d. Student Rate
Student members shall not be liable for dues or any assessment.

e. International Physician Members
The annual dues rates for International Physician Members shall be determined and administered by
the Board of Trustees.

Section 3-Assessments
To meet emergencies the Board of Trustees may levy such assessments as may be necessary,
provided that the total of such assessments in any one-year shall not exceed the amount of the
annual dues. Failure to pay such assessments shall incur the same penalty as failure to pay dues.
Those dropped from membership for nonpayment of dues during the fiscal year in which an
assessment is levied shall be required to pay the assessment prior to reapplying for membership.

Section 4-Refunding Dues
No dues will be refunded if a membership is terminated for cause or because of resignation.

Article IV - Code of Ethics

Section 1
The House of Delegates shall establish a Code of Ethics for the information and guidance of the
members. Members of the Association, in their daily conduct, shall comply with the provisions of the
Code of Ethics. The Code shall cover duties of physicians to patients, duties of physicians to other
physicians and to the profession at large, and responsibilities of physicians to the public. The House
of Delegates shall not adopt any provisions of the Code of Ethics, which may be in conflict with the
Constitution or Bylaws of the Association.

Section 2
The Code of Ethics may be amended by the House of Delegates at any annual meeting by two-thirds
vote of the total number of delegates accredited for voting, provided a copy of the proposed
amendment is deposited with the Chief Executive Officer at least 90 days before the annual meeting
at which it is to be voted upon.

It shall be the duty of the Chief Executive Officer to have the proposed amendment distributed by
first class mail, postage prepaid, to each divisional and specialty society entitled to send voting
representatives to the House of Delegates, posted on the AOA's website, and published in The Journal
of the American Osteopathic Association not later than one month before the annual meeting at which the
amendment is scheduled for consideration.

The American Osteopathic Association has formulated this Code to guide its member physicians in
their professional lives. The standards presented are designed to address the osteopathic physician's
ethical and professional responsibilities to patients, to society, to the AOA, to others involved in
healthcare and to self.

Further, the American Osteopathic Association has adopted the position that physicians should play a
major role in the development and instruction of medical ethics.

**Article V - House of Delegates**

**Section 1-Certification of Delegates and Alternates**

*a. Divisional Societies*

The Chief Executive Officer of this Association shall furnish to the secretary of each divisional
society, 75 days before the first day of the annual meeting of the House of Delegates, a statement of
the number of regular members of this Association located in the area represented by that divisional
society or, in the case of the uniformed services divisional society, the number of regular members
of this Association currently serving in the uniformed services of the United States.

Based on that statement, each divisional society shall select, in a manner prescribed by its
Constitution and Bylaws, the number of delegates (and their alternates) to the House of Delegates of
this Association to which it is entitled under the provisions of the Constitution of the American
Osteopathic Association. Delegates and alternates must be regular or student members in good
standing of this Association and of the divisional societies, which they represent. Delegates (and
their alternates) shall serve during the annual meeting of the House of Delegates and during the
interim between annual meetings or until their successors are elected. The secretary of each
divisional society shall certify its delegates and alternates to the Chief Executive Officer of this
Association in writing at least 30 days prior to the first day of the annual meeting of the House of
Delegates.

In the event that any state, provincial or foreign osteopathic association does not become a
chartered divisional society, the regular members of this Association in that jurisdiction, at a
regularly called meeting, may elect or appoint one delegate (and alternate) as their representative in
the House, and such delegate (and alternate) shall be accredited in the same manner and have the
same privileges as those of a divisional society.

*b. Specialty Colleges*

Each AOA recognized specialty college shall select one delegate and at least one alternate to the AOA
House of Delegates in a manner prescribed in its constitution and Bylaws. No specialty college delegate
or alternate shall also be a member of the divisional society’s delegation to the AOA's House of
Delegates. The Secretary of each specialty college shall certify the name of its delegate and alternate to
the Chief Executive Officer of the AOA at least 30 days prior to the first day of the annual meeting of
the AOA House of Delegates. Each delegate and alternate must be a member in good standing of this
association and his specialty college.

Section 2-Voting

Each delegate shall have one vote in the House, except when one-fourth of the members present shall call for the yeas and nays on any question; the Chief Executive Officer shall, before any other motion can be made, call the roll by divisional societies and enter the yeas and nays in the record. In recording such vote each divisional society shall be given one vote for each 20 regular members of the American Osteopathic Association located in the area represented by that divisional society (or in the case of the uniformed services divisional society, one vote for each 20 regular members of the American Osteopathic Association currently serving in the uniformed services of the United States), as certified to 75 days before the annual meeting of the House of Delegates under the requirements of Section 1 of this Article, and such votes may be cast by any one of the delegation then seated or divided among the various members of the delegation as the delegation in caucus shall decide.

Section 3-Committee on Credentials

The Committee on Credentials shall consist of three or more members appointed by the President and it shall be the duty of the Committee to receive and validate the credentials of the delegates to the House and to report all delegates entitled to be seated in the House. The Chief Executive Officer shall furnish the Credentials Committee a list showing the number of delegates to which each divisional society is entitled. In case any organization has selected more than its legal representation, the Chief Executive Officer shall drop surplus names from the list, beginning at the bottom, and shall notify the divisional society of his action.

Section 4-Seating of Delegates

A delegate having been seated shall remain the accredited delegate throughout the meeting. In the event that an accredited delegate has failed to qualify and assume his seat when the House convenes on the second day of the meeting, his accredited alternate may be seated. If a delegate, having been seated, finds himself unable to be present on account of physical disability or other cause acceptable to the House, his alternate may be seated for that roll call period and shall continue as delegate until the previously seated delegate shall return for duty at a subsequent roll call. In that case the alternate delegate who has been seated may, by direction of the House, be dropped from the roll and the previously seated delegate shall return to his seat in the House.

Section 5-Annual Meeting

The annual meeting of the House of Delegates shall be held during June, July or August, and separate from the annual convention or clinical assembly of the Association, upon call of the President. Special sessions of the House of Delegates may be called by the President. The delegates shall be given at least two weeks notice and the object or objects shall be stated in the call of such special meeting.

Section 6-Presiding Officer

The Speaker of the House of Delegates shall be its presiding officer. The Vice Speaker shall preside over the House of Delegates in the absence of or at the request of the Speaker and assume all duties of the Speaker.

Section 7-New Business

No new business shall be introduced on the last day of the meeting of the House of Delegates except by a two-thirds consent of those members present, provided two-thirds of the seated delegates are in attendance.

Section 8-Quorum

One-half of the accredited delegates of the House shall constitute a quorum.
Section 9-Governing Rules
The meetings of the House of Delegates and of all other bodies of this Association shall be governed by Robert's Rules of Order Newly Revised, except in such instances as are specifically provided for in the Constitution and Bylaws of the Association or in the order of business which may be adopted from time to time. The order of business and any special rules adopted at the beginning of the meeting shall govern the procedure unless unanimously suspended.

Section 10-Representation of Student Councils
The student council of each accredited college of osteopathic medicine and each branch campus may be represented in the House of Delegates by its president (and such president’s alternate elected by such student council) as a member of the delegation of the divisional society representing the state in which such college of osteopathic medicine and branch campus is located. Each such student delegate shall be accredited in the same manner and have the same privileges as the other members of the divisional society delegation; however, the chief administrative officer of each accredited college of osteopathic medicine and each branch campus shall certify the student council president and alternate to the Chief Executive Officer of this Association in writing or by electronic communication at least 30 days prior to the first day of the annual meeting of the House of Delegates and such Chief Executive Officer shall forthwith similarly certify each student council president and alternate to the secretary of the appropriate divisional society.

Section 11-Representation of Osteopathic Physicians In Postdoctoral Training AND/OR NEW PHYSICIANS IN PRACTICE
Osteopathic physicians in postdoctoral training AND/OR NEW PHYSICIANS IN PRACTICE may be represented in the House of Delegates by two individuals who, at the time of the annual meeting, shall be enrolled in postdoctoral training programs OR CURRENTLY A NEW PHYSICIAN IN PRACTICE AS DEFINED BY THE ASSOCIATION. The two individuals and their alternates shall be selected by vote of the AOA’s Council of Interns and Residents BUREAU OF EMERGING LEADERS (BEL). The delegates (and alternate delegates) selected by the Council of Interns and Residents BEL shall serve as the representatives of osteopathic physicians in postdoctoral training AND NEW PHYSICIANS IN PRACTICE. and THESE DELEGATES shall not also be members of a divisional society or specialty college delegation to the AOA’s House of Delegates. The chair of the Council of Interns and Residents CO-CHAIRS OF THE BEL shall certify the nameS of its delegates and alternate delegates to the Chief Executive Officer of the AOA in writing or by electronic communication at least 30 days prior to the first day of the annual meeting of the AOA House of Delegates. Each delegate and alternate must be a member in good standing of this Association.

Section 12—Representation of Student Osteopathic Medical Association
The Student Osteopathic Medical Association (SOMA) may be represented in the House of Delegates by one member of the SOMA Board selected by vote of the SOMA Board (or such SOMA member’s alternate, who shall also be a member of the SOMA Board selected by the SOMA Board). No SOMA delegate or alternate shall also be a member of a divisional society’s delegation representing the state in which such SOMA Board member’s osteopathic college is located. The SOMA delegate shall be accredited in the same manner and have the same privileges as the other members of the divisional society delegation; however, the Chief Administrative Officer of SOMA shall certify the SOMA delegate and alternate to the Chief Executive Officer of this Association in writing or by electronic communication at least 30 days prior to the first day of the annual meeting of the House of Delegates.

Article VI—Elections
Section 1—Qualifications
Except where positions are designated as public members, membership in both the AOA and a
divisional society shall be a requisite for qualification for any officer or for any member of any
department, division, bureau or committee of the Association, however selected, if the incumbent
shall be an osteopathic physician.

Section 2--Nominations
Nomination of all officers and trustees of this Association, and nomination of the Speaker and Vice
Speaker of the House of Delegates, excepting nomination of those otherwise provided for in the
Constitution, shall be a regular order of business in the House of Delegates at the annual meeting of
the House. Nominations may be made from the floor immediately preceding the balloting.
Nominating speeches shall not exceed two minutes.

Section 3--Method of Election
Election of such officers and trustees as are elected by the House of Delegates shall take place during
the last day of the annual meeting. All elections shall be by ballot except as hereinafter provided in this
section and a majority of all votes cast shall be necessary to elect. In recording such vote, each
divisional society shall be given one vote for each 20 regular members of the American Osteopathic
Association located in the area or serving in the uniformed services of the United States represented by
that division, and such votes may be cast by any one of the delegation then seated or divided among
the various members of the delegation as the delegation in caucus shall decide. If there shall be but one
nominee for a given office or trusteeship it shall be the duty of the secretary to cast the elective ballot
for that nominee. The Speaker and Vice Speaker of the House shall be elected to serve for one year or
until their successors are elected and installed.

Section 4--Installation
The officers who have served throughout that meeting shall complete all business of the annual
meeting so far as is practicable. The officers-elect shall be installed as the final order of business and
shall assume the authority of their respective offices upon adjournment of the meeting.

Article VII--Board of Trustees

Section 1--Duties
The Board of Trustees shall:

a. Direct the management of the affairs of the Association between annual meetings. It shall
meet coincident with the annual meeting of the House of Delegates and at other times on call
of the President, shall make all arrangements for the annual meetings, shall appoint all
standing and special committees not otherwise provided for in these Bylaws, and may fill by
appointment any vacancy occurring in its own membership or any other elective office until
the time of the next meeting of the House of Delegates. A quorum of the Board shall be a
majority of the members thereof.

b. Appoint a Chief Executive Officer, a Controller, a General Counsel, and an Editor, and shall
fix the amount of their salaries and the length of their terms of office. It shall fix the duties of
the Chief Executive Officer, Controller, General Counsel, Editor and all other officials,
committees, departments and bureaus necessary to the proper execution of the policies of the
Association and not fixed by these Bylaws.

c. Have the responsibility of management of the finances of the Association and shall authorize
and supervise, the House of Delegates concurring, all expenditures thereof. It shall appoint a
certified public accountant to audit the financial records of the Association and certify to the
accuracy of the statement of financial condition of the Association to be reported at the
annual meetings.
No appropriation shall be made by the House of Delegates except upon recommendation of the Bureau of Finance approved by the Board of Trustees, and all resolutions, motions or otherwise, having for their purpose the appropriation of funds, shall first be referred without discussion to the Bureau of Finance of the Board of Trustees. An adverse ruling on such motions may be overruled by a three-fourths vote of the House of Delegates.

d. Provide for the publication of an official journal of the Association and such other publications as are deemed necessary or shall be directed by the House of Delegates.

e. Maintain and revise the Administrative Guide annually. The general purpose of this manual shall be to provide a handy reference book of concise statements of the duties of all officials, committees, departments, bureaus and employees of the Association, to the end that there shall be no conflict of jurisdiction or duplication of effort. Copies of such Guide shall be furnished to each divisional society and affiliated organization as well as officers of the American Osteopathic Association and other groups or individuals as directed by the Board of Trustees of the Association.

f. Establish such departments, committees, bureaus, councils, and commissions, and authorize the president’s creation of such task forces, as shall be necessary to further the policies of the Association and determined by the House of Delegates and shall determine the duties and powers of such departments, committees, bureaus, councils, commissions and task forces.

g. Approve from its own membership, based on the President’s appointment, the chairs of the departments. The department chairs shall direct the activities of their respective departments. However, the public member of the board shall not be eligible to serve as a department chair. The Board shall also approve, based on the President’s appointment, the members of the various committees, bureaus, councils, commissions and task forces under the departments.

h. Decide finally all questions of an ethical or judicial character. It shall have investigated by the Committee on Ethics all charges or complaints of violation of the Constitution, Bylaws, or of grossly unprofessional conduct of any member. The Board shall have the power to censure, place on probation for not exceeding a three-year period, suspend for not exceeding a three-year period or expel a member, as the findings warrant. A member may be cited to appear before it by the Board of Trustees or the Committee on Ethics to answer charges or complaints of unethical or unprofessional conduct. Upon 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, his license to practice in a state on the grounds of having committed a violation of a disciplinary provision of the licensing law by a duly constituted state licensing agency, or the voluntary surrender of his license while under charges of having committed said violation, such member shall automatically be deemed expelled from membership in this Association; a conviction shall be deemed final for the purposes hereof when affirmed by an appellate tribunal of final jurisdiction or upon expiration of the period allowed for appeal. The Committee on Membership shall be granted the authority to restore to membership a doctor whose license was revoked, and later retroactively reinstated by his licensing board.

If, because of a breach of the Code of Ethics, a member shall have been suspended, or expelled from a divisional society or affiliated organization by proper action of such divisional society or affiliated organization, the Board of Trustees of this Association shall review the record of such decision. The decision may first be referred to the Committee on Ethics for recommendations. If the Board shall concur in the action of the divisional society or affiliated organization, such 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. The Board is authorized to adopt and amend from time to time, in the manner directed by the Board, a Guide for Administrative Procedure regulating the procedure applicable to matters involving violations of the Code of Ethics.

Section 2--Appeal
A minority of one-third or more members of the Board of Trustees present at any session may appeal to the House of Delegates from the decision of the majority on any question at the current meeting.

Section 3--Executive Committee
The Executive Committee shall transact the business of the Board of Trustees between meetings.

Section 4--By-Mail Vote
Between meetings of the Board of Trustees and of the Executive Committee, a by-mail vote, or vote by other means of electronic communications, on any urgent matter may be taken of the members of the Board of Trustees, or Executive Committee, if a consent in writing setting forth the action so taken shall be signed by all of the trustees or members of the Executive Committee entitled to vote with respect to the subject matter thereof, any such vote to be entered into the records at the next meeting of the Board.

Section 5--Indemnification
Each trustee, officer, and employee of this Association now or hereafter in office and his heirs, executors, and administrators, and each trustee, officer, and employee of this Association and his heirs, executors, and administrators who now acts, or shall hereafter act at the request of this Association as employee, trustee, director, or officer of another corporate entity controlled by this Association, shall be indemnified by this Association against all costs, expenses, judgments, fines, and amounts or liability therefore, including counsel fees, reasonably incurred by or imposed upon him in connection with or resulting from any action, suit, proceeding, or claim to which he may be made a party, or in which he may be or become involved by reason of his acts of omission or commission, or alleged acts of omission or commission as such trustee, officer, or employee, or, subject to the subsequent provisions of the section, any settlement thereof, whether or not he continues to be such trustee, officer, or employee at the time of incurring such costs, expenses, judgments, fines or amounts, provided that such indemnification shall not apply with respect to any matters as to which such trustee, officer, or employee shall be finally adjudged in such action, suit, or proceeding to have been individually guilty of misconduct, misfeasance, or malfeasance in the performance of his duty as such trustee, officer, or employee. The indemnification herein provided shall, with respect to any settlement of any such suit, action, proceeding, or claim, include reimbursement of any amounts paid and expenses reasonably incurred in settling any such suit, action, proceeding, or claim, when the Board of Trustees has determined that such settlement and reimbursement appear to be for the best interests of this Association. Such determination shall be made (1) by the Board of Trustees or by a majority vote of a quorum consisting of trustees who were not parties to such action, suit, or proceeding, or (2) if such a quorum is not obtainable (or, even if obtainable, a quorum of disinterested trustees so directs) by independent legal counsel in a written opinion. The foregoing right of indemnification shall be in addition to and not exclusive of any and all other rights as to which any such trustee, officer, or employee may be entitled under any bylaw, agreement, or otherwise.

Expenses incurred in defending a civil or criminal action, suit, or proceeding may be paid by the Association in advance of the final disposition of such action, suit, or proceeding as authorized by the Board of Trustees or Executive Committee in the manner heretofore provided, upon receipt of a written undertaking by or on behalf of the trustee, officer, or employee to repay such amount unless
it shall ultimately be determined that he is entitled to be indemnified by the Association as authorized
in this section.

The Board of Trustees may authorize the Association to purchase and maintain insurance on behalf of
any person who is or was a trustee or employee of the Association or is or was serving at the request
of the Association as a trustee, director, officer, employee, or agent of another corporate entity
controlled by the Association against any liability asserted against him and incurred by him in any such
capacity, or arising out of his status as such, whether or not the Association would have the authority
or power to indemnify him against such liability under the provisions of this section.

Article VIII--Duties of Officers

Section 1--President
The President shall be the chairman of the Board of Trustees and of the Executive Committee and
shall perform the duties usually pertaining to his office. He shall nominate, subject to approval by the
Board of Trustees, all appointive officers, unless otherwise specified in the Bylaws and in accordance
with the directives contained in the Administrative Guide or as established by the Board of Trustees
or the House of Delegates.

Section 2--President-elect
The President-elect shall perform the duties of the office of the President in the absence of or at the
request of the President.

Section 3--Vice-Presidents
The Vice-Presidents, in the order of their designation and in the absence or at the request of the
President and President-elect, shall perform the duties of the office of the President.

Section 4--Speaker/Vice-Speaker of the House of Delegates
The Speaker or the Vice-Speaker of the House of Delegates shall perform such duties as custom and
parliamentary usage require. The Speaker shall appoint reference committees of the House to perform
functions for which they are created subject to the approval of the House. He shall have such other
privileges and duties as may be assigned to him by the House of Delegates, which privileges and duties
shall not be in conflict with the privileges and duties assigned by the Constitution and Bylaws to other
officers of the Association. The Vice-Speaker of the House of Delegates shall assume the duties of the
Speaker in his absence or at his request.

Section 5--Chief Executive Officer
The Chief Executive Officer shall:

a. Be the chief administrative officer of the Association and of the central office. He shall be
   the executive and recording secretary of the Association. He shall counsel with the other
   administrative officers and with the heads of departments in the central office to produce
   the greatest possible cooperation and efficiency in the conduct of the affairs of the
   Association under the President and the Board of Trustees. He shall cooperate with the
   chairmen of various agencies of the Association in the execution of the policies of the
   Association as outlined by the House of Delegates. It shall be his duty to coordinate the
   work performed by the various departments, bureaus, and committees of the Association.

b. Direct the joint activities of the Association and the divisional societies as provided by the
   Bylaws, and may select one or more of the trustees or like officers of the divisional societies,
   to assist him in this work in their respective areas.

c. Be responsible for the correspondence of the Association and shall keep accurate record of the
   proceedings of the House of Delegates and the Board of Trustees. d. Be responsible for the
supervision of assistance to the divisional societies in all matters according to the policies laid
down by the Association and for the supervision of the execution of plans of the Association
with regard to colleges, affiliated organizations and campaigns.

d. Keep on file an accurate record of all transactions of his office, which shall at any time be
subject to examination by the President or the Board of Trustees, shall make an annual report
to the House of Delegates and Board, and shall perform such other duties as are prescribed by
the Board not in conflict with the Constitution and Bylaws of this Association.

e. Be the statistical officer of the Association, and shall have charge of the archives, including
legal, historical and scientific records of value to the Association.

f. Be authorized to provide such assistance as is necessary for the proper conduct of the
central office, subject to the directives of the Board of Trustees, and at the expiration of his
term shall deliver to his successor all property and papers pertaining to his office. He shall
file bond with such surety company and in such amount as the Board of Trustees shall
determine.

Section 6--Controller

The Controller shall:

a. Have charge of the funds and assets of the Association, cooperate with the Chief Executive
Officer and Editor under the direction of the Board of Trustees, and disburse such funds
only in the manner prescribed by the Board of Trustees.

b. Be responsible for the collection of dues and assessments as provided in these Bylaws; shall
cooperate with like officers of the divisional societies and may delegate them to assist him in
their respective societies.

c. Keep on file accurate records of the transactions of his office, which shall at all times be
subject to examination by the Board of Trustees. He shall prepare reports quarterly for the
Board of Trustees and annually for the House of Delegates and the Board, and at the
expiration of his employment; he shall deliver to his successors or to the Board, or their
assigned agent, all monies, records and other property of the Association subject to his
jurisdiction. He shall perform such other duties as may be prescribed by the Board
consistent with the Constitution and Bylaws of the Association.

d. Be provided with such assistance as is necessary to the proper conduct of his office, subject to
the directives of the Board of Trustees through the Chief Executive Officer. He shall file
bond with such surety company and in such sum as the Board of Trustees may determine.

Section 7--General Counsel

The General Counsel shall:

a. Be the chief legal officer of the Association, responsible for oversight and management of all
legal services provided to the Association, its trustees, officers and staff to ensure protection
of the Association’s legal rights and maintenance of its operations consistent with the limits
established by law.

b. Provide legal advice and guidance to the trustees, officers, and staff, bureaus, councils, task
forces, commissions and committees of the Association on the legal implications of matters
relevant to the Association, including compliance with federal, state, and local laws and
regulations applicable to a tax-exempt, not-for-profit membership organization and adherence
to internal organizational policies and procedures.

c. Draft and review contracts and other legal documents, policies and procedures; research
pertinent to legal issues; prepare written and oral opinions and position statements on issues identified by the Association’s trustees, officers, staff, bureaus, councils, task forces, commissions and committees;

d. Represent or coordinate the representation of the Association in judicial and administrative proceedings; and

e. Select and retain outside counsel, as required, to obtain legal opinions or to handle claims and litigation. Supervises legal work of other Association attorneys and outside counsel.

Section 8--Editor

The Editor shall:

a. Have the editorial direction, in accordance with the established policies of the Board of Trustees and House of Delegates, of The Journal of the American Osteopathic Association, other periodical publications of the Association and of the AOA Yearbook and Directory, under the general supervision of the Chief Executive Officer, and shall cooperate with all departments of the central office.

b. Be provided with such assistance as is necessary to the proper conduct of his office, subject to the directives of the Board of Trustees through the Chief Executive Officer.

Article IX--Departments, Bureaus, and Committees

The Board of Trustees and House of Delegates, consistent with the powers given to it by these Bylaws, shall establish and determine the duties of departments, bureaus, councils, commissions, committees, and task forces necessary to further the policies of the Association. The Association’s departments shall include the Departments of Affiliated Affairs, Business Affairs, Educational Affairs, Governmental Affairs, Professional Affairs, and Research, Quality & Public Health. The activities of all departments, bureaus and committees shall, so far as possible, be executed in close cooperation with the Chief Executive Officer. Upon the expiration of the terms of office of chairs and members of the departments, bureaus, or committees, all records of the same shall be delivered by the chairs to the Chief Executive Officer. All employed staff of departments, bureaus, and committees in the offices shall be under the jurisdiction of the Chief Executive Officer.

Article X--Conventions and Meetings

Whenever referred to in this Constitution and Bylaws, the words annual meeting shall refer to the annual meetings of the Board of Trustees or of the House of Delegates, respectively, and the words annual convention or clinical assembly shall refer to the annual clinical assembly of the Association.

Section 1--Annual Clinical Assembly

The annual clinical assembly shall be held at such time and place as may be determined by the Board of Trustees, provided, however, such action may be changed by the House of Delegates by a two-thirds vote of the total number of delegates accredited for voting.

Section 2--Annual Meetings

The annual meetings of the Board of Trustees shall be held at such time and place as may be determined by the Board of Trustees, provided, however, such action may be changed by the House of Delegates by a two-thirds vote of the total number of delegates accredited for voting.

Article XI—Amendments

Section 1--Bylaws

These Bylaws may be amended at any annual or special meeting of the House of Delegates by a two-
thirds vote of the total number of delegates accredited for voting, provided that the amendment shall have been filed with the Chief Executive Officer at least two months before the meeting at which the amendment is to be voted upon. Upon receiving a copy of the amendment, it shall be the duty of the Chief Executive Officer to cause it to be distributed by first class mail, postage paid, to each divisional and specialty society entitled to send voting representatives to the House of Delegates, posted on the AOA’s website, and published in *The Journal of the American Osteopathic Association* at least one month before the meeting. The Board of Trustees may revise the proposed amendment if necessary to secure conformity to this Constitution and Bylaws and shall then refer it to the House for final action not later than the day prior to the end of the meeting.

**Section 2--Articles of Incorporation**

The Articles of Incorporation of this Association may be amended by the adoption of a resolution by the Board of Trustees setting forth the proposed amendment and directing that the amendment be submitted to a vote at a meeting of the House of Delegates, which may be either an annual or a special meeting. Written or printed notice setting forth the proposed amendment or a summary of the changes to be effected thereby shall be posted on the AOA’s website and delivered not less than five nor more than 40 days before the date of the meeting, either personally or by mail, by or at the direction of the President, or the Chief Executive Officer, or the officers or persons calling the meeting, to each delegate entitled to vote at such meeting.

Written or printed notice shall include the printing of the amendment in the electronic and/or printed issue of *The Journal of the American Osteopathic Association* published not less than five days or more than 40 days before the date of the meeting. The proposed amendment shall be adopted upon receiving at least two-thirds of the votes entitled to be cast by the total number of delegates accredited for voting.

**Article XII--Gender Disclaimer**

The American Osteopathic Association is open to persons of both sexes and does not discriminate against any person because of sex; therefore, the wording herein importing the masculine or feminine gender includes the other gender and imports no such discrimination.
American Osteopathic Association

House of Delegates

Ad Hoc Committee

Sean D. Stiltner, DO, Chair
Joseph Zamutto, DO, Vice Chair

July 21, 2017
A/2017

CONSENT AGENDA – FOR COLLECTIVE ACTION BY THE HOUSE OF DELEGATES

Mr. Speaker, I present the following Consent Agenda, and the Committee recommends that it be APPROVED:

H-600 OSTEOPATHIC CERTIFICATIONS – RIGHTS OF MEMBERS TO PROTECT THEIR (H328-A/12)

H-603 OBESITY ACTION COALITION EFFORTS ON THE TREATMENT OF SEVERE OBESITY (H603-A/12)

H-604 OSTEOPATHIC NEUROLOGIC AND PSYCHIATRIC STANDARD OF CARE (H600-A/10)

H-605 PHYSICIAN DEPOSITIONS (H606-A/12)

H-606 UNIVERSAL EXCHANGE LANGUAGE FOR HEALTH CARE INFORMATION – NEED FOR (H609-A/12)

H-607 ICD-10 – OPPOSITION TO FULL IMPLEMENTATION OF (H611-A/12)

H-610 HIV – POSITIVE STATUS AS A DISABILITY FOR PHYSICIANS (H615-A/12)

H-611 MEDICARE AND MEDICAID ABUSE (H616-A/12)

H-612 MEDICARE AND MEDICAID – ETHICAL PHYSICIAN ARRANGEMENTS (H617-A/12)

H-613 MILITARY MEDICAL READINESS (H618-A/12)

H-614 PRE-AUTHORIZED MEDICAL/SURGICAL SERVICES – DENIAL OF PAYMENT OF (H619-A/12)

H-615 PHYSICIAN/PATIENT EDUCATIONAL MATERIALS RECEIVED FROM PHARMACEUTICAL COMPANIES THAT PRODUCE AND/OR MARKET GENERIC MEDICATIONS (H620-A/12)

H-616 HOME HEALTHCARE SERVICE ABUSE (H621-A/12)
H-617  MEDICARE PAYMENT FAIRNESS (H622-A/12)
H-618  PAYMENT FOR PSYCHIATRIC DIAGNOSES AND TREATMENT BY PRIMARY CARE PHYSICIANS (H624-A/12)
H-619  ILLEGAL IMMIGRANTS TO IMMIGRATION AND NATURALIZATION SERVICE – REPORTING OF (H625-A/12)
H-620  TRANSLATOR SERVICES – PAYMENT FOR (H626-A/12)
H-623  OSTEOPATHIC MUSCULOSKELETAL EVALUATION (H633-A/12)
H-625  HIV CONSENT FORM ELIMINATION
H-630  MANDATED REPORTING OF IMMUNIZATIONS GIVEN IN THE VETERANS ADMINISTRATION SYSTEM AND INDIAN HEALTH SERVICES
H-632  PRIOR AUTHORIZATION
H-637  AMERICAN OSTEOPATHIC ASSOCIATION OPPOSES THE MERGING OF STATE OSTEOPATHIC LICENSING BOARDS WITH STATE MEDICAL LICENSING BOARDS
H-638  PRESCRIPTION DRUG PRICING

And I so move. **APPROVED**

H-601  TELEMEDICINE – AOA POLICY ON (H600-A/12)

Mr. Speaker, I present for consideration Resolution No. H-601, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Pg. 1, Line 23: ...of care. Currently, thirty-nine **A MAJORITY OF** states allow some type…

Pg. 1, Line 24: ...Medicaid. Additionally, eighteen **OTHER** states grant…

Pg. 1, Line 24: ...licenses and forty states **A MAJORITY** of states have specific...

Pg. 2, Line 16: ... in the state that the accident **INCIDENT** occurred...

Pg. 3, Line 13: ... AOA believes **SUPPORTS** that a physician is practicing medicine...

Pg. 3, Line 16: .. AOA believes **SUPPORTS**...

Pg. 3, Line 21: ...AOA believes **SUPPORTS**...

Pg. 3, Line 23: ...AOA believes **SUPPORTS**...

Pg. 3, Line 26: ...AOA believes **SUPPORTS**...

Pg. 3, Line 29: ...AOA believes AOA believes **SUPPORTS**...
Pg. 3, Line 32: ...AOA believes SUPPORTS...

Pg. 3, Line 36: ...AOA believes SUPPORTS...

Pg. 4, Line 1: ...AOA believes SUPPORTS...

Pg. 4, Line 2: ...The AOA further believes SUPPORTS...

And I so move. APPROVED

H-602 PRIMARY CARE INCENTIVE PROGRAM – ADJUSTMENT TO (H602-A/12)

Mr. Speaker, I present for consideration Resolution No. H-602, and the Committee recommends that it be APPROVED with the following AMENDMENT:

Line 5: ... non-physician providers (NPPs) SUPERVISED BY PRIMARY CARE PHYSICIANS, who...

And I so move. APPROVED

H-608 DISCRIMINATION – THE PRACTICE OF OSTEOPATHIC MEDICINE (H612-A/12)

Mr. Speaker, I present for consideration Resolution No. H-608, and the Committee recommends that it be APPROVED with the following AMENDMENT:

Line 9: ...experience as recognized and prescribed DEFINED AND SPECIFIED by the...

And I so move. APPROVED

H-609 DRUGS – PRESCRIPTION-USE AMONG THE ELDERLY (H613-A/12)

Mr. Speaker, I present for consideration Resolution No. H-609, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Line 4: SAFE PRESCRIBING SAFE DRUG PRESCRIBING, INCLUDING ELDERLY PATIENTS

Line 6: ...supports STEPS TO MEASURES TO...

Line 8: ...significantly reducing REDUCE...

Line 9: ...harmful drug interactions IN ALL PATIENTS, INCLUDING THE ELDERLY POPULATION AND SUPPORTS HAVING ONLY OSTEOPATHIC AND ALLOPATHIC PHYSICIANS PRESCRIBE OR SUPERVISE PRESCRIPTIONS WRITTEN BY NON-PHYSICIAN CLINICIANS.

Line 9: ...will work with osteopathic and allopathic physicians, the US Congress, the US Department of Health and Human Services, STATE AND FEDERAL.
Ad Hoc Committee 4 A/2017

LAWMAKERS, and other interested parties to assure the appropriate use of therapeutic agents among the elderly. 2002, revised 2007; reaffirmed 2012.

And I so move. **APPROVED**

**H-621** PHYSICIAN FINES IMPOSED BY THIRD PARTY PAYORS (H629-A/12)

Mr. Speaker, I present for consideration Resolution No. H-621, and the Committee recommends that it be **APPROVED** with the following **AMENDMENT**.

Line 1: ...be SUNSET REAFFIRMED:

Line 4: …fines FEES, HOLD BACKS OR OTHER FINANCIAL PENALTIES

Explanatory Statement: **THE COMMITTEE DOES NOT BELIEVE THAT IT IS APPROPRIATE TO SUNSET POLICY NO. H629-A/12 AT PRESENT TIME. THE COMMITTEE RESPECTFULLY DISAGREES WITH THE EXPLANATORY STATEMENT ACCOMPANYING RESOLUTION NO. H-621 AND DOES NOT BELIEVE POLICY NO. H604-A/15 (I.E., PHYSICIAN QUALITY REPORTING AND PAY FOR PERFORMANCE”) ADDRESSES “PUNITIVE FINES.”**

And I so move. **APPROVED as AMENDED**

**H-622** HEALTH CARE INSURANCE OPTIONS (H631-A/12)

Mr. Speaker, I present for consideration Resolution No. H-622, and the Committee recommends that it be **APPROVED** with the following **AMENDMENT**:

Line 7: …employees and that one of the options be a traditional indemnity insurance plan.

And I so move. **APPROVED**

**H-624** PHYSICIAN PAYMENT IN FEDERAL PROGRAMS (H634-A/12)

Mr. Speaker, I present for consideration Resolution No. H-624, and the Committee recommends that it be **APPROVED** with the following **AMENDMENTS**:

Line 7: ...WORKING IN CAPITATED ALTERNATIVE PAYMENT MODELS...

Line 10: ...adopt managed care for ALTERNATIVE payment systems...

And I so move. **APPROVED**

**H-628** DIRECT PRIMARY CARE

Mr. Speaker, I present for consideration Resolution No. H-628, and the Committee recommends that it be **APPROVED** with the following **AMENDMENTS**:

Line 9: ...their office IN ACCORDANCE WITH APPLICABLE FEDERAL AND STATE LAWS; and..
And I so move. **APPROVED**

**H-629**

OPPOSITION TO THE PRACTICE OF LGBTQ+ CONVERSION THERAPY OR REPARATIVE THERAPY BY LICENSED PHYSICIANS AND OTHER MEDICAL AND MENTAL HEALTH PROFESSIONALS

Mr. Speaker, I present for consideration Resolution No. H-629, and the Committee recommends that it be APPROVED with the following AMENDMENTS:

Subject: OPPOSITION TO THE PRACTICE OF LGBTQ+ CONVERSION THERAPY OR REPARATIVE THERAPY BY LICENSED PHYSICIANS AND OTHER MEDICAL AND MENTAL HEALTH PROFESSIONALS

Submitted by: Ohio Osteopathic Association / Michigan Osteopathic Association / **STUDENT OSTEOPATHIC MEDICAL ASSOCIATION**

Pg. 1, Line 1: ...contemporary science RESEARCH that being lesbian, gay, bisexual, or transgender, questioning (LGBT), or identifying as queer, or other than heterosexual (LGBTQ+), is part of the natural spectrum...

Pg. 2, Line 4: …Counselors and Therapists; AND now, therefore be it…

Pg. 2, Line 5: **WHEREAS,** SEXUAL ORIENTATION CHANGE EFFORTS (SOCE) ARE PRACTICES THAT PURPORT TO CHANGE A PERSON’S SEXUAL IDENTITY THROUGH METHODS THAT MAY INCLUDE SEXUAL VIOLENCE, EXERCISES INVOLVING NUDITY AND INTIMATE TOUCHING, AVERSION THERAPY AND PSYCHOTHERAPY; AND

WHEREAS, THERE IS STRONG EVIDENCE INDICATING THAT SOCE Has SEVERELY NEGATIVE OUTCOMES ON A PERSON’S MENTAL AND PHYSICAL HEALTH THAT INCLUDE: DEPRESSION, SUICIDAL THOUGHTS, SOCIAL WITHDRAWAL, SUBSTANCE ABUSE, DECREASED SELF-ESTEEM AND SEXUAL DYSFUNCTION; AND

WHEREAS, THERE IS CONSENSUS AMONG PROFESSIONAL MEDICAL ASSOCIATIONS THAT SOCE CANNOT CHANGE A PERSON’S SEXUAL ORIENTATION, THESE ASSOCIATIONS INCLUDE, BUT ARE NOT LIMITED TO: AMERICAN MEDICAL ASSOCIATION, AMERICAN PSYCHIATRIC ASSOCIATION, AMERICAN PSYCHOLOGICAL ASSOCIATION, AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY, AMERICAN ACADEMY OF PEDIATRICS, AMERICAN COLLEGE OF PHYSICIANS, AND NATIONAL ASSOCIATION OF SOCIAL WORKERS; AND NOW, THEREFORE BE IT

Pg. 2, Line 5: …that the American Osteopathic Association (AOA) affirms that individuals who identify as homosexual, bisexual, transgender, or are otherwise not heteronormative LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUESTIONING,
IDENTIFYING AS QUEER, OR OTHER THAN HETEROSEXUAL (LGBTQ+)…

Pg. 2, Line 10: …identity, by licensed medical and mental health professionals; and, be it further…

Pg. 2, Line 13: …identity, by licensed medical and mental health professionals; AND, BE IT FURTHER…

Pg. 2, Line 15: RESOLVED, THAT THE AOA OPPOSES THE USE OF SEXUAL ORIENTATION CHANGE EFFORTS (SOCE), WHICH IS BASED ON THE ASSUMPTION THAT HOMOSEXUALITY IS A MENTAL DISORDER THAT SHOULD BE CHANGED; AND, BE IT FURTHER

RESOLVED, THAT ANY EFFORT BY AN OSTEOPATHIC PHYSICIAN TO PARTICIPATE IN ANY SOCE ACTIVITY BE CONSIDERED UNETHICAL.

And I so move. APPROVED as AMENDED

H-636 PATIENT INTERPRETERS

Mr. Speaker, I present for consideration Resolution No. H-636, and the Committee recommends that it be APPROVED with the following AMENDMENT:

Line 21: …reimbursement for physicians for this service PATIENT INTERPRETERS; and, be it further

And I so move. APPROVED

H-627 TELEPHONIC MEDICINE

Mr. Speaker, I present for consideration Resolution No. H-627, and the Committee recommends that it be REFERRED to the TEXAS OSTEOPATHIC MEDICAL ASSOCIATION (TOMA).

Explanatory Statement: THE COMMITTEE RESPECTFULLY REFERS RESOLUTION NO. H-627 BACK TO THE TEXAS OSTEOPATHIC MEDICAL ASSOCIATION (TOMA). THE COMMITTEE REQUESTS THAT TOMA REVIEW THEIR PROPOSAL AND CONSIDER HOW IT MIGHT BE REVISED TO INCLUDE A GREATER LEVEL OF SPECIFICITY AROUND THE IMPETUS FOR INTRODUCING SAID RESOLUTION, THE ISSUE IT SEEKS TO ADDRESS, AND HOW IT MIGHT IMPACT PHYSICIANS WORKING COOPERATIVELY WHO MAY NOT HAVE HAD PREVIOUS DIRECT PHYSICAL CONTACT WITH A PATIENT FOR WHOM THEY HAVE TEMPORARILY ASSUMED CARE (E.G., CALL COVERAGE ARRANGEMENTS).

And I so move. APPROVED (for Referral to TOMA)

H-633 SEXUAL HARASSMENT AND SEXUAL MISCONDUCT IN THE MEDICAL WORKPLACE
Mr. Speaker, I present for consideration Resolution No. H-633, and the Committee recommends that it be REFERRED to the DEPARTMENT OF PROFESSIONAL AFFAIRS.


And I so move. APPROVED (for Referral to AOA Dept of Professional Affairs)

H-626 NOTIFYING PHYSICIANS ABOUT SOFTWARE ERRORS IN ELECTRONIC HEALTH RECORDS

Mr. Speaker, I present for consideration Resolution No. H-626, and the Committee recommends that it be DISAPPROVED. To begin discussion I move for approval.


And I so move. DISAPPROVED

H-631 CENSURE

Mr. Speaker, I present for consideration Resolution No. H-631, and the Committee recommends that it be DISAPPROVED. To begin discussion I move for approval.

Explanatory Statement: THE COMMITTEE AGREES WITH THE EXPLANATORY STATEMENT PROVIDED BY THE BOARD OF TRUSTEES. (I.E., “THE AOA BOARD OF TRUSTEES (BOT) BELIEVES THEIR ACTIONS DID NOT MEET THE LEVEL OF CENSURE BECAUSE THERE WAS NO INTENT TO DECEIVE OR NOT TO IMPLEMENT H332-A/16. THE BOT ACCEPTS RESPONSIBILITY TO IMPLEMENT RESOLUTIONS OF THE HOD. FURTHER, THE BOT HAS FORMED A COMMUNICATIONS COMMITTEE WHOSE TASK IS TO REVIEW PROCESSES AND IMPLEMENT IMPROVEMENTS IN THE DISSEMINATION OF INFORMATION TO MEMBERS AND OTHER STAKEHOLDERS WITH THE SUPPORT OF AOA STAFF. IT IS RECOGNIZED THAT THERE HAVE BEEN ISSUES WITH THE DISTRIBUTION OF B/C/C MATERIALS. IT IS
RECOMMENDED THAT THE AOA BOT SPECIFIC DEPARTMENT CHAIR IMMEDIATELY ADDRESS SAID ISSUES TO ENSURE THAT THE STANDARDS SET FORTH ARE BEING ADHERED TO AND FULLY COMPLIED WITH.”

And I so move. **DISAPPROVED**

**H-634** TRANSPARENCY IN PRESCRIPTION DRUG PRICING AND COST

Mr. Speaker, I present for consideration Resolution No. H-634, and the Committee recommends that it be DISAPPROVED. To begin discussion, I move that it be approved.


And I so move. **DISAPPROVED**

**H-635** STANDING AGAINST SEXUAL ORIENTATION CHANGE EFFORTS (SOCE)

Mr. Speaker, I present for consideration Resolution No. H-635, and the Committee recommends that it be DISAPPROVED. To begin discussion, I move that it be approved.


And I so move. **DISAPPROVED**

Mr. Speaker, this concludes the Committee’s report. I would like to thank the members of this Committee.

Committee Members:
1. Sean D. Stiltner, DO – **CHAIR** Ohio
2. Joseph Zamutto, DO – **VICE CHAIR** California
3. Patrick Botz, DO Michigan
4. Michael Chipman, DO Illinois
5. Nate DeLisi, DO New Hampshire
6. Dennis Dowling, DO New York
7. Pat Galvas, DO Montana
8. Pamela S.N. Goldman, DO Pennsylvania
9. Kevin Hubbard, DO Missouri
10. Allison Lukacic, DO South Carolina
11. Brock McConnehey, DO Idaho
12. Ronald Renuart, DO Florida
13. Clayton Royder, DO  Oklahoma
14. Arthur B. Rubin, DO  West Virginia
15. Lee Logan, DO  Tennessee
16. Lisa A. Witherite-Rieg, DO  Pennsylvania

**STAFF**
Sean Grande, MA
Cindy Penkala, CMM, CMPE, CMSCS, CPOM
SUBJECT: H328-A/12 OSTEOPATHIC CERTIFICATIONS – RIGHTS OF MEMBERS TO PROTECT THEIR

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Osteopathic Specialists recommend that the following policy be REAFFIRMED:

H328-A/12 OSTEOPATHIC CERTIFICATIONS, RIGHTS OF MEMBERS TO PROTECT THEIR

The American Osteopathic Association shall not withdraw an osteopathic physician’s certification, due to restrictions placed upon their medical licenses, unless all appeals have been exhausted. 2012

Explanatory Statement:

ACTION TAKEN APPROVED (for reaffirmation)

DATE July 22, 2017
RESOLVED, that the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED:

H600-A/12 TELEMEDICINE – AOA POLICY ON

The American Osteopathic Association adopts the following policy white paper on Telemedicine. (2012)

AOA POLICY STATEMENT--TELEMEDICINE

With the rapid pace of advancement in technology, telemedicine is an evolving practice – both in the scope of practice that is covered, and in the overall meaning of the term “telemedicine.” Telemedicine is a tool used not only to provide direct services to a patient via information technology, but also specialist and primary care consultations, the online storage and sharing of medical information, imaging services through digital transmissions and the interpretation of images, remote patient monitoring, and medical education.

The practice of medicine via electronic and technological means has been occurring for decades. As technology advances and the breadth of medical practice in this area expand, there is an increasing call to regulate patient care delivered through technological resources. Advocates for telemedicine argue that it provides improved access to medical care and services to patients in rural or distant areas. They also emphasize that it allows for easier access to care for immobile patients and those with limited mobility. Cost-effectiveness, through reduced travel times, is also noted as a cause for increased patient demand for health care services through telemedicine.

Despite its advantages, opponents raise concerns over the lack of regulation and oversight to control this practice. The primary issues involving telemedicine are: (1) licensure of out-of-state practitioners who use technology to treat patients in a state where they are not licensed to practice; (2) technological problems and barriers; (3) reimbursement issues regarding payment for services rendered; and (4) quality of care. Currently, thirty-nine A MAJORITY OF states allow some type of reimbursement for telemedicine services under Medicaid.1 Additionally, eighteen OTHER states grant expedited telemedicine licenses and forty A MAJORITY OF states have specific statutes addressing the practice of medicine over technologic networks.2

Access and Quality

Many see telemedicine as a solution to the access to care issues currently facing many in rural and underserved communities. In an effort to improve access to care in rural areas, CMS, in July 2011, instituted a new rule easing the burden of hospital credentialing for providers offering services via

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telemedicine. This change allows rural critical access hospitals to obtain consultations from a subspecialty provider or facility without undertaking the administrative burden of credentialing each provider individually.

While mostly supportive, concerns about the quality of care being provided through telemedicine do exist. Care deemed to be below the acceptable quality standard can be addressed either via the disciplinary action of a state medical board or via civil legal action (medical malpractice claims). Liability rules vary state by state and concerns exist over the determination of venue when a provider is utilizing telemedicine across state lines. Additionally, standard of care must be established and may vary between face-to-face encounters and telemedicine encounters; although, many providers argue against this variation.

Liability Concerns
One issue that arises under the discussion of advancing online medicine is the question of jurisdiction for liability cases. In cases of medical malpractice, where a physician licensed to practice in two or more states practices medicine over state lines through electronic means, and an adverse event occurs.

Current state and federal statutes and case law provide a remedy to overcome this barrier. Patients are provided a pathway to legal recourse in the state that the accident occurred, if there is a reasonable expectation for that harm to have occurred there. So long as the patient can provide evidence confirming that location, ex: location of the IP address, and did not attempt to deceive the physician as to their location. Under this established system, any time a physician is choosing to perform telemedicine, they should have the expectation that they are choosing to be held liable under another state's laws if an adverse event occurs.

Licensure
Telemedicine is a broad area and is not regulated by one specific board or oversight body. There is no standard for telemedicine education and no certification in the provision of telemedicine. Therefore, the burden of oversight currently falls on the state medical boards. Each board defines care that meets an acceptable quality somewhat differently. State licensure requirements also diverge with significant differences in testing, postgraduate education and continuing medical education requirements. Additionally, scopes of practice vary by state with no overall standard in regards to prescription authority or practice rights. Finally, uniformity fails to exist in what constitutes a visit (establishment of the “physician-patient relationship”), with some states requiring a face-to-face visit before a telemedicine relationship can be established. Due to these differences, some advocates have promoted the concept of national licensure. They believe that a national license for the practice of medicine would eliminate barriers that prevent widespread use of telemedicine.

The AOA supports state-based licensure and discipline oversight, believing that states should have the right to directly regulate and provide oversight for services being provided to their citizens. Concerns have been expressed about who would assume responsibility for disciplinary action against providers if a national medical license was initiated. Currently, protection of the residents of the state is a top function and core value of the state licensing boards.

The American Telemedicine Association (ATA) argues that state-by-state licensing, as it currently exists, restricts consumer choice and the free flow of services, protecting some markets from healthy

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economic competition. New Mexico, a state where 91% of the counties qualify as medically underserved, views telemedicine as a lifesaving mechanism to provide primary patient care and specialty consultation services. Senator Tom Udall (D-NM) believes national medical licensure for telemedicine will improve access to health care. Senator Udall has announced plans to allow physicians to provide care using telemedicine and in some instances, travel more freely across state lines to more remote rural areas by establishing a national licensure system.

Conclusion

The AOA recognizes the benefits of online technology to the medical field, and its ability to assist many patients who may not have access to medical care.

The AOA further recognizes the need to provide a broad framework that establishes recommendations to address telemedicine at the national level, while providing enough flexibility to allow each state to incorporate policies that meet the health care needs of their citizens.

The AOA believes that a physician is practicing medicine, in the absence of physical interaction, when medical services are being provided through simultaneous two-way communication, recognizing that some services may require appropriate and corresponding delays in said communication.

The AOA believes that the utilization of technology in patient care should be used to increase access to care, and must not be used in a way that would diminish patient centered comprehensive personal medical care or the quality of care being provided to the patient. To this end, the AOA supports the concept of telemedicine and advocates that public and private payers adopt payment systems that are inclusive of telemedicine.

The AOA believes that the standard of care provided through the use of technology should be equivalent to that of care provided when the physician and patient are within close physical proximity.

The AOA believes that the technological network being used to deliver patient care must have protocols in place that ensure the stability and security of that network to comply with applicable state and federal laws regarding patient privacy issues.

The AOA believes that the scope of care being delivered by the physician and other health care providers through telemedicine should not exceed education, training and applicable state and federal law.

The AOA believes that state-based licensure and the ability of states to govern activities within their borders is paramount and would oppose any national licensure or efforts to pre-empt state statutes.

The AOA believes that malpractice claims that arise from care provided through technological means, when the physician and patient are located in separate jurisdictions, should be adjudicated under the process currently utilized by the judicial system; whereby, the plaintiff has the ability to determine the venue where the case is filed, within the constraints of that system.

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4 American Telemedicine Association, Medical Licensure and Practice Requirements, June 2011
The AOA believes physicians must provide complete transparency to their patients regarding their location, jurisdiction of licensure and any limitations of the technology used to deliver care.

The AOA believes that as physicians provide care in a variety of new ways, including telemedicine, advanced technology can be used to improve patient care. The AOA further believes that online medicine policies directly tie into the Patient-Centered Medical Home (PCMH) model for care, and recognizes that we must simultaneously implement advancements in telemedicine in order to be successful in that new model.

The AOA will monitor developments in telemedicine on an ongoing basis and update this policy as needed.

Explanatory Statement:

ACTION TAKEN  **APPROVED as AMENDED**

DATE  **July 22, 2017**
RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED:

H602-A/12 PRIMARY CARE INCENTIVE PROGRAM – ADJUSTMENT TO
The American Osteopathic Association is supportive of a 10% incentive payment to primary care physicians and non-physician providers (NPPs), SUPERVISED BY PRIMARY CARE PHYSICIANS, who perform the Primary Care Services specified in The Affordable Care Act, Section 5501(a); and, after the demonstration period is completed, the AOA will work to have the US Congress instruct the Centers for Medicare & Medicaid Services (CMS) to continue to modify the existing qualifications in the Affordable Care Act for the 10% incentive payment by eliminating the Physician’s Primary Care Incentive threshold, thereby including many more or all primary care physicians who perform the specified primary care services. 2012

Explanatory Statement:

ACTION TAKEN  APPROVED as AMENDED
DATE  July 22, 2017
SUBJECT: H603-A/12 OBESITY ACTION COALITION EFFORTS ON THE TREATMENT OF SEVERE OBESITY

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be SUNSET:

H603-A/12 OBESITY ACTION COALITION EFFORTS ON THE TREATMENT OF SEVERE OBESITY

The American Osteopathic Association supports the Obesity Action Coalition efforts to secure coverage for all recognized treatment modalities for the treatment of severe obesity and urges federal and state policymakers and third party payers to cover the treatment of severe obesity including both surgical and non-surgical treatments. 2012

Explanatory Statement:
Combined under H440-A/12 OBESITY -- TREATMENT OF

ACTION TAKEN _APPROVED (for sunset)_

DATE _July 22, 2017_
RESOLVED, that the Bureau of State Government Affairs, the Bureau on Federal Health Programs, and the Bureau of Socioeconomic Affairs recommend that the following policy be REAFFIRMED:

**H600-A/10 OSTEOOATHIC NEUROLOGIC AND PSYCHIATRIC STANDARD OF CARE**

The American Osteopathic Association acknowledges the role osteopathic manipulative treatment (OMT) has in the specialty of Osteopathic Neurology and Psychiatry and agrees that when OMT is chosen to be utilized with appropriately selected patients, therapeutic boundaries will be maintained and respected. 2010

**Explanatory Statement:**

**ACTION TAKEN**  
**APPROVED (for reaffirmation)**

**DATE**  
**July 22, 2017**
SUBJECT: H606-A/12 PHYSICIAN DEPOSITIONS

SUBMITTED BY: Bureau of State Government Affairs / Bureau on Federal Health Programs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of State Government Affairs and the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED:

H606-A/12 PHYSICIAN DEPOSITIONS
The American Osteopathic Association believes that physicians being deposed should have the right to review and amend the deposition prior to submission and be provided a complete, final copy of the deposition. 2012

Explanatory Statement:

ACTION TAKEN **APPROVED** (for reaffirmation)

DATE **July 22, 2017**
RESOLVED, that the Bureau of State Government Affairs and the Bureau of Socioeconomic Affairs recommend that the following policy be SUNSET:

H609-A/12 UNIVERSAL EXCHANGE LANGUAGE FOR HEALTH CARE INFORMATION – NEED FOR

The American Osteopathic Association endorses the development, acceptance and implementation of an operational, universal, national protected health information technology infrastructure; and that this infrastructure has as its core function a universal exchange language or interchange portal for healthcare information that will allow electronic medical records systems (EMR) throughout the nation to access important health data anywhere in the country, with a requirement for rigorously protecting privacy and security. 2012

Explanatory Statement:
Covered under interoperability language in policy H605-A/14 HEALTH INFORMATION TECHNOLOGY SOFTWARE—REGULATION OF.

ACTION TAKEN  APPROVED (for sunset)

DATE  July 22, 2017
SUBJECT: H611-A/12 ICD-10 – OPPOSITION TO FULL IMPLEMENTATION OF

SUBMITTED BY: Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of State Government Affairs and the Bureau of Socioeconomic Affairs recommend that the following policy be SUNSET:

H611-A/12 ICD-10 – OPPOSITION TO FULL IMPLEMENTATION OF

The American Osteopathic Association opposes full implementation of ICD-10 as currently proposed, lacking sufficient evidence that the improvement in cost-effective patient care outweighs the anticipated burden to physicians, other health care entities (providers) or patients.

2012

Explanatory Statement:
Full implementation of ICD-10 occurred in 2016.

ACTION TAKEN: APPROVED (for sunset)

DATE: July 22, 2017
RESOLVED, that the Bureau of State Government Affairs, the Bureau on Federal Health Programs, and the Bureau of Socioeconomic Affairs recommend that the following policy be REAFFIRMED:

**H612-A/12 DISCRIMINATION – THE PRACTICE OF OSTEOPATHIC MEDICINE**

The American Osteopathic Association: (1) supports the inclusion of osteopathic physicians in all healthcare delivery systems; (2) opposes restraint of trade and supports the ability of all osteopathic physicians to practice freely in all institutions, as qualified by training and experience as recognized and prescribed DEFINED AND SPECIFIED by the AOA; and (3) opposes discrimination against osteopathic physicians. 1987; revised 1992, 1997, 2002; revised 2007; reaffirmed as amended 2012

**Explanatory Statement:**

**ACTION TAKEN APPROVED as AMENDED**

**DATE** _July 22, 2017_
SUBJECT: H613-A/12 DRUGS – PRESCRIPTION-USE AMONG THE ELDERLY

SUBMITTED BY: Bureau of State Government Affairs / Bureau on Federal Health Programs / Bureau of Socioeconomic Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of State Government Affairs, the Bureau on Federal Health Programs, and the Bureau of Socioeconomic Affairs recommend that the following policy be REAFFIRMED as AMENDED:

H613-A/12 DRUGS – PRESCRIPTION-USE AMONG THE ELDERLY SAFE DRUG PRESCRIBING, INCLUDING ELDERLY PATIENTS

The American Osteopathic Association supports STEPS TO MEASURES TO having only osteopathic and allopathic physicians prescribe or supervise prescriptions written by non-physician clinicians as another important step in significantly reducing REDUCE the problems of over-medication, under-medication and / or harmful drug interactions IN ALL PATIENTS, INCLUDING THE ELDERLY POPULATION AND SUPPORTS HAVING ONLY OSTEOPATHIC AND ALLOPATHIC PHYSICIANS PRESCRIBE OR SUPERVISE PRESCRIPTIONS WRITTEN BY NON-PHYSICIANS CLINICIANS. and will work with osteopathic and allopathic physicians, the US Congress, the US Department of Health and Human Services, STATE AND FEDERAL LAWMAKERS, and other interested parties to assure ENSURE the appropriate use of therapeutic agents among the elderly. 2002, revised 2007; reaffirmed 2012

Explanatory Statement:

ACTION TAKEN APPROVED as AMENDED

DATE July 22, 2017
RESOLVED, that the Bureau of State Government Affairs and the Bureau of Socioeconomic Affairs recommend that the following policy be REAFFIRMED:

**H615-A/12 HUMAN IMMUNODEFICIENCY VIRUS (HIV) – POSITIVE STATUS AS A DISABILITY FOR PHYSICIANS**

The American Osteopathic Association supports efforts to require all disability insurance contracts to recognize HIV positive status as a disability for all physicians, regardless of specialty, provided that the physician can demonstrate that this status has caused a significant loss of patients, income or privileges. 1992; revised 1997; reaffirmed 2002; 2007; 2012

Explanatory Statement:

**ACTION TAKEN** APPROVED (for reaffirmation)

**DATE** _July 22, 2017_
RESOLVED, that the Bureau of State Government Affairs, the Bureau on Federal Health Programs, and the Bureau of Socioeconomic Affairs recommend that the following policy be REAFFIRMED as AMENDED:

H616-A/12   MEDICARE AND MEDICAID HEALTH CARE FRAUD AND ABUSE

The American Osteopathic Association continues to pledge its full cooperation and support of all reasonable and appropriate efforts by the federal government and the states to stop all fraud and abuse of Medicare and Medicaid IN HEALTH CARE. 1977; revised and reaffirmed 1982; revised 1987; reaffirmed 1992, 1997, 2002; 2007; 2012

Explanatory Statement:

ACTION TAKEN  APPROVED (as amended)

DATE  July 22, 2017
RESOLVED, that the Bureau on Federal Health Programs and the Bureau of Socioeconomic Affairs recommend that the following policy be REAFFIRMED:

H617-A/12  MEDICARE AND MEDICAID – ETHICAL PHYSICIAN ARRANGEMENTS

The American Osteopathic Association will continue to inform its members regarding the safe harbor rules as put forward by the HHS Inspector General. 1992; revised 1997; reaffirmed 2002; 2007; 2012

Explanatory Statement:

ACTION TAKEN  APPROVED (for reaffirmation)

DATE  July 22, 2017
RESOLVED, that the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED:

H618-A/12 MILITARY MEDICAL READINESS

The American Osteopathic Association supports efforts by the Department of Defense which encourage the voluntary participation of osteopathic physicians in the military and improves the military medical readiness of America. 1987; revised 1992; reaffirmed 1997; 2002; 2007; 2012

Explanatory Statement:

ACTION TAKEN **APPROVED (for reaffirmation)**

DATE **July 22, 2017**
SUBJECT: H619-A/12 PRE-AUTHORIZED MEDICAL/SURGICAL SERVICES – DENIAL OF PAYMENT OF

SUBMITTED BY: Bureau on Federal Health Programs / Bureau of Socioeconomic Affairs / Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau on Federal Health Programs, the Bureau of Socioeconomic Affairs, and the Bureau of State Government Affairs recommend that the following policy be SUNSET:

**H619-A/12 PRE-AUTHORIZED MEDICAL/SURGICAL SERVICES – DENIAL OF PAYMENT OF**

The American Osteopathic Association supports legislation that would prohibit any healthcare insurer from retrospectively denying payment for any medical or surgical service or procedure that has already been pre-authorized by such health insurer; and, furthermore, any such letters by health insurers to physicians and patients indicating that the medical services/procedures that have been pre-authorized may not necessarily be compensated for should cease and desist.

1997; revised 2002; 2007; reaffirmed 2012

Explanatory Statement:
Covered in policy H640-A/16 PRIOR AUTHORIZATION.

ACTION TAKEN _APPROVED (for sunset)___

DATE _July 22, 2017__________


SUBJECT: H620-A/12 PHYSICIAN/PATIENT EDUCATIONAL MATERIALS RECEIVED FROM PHARMACEUTICAL COMPANIES THAT PRODUCE AND/OR MARKET GENERIC MEDICATIONS

SUBMITTED BY: Bureau of Osteopathic Clinical Education and Research

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that
the following policy be REAFFIRMED:

H620-A/12 PHYSICIAN/PATIENT EDUCATIONAL MATERIALS RECEIVED FROM 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; reaffirmed 2012

Explanatory Statement:

ACTION TAKEN APPROVED (for reaffirmation)

DATE July 22, 2017
RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be SUNSET:

H621-A/12   HOME HEALTHCARE SERVICE ABUSE

The American Osteopathic Association encourages its members to prevent fraud and abuse of home health care services. 1997; revised 2002; 2007; reaffirmed as amended 2012

Explanatory Statement:
Covered in policy H616-A/12 MEDICARE AND MEDICAID ABUSE.

ACTION TAKEN:  **APPROVED (for sunset)**

DATE:  **July 22, 2017**
RESOLVED, that the Bureau of Socioeconomic Affairs and the Bureau on Federal Health Programs recommend that the following policy be SUNSET:

H622-A/12  MEDICARE PAYMENT FAIRNESS

The American Osteopathic Association supports the concept of equitable Medicare funding and benefits for all Medicare beneficiaries and will make every effort to convince the Centers for Medicare and Medicaid Services (CMS) to make more equitable payment for medical services provided under Medicare risk contracts. 1997; revised 2002; 2007; reaffirmed as amended 2012

Explanatory Statement:
Setting equitable benefits and funding for all Medicare beneficiaries would create significant burden to those seniors in high-cost areas of the United States

ACTION TAKEN  APPROVED (for sunset)

DATE  July 22, 2017
RESOLVED, that the Bureau of Socioeconomic Affairs, the Bureau of State Government Affairs, and the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED as AMENDED:

**H624-A/12 PAYMENT FOR PSYCHIATRIC DIAGNOSES AND TREATMENT BY PRIMARY CARE PHYSICIANS**

The American Osteopathic Association: (1) strongly objects to any insurance plan refusal to pay primary care physicians for treating patients with psychiatric diagnoses without a referral from the behavioral medicine agency or provider; (2) will make every effort to influence these insurers to reverse this policy and allow primary care physicians to provide care for these patients and be paid for these services; and (3) will communicate with the Department of Health REGULATORS and respective third-party payers to eliminate the mandatory referral in order to be paid when proper documentation is provided. 2007; reaffirmed as amended 2012

Explanatory Statement:

ACTION TAKEN  **APPROVED (as amended)**

DATE  **July 22, 2017**
SUBJECT: H625-A/12 ILLEGAL IMMIGRANTS TO IMMIGRATION AND NATURALIZATION SERVICE – REPORTING OF

SUBMITTED BY: Bureau on Federal Health Programs / Bureau of State Government Affairs

REFERRED TO: Ad Hoc Committee

RESOLVED, that the Bureau of State Government Affairs and the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED:

H625-A/12 ILLEGAL IMMIGRANTS TO IMMIGRATION AND CUSTOMS ENFORCEMENT – REPORTING OF

The American Osteopathic Association will petition the Centers for Medicare and Medicaid Services, and relevant state agencies, to review and modify their rules and regulations to ensure that physicians are indemnified and therefore not held responsible to identify the legal resident status of any patient. 2007; reaffirmed as amended 2012

Explanatory Statement:

ACTION TAKEN APPROVED (for reaffirmation)

DATE July 22, 2017
RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be REAFFIRMED:

H626-A/12 TRANSLATOR SERVICES – PAYMENT FOR
The American Osteopathic Association will work with third party payers and government insurers to develop a system wherein physicians will be offered additional payment when the use of translators is necessary for the care of the patient. 2007; reaffirmed as amended 2012

Explanatory Statement:

ACTION TAKEN APPROVED (for reaffirmation)

DATE July 22, 2017
RESOLVED, that the Bureau of Socioeconomic Affairs recommend that the following policy be SUNSET REAFFIRMED:

H629-A/12 PHYSICIAN FINES IMPOSED BY THIRD PARTY PAYORS

The American Osteopathic Association opposes all punitive fines, hold backs or other financial penalties levied on physicians for acts committed by patients that are not under the absolute control of the physician. 2007; reaffirmed 2012

Explanatory Statement:
H604-A/15 PHYSICIAN QUALITY REPORTING AND PAY FOR PERFORMANCE comprehensively addresses pay-for-performance.

Reference Committee Explanatory Statement:
The committee does not believe that it is appropriate to sunset policy No. H629-A/12 at present time. The committee respectfully disagrees with the explanatory statement accompanying resolution no. H-621 and does not believe policy No. H604-a/15 (i.e., physician quality reporting and pay for performance”) addresses “punitive fines.”

ACTION TAKEN: APPROVED as AMENDED

DATE: July 22, 2017
RESOLVED, that the Bureau of Socioeconomic Affairs, the Bureau on Federal Health Programs, and the Bureau of State Government Affairs recommend that the following policy be REAFFIRMED:

**H631-A/12 HEALTH CARE INSURANCE OPTIONS**

The American Osteopathic Association supports legislation that requires employers who are obligated by law to provide insurance to offer more than one option for health insurance for their employees and that one of the options be a traditional indemnity insurance plan. 1986; revised 1991, 1992, 1997; revised 2002; 2007; reaffirmed as amended 2012

Explanatory Statement:

ACTION TAKEN  **APPROVED as AMENDED**

DATE  **July 22, 2017**
RESOLVED, that the Bureau of Osteopathic Clinical Education and Research recommend that the following policy be REAFFIRMED:

H633-A/12  OSTEOPATHIC MUSCULOSKELETAL EVALUATION

The American Osteopathic Association policy urges the osteopathic physician to integrate the musculoskeletal evaluation, along with the concepts of body unity, self-regulation, and structure-function interrelationships, into their clinical evaluation of each patient and include the findings in a plan for treatment. 1982; reaffirmed 1987; revised 1992, 1997, 2002; 2007; reaffirmed as amended 2012

Explanatory Statement:

ACTION TAKEN  APPROVED (for reaffirmation)

DATE  July 22, 2017
RESOLVED, that the Bureau of Socioeconomic Affairs and the Bureau on Federal Health Programs recommend that the following policy be REAFFIRMED as AMENDED:

H634-A/12 PHYSICIAN PAYMENT IN FEDERAL PROGRAMS

The American Osteopathic Association recommends that educational programs for osteopathic medical students, interns, residents and practicing physicians should include utilization management and cost-effectiveness TO SUPPORT THEIR UNDERSTANDING OF WORKING IN CAPITATED ALTERNATE PAYMENT MODELS in the curricula; recommends that the osteopathic staff members of health care institutions should continue to improve utilization review programs for all patients, consistent with quality assurance and sound osteopathic medical practice; and if states adopt managed care for capitated ALTERNATE payment systems for Medicaid, that they contain a provision to ensure the fullest participation of all physicians, ensuring best patient care and adequate compensation to all parties concerned, while preserving referral patterns as established by the osteopathic profession. 1986; revised 1991, 1992, 1997; reaffirmed 2002; 2007; reaffirmed as amended 2012

Explanatory Statement:

ACTION TAKEN APPROVED as AMENDED

DATE July 22, 2017
WHEREAS, in 1981 a medical syndrome was discovered in the United States with impaired immune individuals showing symptoms of Pneumocystis carinii and Kaposi's Sarcoma and in 1982 the Center for Disease Control (CDC) named the syndrome Acquired Immune Deficiency Syndrome (AIDS); and

WHEREAS, in 1983 the virus that caused AIDS was discovered and in 1986 was named Human Immunodeficiency Virus; and

WHEREAS, the first medication was developed in 1987 and multiple medications have developed since with great success. The morbidity and mortality rates have declined with the advent of early diagnosis and medication usage. The mortality rate is extremely low in the United States as long as the individual with HIV takes daily medication; and

WHEREAS, the stigma and prejudice of HIV in the 1980s and 1990s was high, federal and state governments required the use of HIV consent forms for testing individuals. While this may have been helpful with a disease that had poor outcomes and a high mortality rate, in 2016 the use of mandatory consent forms are now overbearing, time consuming, and cost prohibitive. More HIV screenings would be performed without the consent forms; and

WHEREAS, in 2006 the CDC released their revised HIV testing recommendations in healthcare settings, that:

1) all patients between 13-64 should have an HIV screening blood test,
2) screening should be incorporated into the general consent for medical care; separate written consent is not recommended,
3) prevention counseling should not be required with HIV diagnostic testing or as part of HIV screening programs in Healthcare settings.; and

WHEREAS, there are no other diseases or disorders requiring consent forms or pre and post test forms; i.e. gonorrhea, syphilis, chlamydia, herpes, diabetes, factor leiden, hemophilia, Helicobacter pylori, or hundreds of others; now, therefore be it

RESOLVED, that the American Osteopathic Association support the elimination of the requirement of physicians and healthcare settings to have consent forms completed before an HIV test.

ACTION TAKEN  **APPROVED**

DATE  **July 22, 2017**
SUBJECT: NOTIFYING PHYSICIANS ABOUT SOFTWARE ERRORS IN ELECTRONIC HEALTH RECORDS

SUBMITTED BY: American College of Osteopathic Family Physicians

REFERRED TO: Ad Hoc Committee

1. WHEREAS, osteopathic physicians are adopting electronic health records software at an accelerating rate; and

2. WHEREAS, errors within software design or code may produce incorrect results; and

3. WHEREAS, incorrect health record data may lead to patient harm; and

4. WHEREAS, software developers may be reluctant to reveal known errors in their software products; and

5. WHEREAS, the 2013 American College of Osteopathic Family Physicians (ACOFP) Congress of Delegates Adopted Policy #17 that supports efforts to require vendors of electronic health records software to report known software errors to their physician clients in order to enhance patient safety; now, therefore be it

RESOLVED, that the American Osteopathic Association adopt as policy that it requests vendors of electronic health records to notify physician clients of reported software errors and provide software updates in a systematic and timely fashion as is standard in other industries that correct these errors to enhance patient safety.

Reference Committee Explanatory Statement:
The Committee believes Resolution No. H-626 is unnecessary due to the fact that the subject matter and statements contain within the proposal have already been addressed in policy no. H630-A/14 (I.E., “Electronic Health Records Software – Reporting Errors to Physicians”).

ACTION TAKEN: **DISAPPROVED**

DATE: **July 22, 2017**
SUBJECT: TELEPHONIC MEDICINE

SUBMITTED BY: Texas Osteopathic Medical Association

REFERRED TO: Ad Hoc Committee

WHEREAS, telemedicine is making rapid advances in quality patient care services that can be delivered to patients in remote areas; and

WHEREAS, telemedicine has the potential for increasing access and quality while reducing the cost of medicine in rural Texas; and

WHEREAS, rules and provisions are presently being developed to ensure that the delivery of patient care via telemedicine is safe, effective and does not compromise quality or safety of the patients served; and

WHEREAS, there are companies in Texas who are masquerading their telephonic medicine (the delivery of medical prescriptions and advice by physicians to customers whom they have never met and with whom they have not had visual contact nor previous physical contact) as "telemedicine" even though their prescriptions and advice are based on simple, non-enhanced telephone conversations, no real verification of caller's identity or the verity of their complaints, minimal quality control, and no security to protect the consumer; now, therefore be it

RESOLVED, that the Texas Osteopathic Medical Association supports efforts to improve and implement advances of best quality and best practices in telemedicine utilizing safe, well controlled, advanced technology in the delivery of a high standard of care especially to rural and underserved areas of Texas; and, be it further

RESOLVED, that the American Osteopathic Association strongly oppose the use of simple telephone conversations, with no technological enhancements to ensure a quality visual examination (known as telephonic medicine), for the delivery of prescriptions to patients not known to the prescribing physician and in the absence of previous physical examination or previous physical contact.

Reference Committee Explanatory Statement:
The committee respectfully refers resolution no. H-627 back to the Texas Osteopathic Medical Association (TOMA). The committee requests that TOMA review their proposal and consider how it might be revised to include a greater level of specificity around the impetus for introducing said resolution, the issue it seeks to address, and how it might impact physicians working cooperatively who may not have had previous direct physical contact with a patient for whom they have temporarily assumed care (e.g., call coverage arrangements).

ACTION TAKEN _REFERRED (to Texas Osteopathic Medical Association)_

DATE _July 22, 2017_
WHEREAS, direct primary care is a growing health care model in which patients pay directly for services in a periodic fashion and third parties are not billed on a fee-for-service basis; and

WHEREAS, direct primary care has been shown to provide patients with extensive benefits such as substantial savings in health care costs, improved patient access to care, increased time spent with their physician, improved preventive health care, and fewer emergency department visits; and

WHEREAS, many direct primary care practices distribute prescription medications out of their office IN ACCORDANCE WITH APPLICABLE FEDERAL AND STATE LAWS; and

WHEREAS, that within the Affordable Care Act health insurance exchange rules, the US Department of Health and Human Services recognizes that direct primary care medical homes are providers and not insurance companies; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) support the direct primary care model of practice and specify that it is not insurance; and, be it further

RESOLVED, that the AOA support patients’ payments to direct primary care practices as qualified medical expenses eligible for Health Savings Accounts through federal changes to Internal Revenue Code 213(d) and 223(c); and, be it further

RESOLVED, that the AOA support a physician’s ability to dispense prescription medications from their office IN ACCORDANCE WITH APPLICABLE FEDERAL AND STATE LAWS; and, be it further

RESOLVED, that the AOA support mechanisms allowing Medicaid and Medicare patients access to direct primary care services while preserving physician autonomy.

Explanatory Statement:

REFERENCES


ACTION TAKEN  APPROVED as AMENDED

DATE  July 22, 2017
SUBJECT: OPPOSITION TO THE PRACTICE OF LGBTQ+ CONVERSION THERAPY OR REPARATIVE THERAPY BY LICENSED PHYSICIANS AND OTHER MEDICAL AND MENTAL HEALTH PROFESSIONALS

SUBMITTED BY: Ohio Osteopathic Association / Michigan Osteopathic Association / STUDENT OSTEOPATHIC MEDICAL ASSOCIATION

REFERRED TO: Ad Hoc Committee

WHEREAS, contemporary science RESEARCH recognizes that being lesbian, gay, bisexual, or transgender (LGBT), or identifying as queer, or other than heterosexual (LGBTQ+), is part of the natural spectrum of human identity and is not a disease, disorder, or illness; and

WHEREAS, the Federal Substance Abuse and Mental Health Services Administration states that “interventions aimed at a fixed outcome, such as gender conformity of heterosexual orientation, including those aimed at changing gender identity, gender expression, and sexual orientation are coercive, can be harmful, and should not be part of behavioral health treatment,”; and

WHEREAS, investigative studies have shown there is insufficient evidence to support the use of psychological or other purportedly therapeutic interventions to change sexual orientation or gender identity, and the benefits reported by participants in sexual orientation change efforts can be gained through approaches that do not attempt to change sexual orientation; and

WHEREAS, the practice of conversion therapy, also known as reparative therapy, or “Sexual Orientation Change Efforts (SOCE),” generally refers to any practices by medical or mental health providers that seek to change an individual’s sexual orientation or gender identity; and

WHEREAS, often, this practice is used on minors, who lack the legal authority to make their own medical and mental health decisions; and

WHEREAS, the practice of conversion therapy or reparative therapy does not include counseling or therapy for an individual seeking to transition or transitioning from one gender to another gender that provides acceptance, support, and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity; and

WHEREAS, the following professional organizations affirm that non-heterosexual identities are normal and that efforts to change sexual orientation are harmful and dangerous to youth: American Medical Association; American Academy of Pediatrics; American
WHEREAS, SEXUAL ORIENTATION CHANGE EFFORTS (SOCE) ARE PRACTICES THAT PURPORT TO CHANGE A PERSON’S SEXUAL IDENTITY THROUGH METHODS THAT MAY INCLUDE SEXUAL VIOLENCE, EXERCISES INVOLVING NUDITY AND INTIMATE TOUCHING, AVERSION THERAPY AND PSYCHOTHERAPY 1, 2; AND

WHEREAS, THERE IS STRONG EVIDENCE INDICATING THAT SOCE HAS SEVERELY NEGATIVE OUTCOMES ON A PERSON’S MENTAL AND PHYSICAL HEALTH THAT INCLUDE: DEPRESSION, SUICIDAL THOUGHTS, SOCIAL WITHDRAWAL, SUBSTANCE ABUSE, DECREASED SELF-ESTEEM AND SEXUAL DYSFUNCTION 3, 4, 5, 6, 7; AND

WHEREAS, THERE IS CONSENSUS AMONG PROFESSIONAL MEDICAL ASSOCIATIONS THAT SOCE CANNOT CHANGE A PERSON’S SEXUAL ORIENTATION, THESE ASSOCIATIONS INCLUDE, BUT ARE NOT LIMITED TO: AMERICAN MEDICAL ASSOCIATION, AMERICAN PSYCHIATRIC ASSOCIATION, AMERICAN PSYCHOLOGICAL ASSOCIATIONS, AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY, AMERICAN ACADEMY OF PEDIATRICS, AMERICAN COLLEGE OF PHYSICIANS, AND NATIONAL ASSOCIATION OF SOCIAL WORKERS; NOW, THEREFORE BE IT

RESOLVED, that the American Osteopathic Association (AOA) affirms that individuals who identify as homosexual, bisexual, transgender, or are otherwise not heteronormative LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUESTIONING, IDENTIFYING AS QUEER, OR OTHER THAN HETEROSEXUAL (LGBTQ+) are not inherently suffering from a mental disorder; and, be it further

RESOLVED, that the AOA strongly opposes the practice of conversion therapy, reparative therapy, or other techniques aimed at changing a person’s sexual orientation or gender identity, by licensed medical and mental health professionals; and, be it further

RESOLVED, that the AOA supports potential legislation, regulations, or policies that oppose the practice of conversion therapy, reparative therapy, or other techniques aimed at changing a person’s sexual orientation or gender identity, by licensed medical and mental health professionals; AND, BE IT FURTHER

RESOLVED, THAT THAT THE AOA OPPOSES THE USE OF SEXUAL ORIENTATION CHANGE EFFORTS (SOCE), WHICH IS BASED ON THE ASSUMPTION THAT HOMOSEXUALITY IS A MENTAL DISORDER THAT SHOULD BE CHANGED; AND, BE IT FURTHER
RESOLVED, THAT ANY EFFORT BY AN OSTEOPATHIC PHYSICIAN TO
PARTICIPATE IN ANY SOCE ACTIVITY BE CONSIDERED
UNETHICAL.

Explanatory Statement:
“Conversion Therapy” continues to be practiced in Ohio by non-licensed religious lay people, clergy,
and licensed counselors, social workers, marriage and family therapists, psychologists, psychiatrists, and
other physicians. The practices of licensed medical and mental health care professionals, who indicate
to a parent or patient that being LGBTQ is a disease, disorder, or illness that can be “fixed”, fit within
the definition of conversion therapy. This highlights the compelling interest Ohio physicians have to
ensure the physical and psychological welfare of our patients, including LGBTQ individuals, by
protecting them from exposure to the detrimental practices of conversion therapy.

REFERENCES:
https://www.splcenter.org/issues/lgbt-rights/conversion-therapy
Efforts (SOCE) and Conversion Therapy with Lesbians, Gay Men, Bisexuals, and Transgender
Persons. Retrieved September 4, 2016, from:
Efforts (SOCE) and Conversion Therapy with Lesbians, Gay Men, Bisexuals, and Transgender
Persons. Retrieved September 4, 2016, from:
4. American Psychological Association, Task Force on Appropriate Therapeutic Responses to
Appropriate Therapeutic Responses to Sexual Orientation. Retrieved March 13, 2017, from:
Counseling and Clinical Psychology, 62, 221-227.
http://www.naswdc.org/diversity/lgb/reparative.asp
8.
Conversion Therapy: Supporting and Affirming LGBTQ Youth. Retrieved from
http://store.samhsa.gov/shin/content/SMA15-4928/SMA15-4928.pdf
https://www.whitehouse.gov/blog/2015/04/08/petition-response-conversion-therapy


RELEVANT AOA AND OOA POLICY:

H403-A/14 SAME-SEX RELATIONSHIPS AND HEALTHY FAMILIES The American Osteopathic Association (AOA) recognizes the need of same-sex households to have the same access to health insurance and health care as opposite-sex households and supports measures to eliminate discrimination against same-sex households in health insurance and health care. The AOA supports children’s access to a nurturing home environment, including through adoption or foster parenting without regard to the sexual orientation or the gender identity of the parent(s). The AOA recognizes and promotes healthy families by lessening disparities and increasing access to healthcare for same-sex marriages and civil unions and the children of those families. 2014

H445-A/15 GENDER IDENTITITY NON-DISCRIMINATION The American Osteopathic Association supports the provision of adequate and medically necessary treatment for transgender and gender-variant people and opposes discrimination on the basis of gender identity. 2010; reaffirmed 2015

H439-A/16 LESBIAN, GAY, BISEXUAL, TRANSGENDER, QUEER/QUESTIONING PROTECTION LAWS The American Osteopathic Association (AOA) supports the protection of Lesbian, Gay, Bisexual, Transgender, Queer/Questioning (LGBTQ) individuals from discriminating practices and harassment and reaffirms equal rights and protections for all patient populations as stated in AOA policy H506-A14. 2016

Corresponding OOA Policy (2016): Lesbian, Gay, Bisexual, Transgender, Queer/Questioning Protection Laws
H647-A/16 EXPANDING GENDER IDENTITITY OPTIONS ON PHYSICIAN INTAKE FORMS
The American Osteopathic Association (AOA) supports the inclusion of a two-part demographic inquiry on patient intake forms, requesting patients indicate both their sex at birth (male, female, intersex) and gender identity (male, female, transgender, additional category). 2016

Corresponding OOA Policy (2016): Expanding Gender Identity Options on Physician Intake Forms to be More Inclusive of LGBTQ Patients

RELEVANT LEGISLATIVE EFFORTS NATIONWIDE:
Ohio Senate Bill 74 (2016 – likely to be resubmitted this legislative session): To prohibit certain health care professionals from engaging in sexual orientation change efforts when treating minor patients. https://www.legislature.ohio.gov/legislation/legislation-summary?id=GA131-SB-74

California Legislative Conversion Therapy Ban: Senate Bill 1172: Sexual orientation change efforts. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201120120SB1172

New Jersey Legislative Conversion Therapy Ban: Assembly Bill 3371: AN ACT concerning the protection of minors from attempts to change sexual orientation and supplementing Title 45 of the Revised Statutes. http://www.njleg.state.nj.us/2012/Bills/A3500/3371_I1.HTM

Oregon Conversion Therapy Ban: House Bill 2307: Youth Mental Health Protection Act: https://olis.leg.state.or.us/liz/2015R1/Downloads/MeasureDocument/HB2307/Enrolled

ACTION TAKEN  **APPROVED as AMENDED**

DATE  **July 22, 2017**
WHEREAS, immunization, especially against pneumonia and tetanus and pertussis, have been proven to reduce morbidity and mortality; and

WHEREAS, reporting system exist within states to inform clinicians in different system of an individual’s status regarding immunization completion; and

WHEREAS, when such reporting system are not utilized there is potential over or under utilization and confusion regarding immunization status; and

WHEREAS, clinics, hospitals and pharmacies are required to report immunization to state immunization registries; and

WHEREAS, many Native Americans receive part of their care through the Indian Health Services system which is not at this time a mandated reporter of immunization leading to confusion and likely over or under utilization of immunizations; and

WHEREAS, many veterans receive part of their care through the Veterans Administration system which is not at this time a mandated reporter of immunization leading to confusion and likely over or under utilization of immunizations; now, therefore, be it

RESOLVED, that the American Osteopathic Association work with the Veterans Administration and Indian Health Services to become mandated reporters of immunization given within their facilities.

Explanatory Statement:

ACTION TAKEN  **APPROVED**

DATE  **July 22, 2017**
WHEREAS, the House of Delegates is the legislative body of the American Osteopathic Association (AOA); and

WHEREAS, AOA is authorized by the AOA Constitution to exercise the delegated powers of the divisional societies in the affairs of this Association; and

WHEREAS, the 2016 House of Delegates acted within its rightful capacity as the legislative body of the AOA when it adopted Resolution H332-A/16, Timely Posting of Agendas and Meeting Materials; and

WHEREAS, this policy has yet to be implemented by the AOA as evidenced by many committee members reporting meeting material including agendas not being sent at least ten business days in advance and minutes not being posted to a dedicated web page; and

WHEREAS, the failure of the AOA to implement a duly adopted resolution of the House of delegates and raises grave concerns for the organization structure of the Association and threatens to undermine members’ confidence in the AOA Offices, trustees, and staff; now, therefore be it

RESOLVED, that the 2017 House of Delegates hereby brings this Motion of Censure against the Officers, trustees, and staff of the American Osteopathic Association (AOA) for their failure to implement a duly adopted resolution of the House of Delegates; and, be it further

RESOLVED, that the AOA is hereby directed to immediately implement H332-A/16; and, be it further

RESOLVED, that the AOA is further directed to provide to each House of Delegates, a report detailing the steps taken to implement each and every resolution adopted by the previous year’s House of Delegates; and be it further

RESOLVED, that the AOA shall provide this report annually to the House of Delegates until such time as the House may by separate resolution direct.

Reference Committee Explanatory Statement:
The Committee agrees with the explanatory statement provided by the Board of Trustees. (i.e., “The AOA Board of Trustees (BOT) believes their actions did not meet the level of censure because there was no intent to deceive or not to implement H332-A/16. The BOT accepts responsibility to implement resolutions of the HOD. Further, the BOT has formed a communications committee whose
task is to review processes and implement improvements in the dissemination of information to members and other stakeholders with the support of AOA Staff. It is recognized that there have been issues with the distribution of b/c/c materials. It is recommended that the AOA BOT specific department chair immediately address said issues to ensure that the standards set forth are being adhered to and fully complied with.”).

ACTION TAKEN **DISAPPROVED**

DATE **July 22, 2017**
WHEREAS, medical claims payers and pharmacy benefit managers have for years used prior
authorization requirements, allegedly to control costs of medical care and
pharmaceutical agents; and

WHEREAS, the use of prior authorization has in recent years greatly expanded to include
requirements for prior authorization of diagnostic testing, medical procedures, and
pharmaceutical agents, including even some generic medications; and

WHEREAS, this expansion of prior authorization now greatly interferes with, prohibits, and or
delays patient access to medically indicated and necessary diagnostic and therapeutic
services and agents; and

WHEREAS, the expansion of prior authorization requirements has added substantial
uncompensated costs to medical practices and to the healthcare system; and

WHEREAS, many claims payers and pharmacy benefit managers refuse to disclose the criteria
they use to make decisions on prior authorization requests, make decisions contrary to
their published policies, render decisions which are arbitrary and capricious, and or fail
to disclose information on how to contact them; now, therefore be it

RESOLVED, that the American Osteopathic Association (AOA) work to seek legislation
which would require insurance claims payers and pharmacy benefit managers to:

• Disclose in sales, promotional materials and advertising that their products utilize a
  prior authorization process which may result in a delay in or denial of diagnosis and
  or treatment which may be detrimental to the patient’s health or well being
• Require contracts with healthcare providers to include hold harmless clauses
  indemnifying healthcare providers against financial loss due to injury to a patient as
  a result of their failure or refusal to timely grant a prior authorization request
• Include a correct phone number and web address on the patient identification card
  for initiating the prior authorization process
• Make all forms used in the prior authorization process readily available to healthcare
  providers
• Publish and make available to the public all requirements for prior authorization and
  follow those published policies
• Provide sufficient knowledgeable staff to ensure that healthcare providers are able
  to contact medical claims payers and pharmacy benefit managers without average
  hold times exceeding 10 minutes
• Compensate medical practices and healthcare providers for the cost of time spent on inappropriately denied PA requests

• The medical director of the payor /claim adjudicator shall be identifiable and shall be held accountable for the results of their decisions.

ACTION TAKEN  APPROVED

DATE  July 22, 2017
WHEREAS, sexual harassment and sexual misconduct exists throughout all aspects of American society and has recently become a high profile issue in the medical workplace; now, therefore be it

RESOLVED, that the American Osteopathic and other state Osteopathic associations create a program to educate Michigan's Osteopathic Physicians on how to conduct themselves professionally in order to avoid behaviors that constitute sexual harassment and sexual misconduct in the medical workplace.

Reference Committee Explanatory Statement:
The committee respectfully disagrees with the Board of Trustees’ (BOT) referral of resolution no. H-633 to the Michigan Osteopathic Association (MOA). The committee concurs with the BOT’s opinion that programming already exists in a variety of formats to train physicians and osteopathic medical students on what is appropriate and inappropriate within the workplace. To provide for further input from stakeholders, the committee respectfully refers resolution no. H-633 to the Department of Professional Affairs for review and further comment on how the development of programs by the American Osteopathic Association and/or state osteopathic associations would supplement and/or fill a void in existing training and education on sexual harassment and/or misconduct within the workplace.

ACTION TAKEN REFERRED (to AOA Dept. of Professional Affairs)

DATE July 22, 2017
WHEREAS, on October 16, 2016 the Centers for Medicaid and Medicare Services (CMS) implemented final rules via Section 1557 of the Affordable Care Act (ACA), that requires all physicians receiving federal funds to implement non-discrimination policies within their practices; and

WHEREAS, the final rule mandates that physicians provide free access to interpreter services for patients with Limited English Proficiency (LEP); and

WHEREAS, physician access in many areas is already insufficient to meet the demands of many rural and urban populations, and this unfunded mandate could lead to more physicians selecting to not participate in the Medicaid and Medicare programs, resulting in further reduction in access to physician care; and

WHEREAS, while the AOA appreciates the intent of Section 1557 of the ACA, and believes that patients should not be discriminated against based on sex, sex identity, ethnic origin, or in any other way, the requirement of the regulation mandating physicians provide interpreters free of charge to those with LEP places additional costly burden on physicians providing much needed care to underserved populations that may result in the unintended consequence of reduced access to qualified physician care; now, therefore be it

RESOLVED, the American Osteopathic Association supports efforts to remove from Section 1557 of the Affordable Care Act the unfunded mandate on physicians to provide interpreters for those patients with Limited English Proficiency (LEP) by revising the current federal policy to include adequate reimbursement for physicians for this service; and, be it further

RESOLVED, that the American Osteopathic Association (AOA) increase advocacy efforts and make this a high priority issue in the AOA’s annual Legislative Agenda to hasten policy change; and, be it further

RESOLVED, that the AOA report efforts and results on this issue to the AOA House of Delegates on an annual basis until desired policy change is enacted.

Explanatory Statement:

ACTION TAKEN  APPROVED as AMENDED

DATE  July 22, 2017
WHEREAS, the Federation of State Medical Boards (FSMB) is a national nonprofit representing the 70 medical and osteopathic boards of the United States and its territories and the District of Columbia that recognizes the distinctive practice of osteopathic medicine and supports the use of the COMLEX-USA to affirm that a DO has a skills necessary to be licensed to practice osteopathic medicine in each of these jurisdictions; and

WHEREAS, the FSMB supports its member boards as they fulfill their mandate of protecting the public’s health, safety and welfare through the proper licensing, disciplining, and regulation of physicians; and

WHEREAS, currently there are fourteen (14) states, (Arizona, California, Florida, Maine, Michigan, Nevada, New Mexico, Oklahoma, Pennsylvania, Tennessee, Utah, Vermont, Washington, West Virginia) that have separate Osteopathic Licensing Boards; and

WHEREAS, Osteopathic physicians complete unique education and training that prepares them for the distinctive practice of osteopathic medicine; and

WHEREAS, a large number of new osteopathic physicians will be entering the physician workforce from many states as a direct result of new osteopathic medical schools and increasing enrollment for existing medical schools which necessitates self-regulation; and

WHEREAS, as with the FSMB mission to protect patients and public health, DOs must be licensed and regulated under the supervision of those individuals with the expertise to understand the differences represented in osteopathic medical education and training and experience in the practice of osteopathic medicine; and

WHEREAS, DOs have received the educational and legislative accountability to regulate their peers through their licensing board to ensure public safety as well as equitable treatment to practice within the full scope of their medical license; now, therefore be it

RESOLVED, that the AOA stands in opposition to the consolidation of any state osteopathic and medical licensure boards; and, be it further

RESOLVED, that the AOA should actively monitor for activities that threaten separate state osteopathic licensing boards in the fourteen states where they exists; and, be it further
RESOLVED, that the AOA prioritize its resources to aggressively combat any and all threats to consolidate state osteopathic and medical licensing boards.

Explanatory Statement:

ACTION TAKEN **APPROVED**

DATE **July 22, 2017**
WHEREAS, physicians prescribe pharmaceutical treatments to patients based on a variety of clinical factors including the patient's symptoms or disease intended for treatment, patient's general health or presence of co-morbidities, patient's allergies, drug contraindications, and previous success with the drug in patients with similar typology;

WHEREAS, cost, in terms of drug list price and patient out of pocket, of pharmaceutical drugs is a growing concern;

WHEREAS, recent pharmaceutical list price increases for legacy drugs have added cost to the healthcare system without reciprocal increases in healthcare quality or medical innovation;

WHEREAS, increased costs limit physician practices’ and hospitals’ abilities to access drugs and limit the drugs’ availability;

WHEREAS, increased drug costs may be transferred to the patient in higher co-pays, co-insurance, pharmaceutical deductibles, or the availability of affordable healthcare plans that cover the drug, and that these factors may decrease patient compliance and therefore hinder clinical outcomes;

RESOLVED, the American Osteopathic Association advocate for policies that encourage pharmaceutical manufacturers, prescription drug benefit managers, pharmacies, and payers to price drugs and insurance products on those drugs in order to promote access, affordability, and continued advancement of healthcare quality and innovation.

Explanatory Statement:

FISCAL IMPACT: $0

ACTION TAKEN  APPROVED

DATE  July 22, 2017
Mr. Speaker, I present for consideration, Resolution No. H-700, and the Committee recommends that it be APPROVED:

H-700 - APPROVAL OF THE AOA PROPOSED BUDGET, FISCAL YEAR 2018

RESOLVED, that the Fiscal Year 2018 Proposed Budget of the American Osteopathic Association be approved as submitted.

And I so move. APPROVED

Mr. Speaker, this concludes the Committee’s report. I would like to thank the members of the Committee.

Committee Members:

John W. Becher, DO, Chair
Joseph A. Giaimo, DO, Vice Chair
Thomas L. Ely, DO
Geraldine T. O’Shea, DO
Emily K. Hurst, DO
William A. Wewer, DO
Ronnie B. Martin, DO
Monte E. Troutman, DO
Robert S. Juhasz, DO

Staff
Frank W. Bedford, CPA
RESOLVED, that the Fiscal Year 2018 Proposed Budget of the American Osteopathic Association be approved as submitted.
FY 2017-2018
PROPOSED AOA BUDGET

July 2017

AOA Strategic Plan

2025 Rooftop Goals

Member Model, Value & Relevance
Enhance Board Certification Services
Affiliate Alignment
International Impact
Governance Alignment

Phase 1
Expense Control & Revenue Enhancement
Increase Osteopathic Medical Research Impact
Expand OGME and Enhance Quality
Enhance Public Policy Impact
Brand Visibility Campaign

Phase 2
Increase in awareness of osteopathic medicine
Increase in engagement with DOs
Increase in international awareness of DOs
Date: July 11, 2017

To: House of Delegates

From: Adrienne White-Faines, CEO
      Frank Bedford, CFO/Controller

CC: Boyd R. Buser, DO, President
    Mark A. Baker, DO, President Elect
    Joseph A. Giiamo, DO, Chair, Department of Business Affairs
    John W. Becher, DO, Chair, Finance Committee
    Ray L. Morrison, DO, Speaker, HOD
    David Broder, DO, Vice-Speaker, HOD
    Senior Leadership Team
    Michael Schultz, Assistant Controller

RE: Budget FY 2017-18

The American Osteopathic Association (AOA) continues to grow, change, and evolve to advance the 5 following new strategic priorities of the AOA:

1) Increase Member Model, Value and Relevance,
2) Enhance Board Certification Services,
3) Enhance Affiliate Alignment,
4) Expand International Impact , and
5) Governance Alignment.

The proposed budget for FY 2017-18 is integral to the continued successful implementation of these strategies. It is attached for your consideration and approval, as recommended by the AOA Finance Committee.

Budget Overview

A brief overview of our fiscal status and the proposed budget follows.

FY 2017. The AOA finished FY 2017 in a strong financial position, accurately managing to approved budget parameters. Operating cash and investments are estimated to be $51.7 million, and the ending Reserve Fund balance of $38.1 million is 93% of total operating expenses two years prior and is $7.5 million in excess of the $30.6 million Reserve Requirement, which is defined as 75% of total operating expenses two years prior. Year-end net operating surplus is $1.5 million, as compared to a budgeted net operating surplus of $13,112.

FY 2018. Moving forward into our next fiscal year that began on June 1, the proposed budget for FY 2018 is balanced with a surplus $4,359. The proposed FY 2017-2018 budget contains a $4.3 million use of excess reserves for one time allocation spends for various activities.

Conclusion

The fiscal position of the AOA is very strong and we are committed to maintaining this strong financial position as we continue to strategically evolve our association for impactful sustainability in the years ahead.
Strategic Work Plan
### ROOF TOP GOALS

100% increase in the awareness of Osteopathic medicine
50% increase with engagement of DOs
100% increase in international awareness of DOs

### PHASE I: Strategic Priority Window: Brand Visibility

**Operational Metrics:** 2014-2016 (Operations continuance 2017-2019)

**Description:** ESTABLISH NEW METRIC DASHBOARDS FOR 2017-2019!

- Establish initial market awareness baseline for 2014
- Raise from baseline by at least 10% across at least two designated audiences

<table>
<thead>
<tr>
<th>FY 2018 Key Work Plan Activities:</th>
<th>% Completed by Year End FY2018</th>
<th>Notes</th>
<th>B/C/C/T</th>
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<tbody>
<tr>
<td><strong>Affiliate Affairs</strong></td>
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<tr>
<td>o Develop brand update meeting to share details of campaign and learnings; tools to leverage campaign;</td>
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<td>AOSED and SOSE</td>
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<td>o Access regional Brand capacity and efforts to determine more mechanisms for cross support.</td>
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<tr>
<td>o Continue to expand participation by affiliates with OMED</td>
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<td><strong>AOIA</strong></td>
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<td>AOIA Board</td>
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<tr>
<td>• Continue to align practice management website with brand quality</td>
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<td>• Leverage relations with health technology incubators (MATTER and Catalyst) for potential new products and services for members while increasing awareness of osteopathic medicine in the HIT entrepreneurial communities</td>
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<td><strong>Certifying Board Services</strong></td>
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<td>BOS / BEL / SOMA</td>
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<tr>
<td>• CBS will continue to work with communications to enhance brand visibility—emphasizing “AOA board certification”—to students, residents and physicians</td>
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<td>• Education and marketing expansion of AOA Brand to Health Care Facilities to enhance acceptance and demand.</td>
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<td>FY 2018 Key Work Plan Activities:</td>
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<tr>
<td><strong>Communications</strong></td>
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<tr>
<td>• Leadership and involvement throughout all Initiatives</td>
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<td>JAOA</td>
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<tr>
<td>• Establish and report brand, media, marketing and communication metrics for 2017-2019</td>
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<td>BOT</td>
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<td>• Phase III of Brand Campaign w/ Refresh of look</td>
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<td>BSPA</td>
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<tr>
<td>• Do consumer market research to support phase 3</td>
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<td>BOCER</td>
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<tr>
<td>• Implement successful, breakeven OMED, as flagship event for unification of profession. Additions include ACOS and ACOOG at conference.</td>
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<td>Bureau of OMED</td>
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<td>• Co-sponsor Aspen Spotlight Health for industry visibility</td>
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<td>• Complete at least 8 CME activities, including online webcasts, live webcasts, JAOA monographs and supplements and AOA Health Watch issues.</td>
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<tr>
<td><strong>Education /Research</strong></td>
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<tr>
<td>• Enhancing osteopathic medicine visibility through medical education and accreditation:</td>
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<tr>
<td>o Develop research project w/ FSMB on the profession, to highlight impact of osteopathic medicine.</td>
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<td>o Develop physician wellness App for connecting resources.</td>
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<td><strong>Finance/HR</strong></td>
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<td>Finance Committee</td>
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<tr>
<td>• Support Brand Advertising from Reserves</td>
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<tr>
<td><strong>International</strong></td>
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<td>BIOM</td>
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<tr>
<td>• Work with Communications/Marketing to develop educational template and branded video on Osteopathic Physicians and DOs.</td>
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<td><strong>Information Technology</strong></td>
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<td>• Phase II of the redesign of osteopathic.org.</td>
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<td><strong>Membership</strong></td>
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<td>• Continue work w/ AOIA and communications for growth of CME activities in the healthcare space (FDA, Brookings Institute (REMS), AMA, AAFP, FSMB, ACCME, ACEHp, etc.) about DOs and AOA’s role in medical education for physicians – ongoing</td>
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<td>• Distribute brand campaign tools, especially talking points, to students during NOM Week. – March 2018</td>
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<td>• Design brand campaign video tools for PreSOMA to distribute to college students</td>
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<td>FY 2018 Key Work Plan Activities:</td>
<td>% Completed by Year End FY2018</td>
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<tr>
<td><strong>Public Policy</strong>&lt;br&gt;<em>Raise visibility of DOs amongst policymakers:</em>&lt;br&gt;- Educate Administration, Members of Congress, and state policymakers about the osteopathic profession&lt;br&gt;  o Use state-specific data, where possible&lt;br&gt;- Leverage new grassroots advocacy strategies and campaigns to strengthen and amplify the osteopathic brand&lt;br&gt;- Secure at least 5 key appointments to high-level Federal &amp; State panels and committees.&lt;br&gt;- Protect state osteopathic medical boards and use this distinction in those 14 states to increase awareness and membership&lt;br&gt;- Work to ensure and protect the full recognition of osteopathic physician credentials and certification by all public and private payers.&lt;br&gt;- Advocate for PCPCC Shared Principals w/ unique tie to OM. Promote in healthcare environments as well as patient education to improve public health, and highlight DOs practice and training.</td>
<td>BFHP&lt;br&gt;BSGA&lt;br&gt;Strategic Consulting Firm - Powers</td>
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<td><strong>Research</strong>&lt;br&gt;- Support JAOA in strengthening its Engage Initiative.</td>
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<td>JAOA / BOCER</td>
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</table>
## PHASE I: Strategic Priority Window: Research


**Description:** ESTABLISH NEW METRIC DASHBOARDS FOR 2017-2019!

- Develop four new research partnerships in three years
- Increase the number of published articles by 20% within three years
- Expand internal research on profession

### FY 2018 Key Work Plan Activities:

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<tr>
<th>Activity</th>
<th>% Completed by Year End FY2018</th>
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<tbody>
<tr>
<td><strong>Affiliate Affairs</strong></td>
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<tr>
<td>• Provide forums to educate on opportunities to advance research initiatives and funding</td>
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<td>AOSED / SOSE</td>
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<tr>
<td>• Further engage SOMA for a higher level of participation in, and support of, annual OMED call for abstracts and research grants</td>
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<td>SOMA</td>
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<tr>
<td><strong>AOIA/Legal</strong></td>
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<td>AOIA / Membership Comm</td>
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<tr>
<td>• Physician Services, where possible, utilize research to support advocacy with insurers and other payors with data supporting OMT, physician empathy, etc.</td>
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<td>BOCER</td>
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<tr>
<td>• Establish and articulate updated Conflict of Interest policies for grant funding</td>
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<tr>
<td><strong>Certifying Board Services</strong></td>
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<td>BOS</td>
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<tr>
<td>• Build Market research based on demographic and GME data – review at Cert Board Summit</td>
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<tr>
<td><strong>Communications</strong></td>
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<td>JAOA Ed Board</td>
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<tr>
<td>• Support JAOA’s Editor-in-Chief’s Engage program to promote osteopathic focused research, including attendance and participation at COM and educator events</td>
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<tr>
<td>• Continue JAOA Impact Factor to elevate prominence and reputation, and promote high-quality research submissions</td>
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<td>• Position JAOA as a media outlet by hosting panels and presentations at OMED and other medical meetings</td>
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<td>• Convert JAOA market of new residents to ‘Digital Only’ copy</td>
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<tr>
<td>• Initiate plan to enhance revenue for JAOA through solicitation of institutional subscriptions, advertising outreach, article packaging and other strategies.</td>
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<td>FY 2018 Key Work Plan Activities:</td>
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<tr>
<td><strong>Education</strong></td>
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<tr>
<td>• Support advancement of research opportunities with FSMB and ACGME data to create more content and evidence on outcomes of training and workforce.</td>
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<td>BOCER</td>
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<tr>
<td>• Enhanced electronic COCA database also allows for higher quality data on our profession, especially the educational endeavors of our profession. Work to generate more publications surrounding the osteopathic medical education advantage.</td>
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<td>COCA</td>
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<tr>
<td>• Publish on the results of the SAS surveys</td>
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<td>CCME</td>
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<tr>
<td>• Build awareness among all CME Sponsors (not just AOA affiliates) regarding AOA’s Core REMS grants that are available to conduct a formal “live” REMS program(s), and the application process – ongoing</td>
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<td>AOSED</td>
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<tr>
<td>• Publish on the results of the SAS surveys</td>
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<td>SOSE</td>
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<td><strong>Finance</strong></td>
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<tr>
<td>• Ensure Research grant funding continues at FY17 levels</td>
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<tr>
<td><strong>International</strong></td>
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<td>BIOM</td>
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<tr>
<td>• Educate and make recommendations to BOCER on strategy to expand research collaboration capacity internationally. With BOCER, have phase I international research expansion strategy proposed to BOT.</td>
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<td>BOCER</td>
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<tr>
<td><strong>Information Technology</strong></td>
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<tr>
<td>• Provide technology support as needed for Webinars, voice and video conferencing and to support public policy initiatives.</td>
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<tr>
<td><strong>Member Services</strong></td>
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<tr>
<td>• Evaluate research opportunities to tie with new member model offerings.</td>
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<tr>
<td><strong>Public Policy</strong></td>
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<td>BFHP/ AACOM</td>
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<tr>
<td>• Facilitate continued recruitment and participation in NAM Osteopathic Anniversary Fellowship</td>
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<td>• Leverage NAM fellow to inform the work of appropriate b/c/c’s</td>
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<td>• Assist in securing grant partners where appropriate (i.e. CMS and PCORI).</td>
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<td>• Continue engagement with industry partners in order to identify potential research synergy opportunities for internal consideration</td>
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<tr>
<td><strong>Research</strong></td>
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<td>BOCER</td>
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<tr>
<td>• Collaborate with 3-4 organizations and apply for 5-6 grants (key organizations e.g., American Dental Association, American Diabetes Association).</td>
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<td>• Continue providing grant writing and publication workshops available to students, residents and junior faculty.</td>
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<td>• Continue establishment of searchable database that acts as a warehouse of all research studies and articles pertaining to the osteopathic community (research conducted by DOs as well as research generated within the osteopathic community).</td>
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<tr>
<td>• Launch new grants cycle for 5 research focus areas.</td>
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<tr>
<td>• Analyze and develop reports using data from shared AOA/AACOM database, PCORI survey, Physician Marketing Survey and CAP.</td>
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<td>• Support AACOM Empathy Study both on plan development, implementation, delivery and financial support</td>
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</table>
American Osteopathic Association  FY 2018 Strategic Plan

ROOF TOP GOALS

100% increase in the awareness of Osteopathic medicine
50% increase with engagement of DOs
100% increase in international awareness of DOs

PHASE I: Strategic Priority Window: Public Policy


Description: ESTABLISH NEW METRIC DASHBOARDS FOR 2017-2019!

- Expand GOAL enrollment to 90% of members, including SOMA, State, Specialty and Advocates Affiliates
- A Completed SGR Path (April 2015)
- Increase number of AOA advocacy engagement opportunities by 100%
- Design and implement increased state office visit initiative, followed by expanded, large impact DO Day every three years

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<tr>
<td><strong>Affiliate Affairs</strong></td>
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<tr>
<td>• Use BEL and SOMA to increase student participation in AOA advocacy activities – begin Fall 2016 and ongoing after</td>
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<td>BEL SOMA BSGA</td>
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<td>• Collaborate with Public Policy in regard to state affiliates increasing awareness of the AOA and osteopathic medical profession among state policymakers.</td>
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<td>• Determine options for SOMA and BEL to provide vehicle for OPAC solicitation</td>
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<tr>
<td>• Enhance leadership development &amp; education on public policy matters for state &amp; specialty affiliates through AHP, ROME presentations</td>
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<tr>
<td><strong>AOIA/Legal</strong></td>
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<tr>
<td>• Continue to provide MACRA education and materials / tools to assist physicians with changes in reimbursement.</td>
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<td>• Promote payment, auditing and coding work to members</td>
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<td>• Provide administrative and financial support for OPAC</td>
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<td><strong>Certifying Board Services</strong></td>
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<td>• Cooperate on programs that bring value added benefits to Diplomates such as Physician Compare.</td>
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<td>• Collaborate on grassroots lobbying campaign regarding education and impact of OCC / MOC</td>
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<td><strong>Communications</strong></td>
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<tr>
<td>• Leverage member communication channels to drive awareness and understanding of policy priorities</td>
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<td>• Partner w/ Public Policy team to develop messages and channels around key issues, such as healthcare reform, MACRA, opioid abuse, OMT, and key priorities.</td>
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<td>• Pursue earned media and events/speaking platforms to deliver osteopathic perspective on issues</td>
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<td>• Leverage member digital/social channels to support advocate recruitment and mobilization efforts, including DO Day</td>
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<td>Education</td>
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<td>COCA</td>
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<td>• Work w/ COCA and Public Policy team to make certain that newly developed outcomes measures on student debt in the accreditation rules are appropriate for our accrediting agency and schools.</td>
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<td>ACGME</td>
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<td>• Provide expertise to support policy development in the education arena</td>
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<td>• Support lobby efforts regarding HR 6333 against SAS</td>
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<td>Finance/HR</td>
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<td>• Manage Lobbying expense use</td>
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<tr>
<td>• Manage Grassroots expense use</td>
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<td>International</td>
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<tr>
<td>Information Technology</td>
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<tr>
<td>• Provide technology support as needed for Webinars, voice and video conferencing and to support public policy initiatives.</td>
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<tr>
<td>Member Services</td>
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<tr>
<td>• Customer Service Center gain training on key public policy issues to help with grassroots initiatives when they arise.</td>
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<td>Public Policy</td>
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<tr>
<td>Strategic Planning:</td>
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<tr>
<td>• Update annual grassroots, state and federal strategic focus with Dentons Lobbying firm and public B/C/C</td>
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<td>BFHP</td>
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<tr>
<td>• Increase key agency relationship growth for new Administration</td>
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<td>BSGA</td>
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<tr>
<td>• Update programming for Advocacy for Healthy Partnerships &amp; Executive Director Institute to improve relevance and value for attendees</td>
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<td>BSA</td>
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<tr>
<td>• Solicit sponsorship for DO Day in Spring 2018</td>
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<tr>
<td>Member Engagement:</td>
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<tr>
<td>• Continue to generate opportunities for DO appointees to attend events, Capital Hill testimony and meetings of federal panels.</td>
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<tr>
<td>• Advance key nomination process for federal panels and committees, such as MedPAC.</td>
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<tr>
<td>• Develop vignettes of top 20 DO profiles</td>
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<tr>
<td>• Enhance functionality of ambassador database</td>
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<tr>
<td>• Execute grassroots enrollment drive to increase by 30% advocates &amp; ambassadors</td>
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<tr>
<td>• Conduct DO Day in Spring 2018</td>
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<tr>
<td>• Plan Fall “mini” DO Day advocacy for 2017 to test pilot for practicing physicians.</td>
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<tr>
<td>• Expand AHP for stronger policy education to all physician attendees at OMEL</td>
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<tr>
<td>FY 2018 Key Work Plan Activities:</td>
<td>% Completed by Year End FY2018</td>
<td>Notes</td>
<td>B/C/C/T</td>
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<tr>
<td>• Enhance education and intentional engagement on public policy matters for state &amp; specialty affiliates by providing: o Town Halls (3 at affiliate events) o Webinars (4 co-branded) • Launch in-district key contact program • Collaborate with state affiliates on state legislative and regulatory proposal comments to increase awareness of the AOA and osteopathic medical profession among state policymakers • Expand external partnerships by 10 percent to leverage nationwide access and exposure to DOs in states and specialty colleges. (eg: NABP, FSMB, FSPHP, PCPCC, etc.)</td>
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</table>

**Policy Advancement & Advocacy:**
- Proactively engage in monitoring, addressing, and advancing osteopathic public policies on the state and federal level as guided by the 3-year public policy strategic plan
- Develop comprehensive public policy issue resource center with background documents and talking points on 6 key issue areas
- Coordinate and appropriately engage in MACRA implementation discussions with policy makers and internal stakeholders.
- Continued advocacy for workable payment recommendations to CMS thorough representation on the RUC and CPT.
  - Implement apprenticeship program to train pipeline for both CPT and RUC’s long-term representation.

**Research**
- Provide key research findings to support policy development.
- Help identify key members of the osteopathic profession to serve on panels, councils and in other public policy activities.
ROOF TOP GOALS

100% increase in the awareness of Osteopathic medicine
50% increase with engagement of DOs
100% increase in international awareness of DOs

PHASE I: Strategic Priority Window:
OGME Development - Transition to Single Accreditation System


Description: ESTABLISH NEW METRIC DASHBOARDS FOR 2017-2019!

- Increase the number of Osteopathic residency and fellowship positions and programs in process by cultivating at least 10 new leads per year
- Evaluate and expand options for non-traditional funding of Graduate Medical Education
- Implement Single Accreditation System (approved Feb 2014/July 2014)

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<thead>
<tr>
<th>FY 2018 Key Work Plan Activities:</th>
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</thead>
<tbody>
<tr>
<td><strong>Affiliate Affairs</strong></td>
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<tr>
<td>Maintain ongoing updates on progress of transition to SAS</td>
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<tr>
<td><strong>AOIA/Legal</strong></td>
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<tr>
<td>Establish a student loan advising service to help maintain engagement of OMS4 students through all of residency.</td>
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<td></td>
<td>AOIA</td>
</tr>
<tr>
<td>General Counsel to provide continued support on implementation of single accreditation system at meetings of ACGME-AOA-AACOM operations committees</td>
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<td>BOT</td>
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<tr>
<td><strong>Certifying Board Services</strong></td>
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<tr>
<td>Support marketing to residents for Cert Board Services</td>
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<td>BOS</td>
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<tr>
<td>Provide market program to raise awareness of AOA Boards by sending Program Directors “Congratulations from AOA CBS” when they achieve ACGME accreditation and osteopathic recognition.</td>
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<tr>
<td>Establish policies for MDs, and clarify terms to access for non-AOA DOs and/or non OR program graduates</td>
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<tr>
<td><strong>Communications</strong></td>
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<tr>
<td>Provide strategic counsel, messages and resources to promote program transition to the Single Accreditation System; underscore value of seeking osteopathic recognition</td>
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<tr>
<td>o Provide messages and channels/vehicles for students to advocate for programs to seek osteopathic recognition</td>
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<tr>
<td>o Support Government Relations in efforts to promote increased federal funding of graduate medical education</td>
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</table>
### FY 2018 Key Work Plan Activities:

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<tr>
<th>% Completed by Year End FY2018</th>
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<tbody>
<tr>
<td><strong>Education</strong></td>
<td></td>
<td>BOGMED/BOE BOGMED</td>
</tr>
<tr>
<td>- Align Education Bureaus and Councils to accommodate transition in volume of activity in Single Accreditation System.</td>
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<tr>
<td>- Begin downsize transition plan for expense control in GME accreditation</td>
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<tr>
<td>- Accommodate the growing demand for the Application Assistance Program (AAP).</td>
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<tr>
<td>- Continue to proactively reach out to select groups of program directors to encourage osteopathic recognition and provide application support.</td>
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<tr>
<td>- Hold at least 10 meetings with the ACGME staff to review and resolve single accreditation issues.</td>
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<tr>
<td>- Have at least one staff person cover the AAP phone line during normal business hours</td>
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<tr>
<td>- For osteopathic recognition, reach out to all program directors by October 2017 and appropriate allopathic family program directors by December 2017.</td>
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<tr>
<td>- Reach out to all ‘Unsure’ Program Directors with specific strategy for potential conversion to ‘apply’</td>
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<tr>
<td>- Have BOGMED give or sponsor at least one presentation on growing OGME at OMEL 2018.</td>
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<tr>
<td><strong>Finance/HR</strong></td>
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<tr>
<td>- Expense control for transition of GME accreditation</td>
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<td>Finance</td>
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<tr>
<td><strong>International</strong></td>
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<tr>
<td>- Help to communicate AOA GME programs in ACGME as key support for International Practice Equity</td>
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<tr>
<td><strong>Information Technology</strong></td>
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<tr>
<td>- Provide technology support as needed to support OGME initiatives.</td>
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<tr>
<td><strong>Member Services</strong></td>
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<tr>
<td><strong>Public Policy</strong></td>
<td></td>
<td>Public Policy</td>
</tr>
<tr>
<td>- Educate BOGMED on GME legislation from the 114th Congress to inform AOA’s 115th Congress strategy</td>
<td></td>
<td>B/C/Cs</td>
</tr>
<tr>
<td>- Work with legislative &amp; regulatory bodies to advance policies conducive to establish and/or maintaining:</td>
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<tr>
<td>o The Teaching Health Center GME program – securing a permanent funding stream</td>
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<tr>
<td>o Flexibility for rural GME training opportunities</td>
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<tr>
<td>o Training opportunities within the VA Health system</td>
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<tr>
<td>o AOA-supported GME principles of the Institute of Medicine Report</td>
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<tr>
<td>o Residency funding direct to the sponsoring institution allowing for greater flexibility in site of training, and therefore, specialty or primary care designation.</td>
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<tr>
<td>o Residency training opportunities and exposure to veterans and those in underserved rural and urban areas.</td>
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<tr>
<td>FY 2018 Key Work Plan Activities:</td>
<td>% Completed by Year End FY2018</td>
<td>Notes</td>
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<tr>
<td>• Continue to promote state funding of GME and develop materials that educate policymakers how investment in OGME can help meet current and future workforce needs</td>
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<tr>
<td><strong>Research</strong></td>
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<tr>
<td>• Creation of consultant list and templates to assist existing and new training programs with obtaining osteopathic recognition in the single accreditation system for GME.</td>
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</tbody>
</table>
American Osteopathic Association

FY 2018 Strategic Plan

Phase I: Strategic Priority Window: Revenue Enhancement / Expense Control


Description: ESTABLISH NEW METRIC DASHBOARDS FOR 2017-2019!

- Weighted increase in funding for strategic priority areas
- Enhance corporate giving for publications, research, OMED
- Align expenses and create new non-dues revenue streams

<table>
<thead>
<tr>
<th>FY 2018 Key Work Plan Activities:</th>
<th>% Completed by Year End FY2018</th>
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<th>B/C/C/T</th>
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<tbody>
<tr>
<td><strong>Affiliate Affairs</strong></td>
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<tr>
<td>• Conduct a cost/benefits analysis of management services offered to affiliated organizations.</td>
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<td>Affiliate Alignment Task Force SOSE/ AOSED</td>
</tr>
<tr>
<td>• Drop management of AODME due to AACOM move</td>
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<tr>
<td>• Complete affiliate alignment models to recommend to BOT, and support communication efforts across affiliates on model options.</td>
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<tr>
<td><strong>AOIA/Legal</strong></td>
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<tr>
<td>• Increase profiles price to $23</td>
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<td>AOIA</td>
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<tr>
<td>• Market profiles service to ambulatory surgery centers</td>
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<tr>
<td><strong>Certifying Board Services</strong></td>
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<tr>
<td>• Complete Phase 2 financial assumptions to identify additional efficiencies and consistency across boards (Honorariums, inspection fees, psychometric consultants)</td>
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<td>BOS</td>
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<tr>
<td>• Recruit psychometrician to reduce total current allocated costs</td>
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<tr>
<td><strong>Communications</strong></td>
<td></td>
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<tr>
<td>• Strengthen industry partnerships to support research, increase CME projects and engagement with OMED through symposia offerings and sponsorships</td>
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<td></td>
<td>Bureau of Omed</td>
</tr>
<tr>
<td>• Increase online display advertising for JAOA.org and partnership with Association Revenue Partners.</td>
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<td>JAOA</td>
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</tbody>
</table>

Roof Top Goals:
- 100% increase in the awareness of Osteopathic medicine
- 50% increase with engagement of DOs
- 100% increase in international awareness of DOs
<table>
<thead>
<tr>
<th>FY 2018 Key Work Plan Activities:</th>
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<th>Notes</th>
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<tbody>
<tr>
<td><strong>Education</strong></td>
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<tr>
<td>• Communicate COCA fee increase to COMs</td>
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<tr>
<td>• Complete all COCA survey activity as planned.</td>
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<tr>
<td>• The AOA staff will continue to enhance their knowledge of ACGME application process and ADS to minimize consultant cost for the Application Assistance Program</td>
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<tr>
<td>• Review, restructure and increase accreditation and recording fees for CME sponsors – by August 2016</td>
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<tr>
<td>• Roll-out revenue sharing module for on-demand Category 1 CME programs for AOA Category 1 CME sponsors – ongoing</td>
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<tr>
<td><strong>Finance/HR</strong></td>
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<tr>
<td>• Expense Control</td>
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<tr>
<td>• Ensure departments have talent and skills necessary to do their jobs, providing training where there are skill gaps.</td>
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<tr>
<td>• Actively work with operations and facilities to make sure spending on occupancy is kept within budget and we are always focused on being mindful of spending.</td>
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<tr>
<td>• Create and rollout annual staff budget development training</td>
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<tr>
<td><strong>International</strong></td>
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<tr>
<td>• Work with AOF to develop resource pipelines to support mission and education outreach in International Affairs</td>
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<tr>
<td><strong>Information Technology</strong></td>
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<tr>
<td>• Continue to develop capacity for TraCME, new CME, OCC tracking, and others.</td>
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<tr>
<td>• Complete the iMIS version 20 upgrade</td>
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<tr>
<td>• Upgrade single sign-on (SSO) system for all websites.</td>
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<tr>
<td>• Implement AOA telephone system upgrade.</td>
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<tr>
<td>• Complete infrastructure upgrades to replace outdated server equipment and improve service reliability.</td>
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<tr>
<td><strong>Member Services</strong></td>
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<tr>
<td>• Design new invoice for spring 2018</td>
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<tr>
<td>• Track and report new dashboard measures to monitor membership renewal</td>
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<tr>
<td>• Implement new fee models from Membership Alignment efforts</td>
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<tr>
<td><strong>Public Policy</strong></td>
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<tr>
<td>• Continue to seek outside funding for AHP, and other opportunities, to offset costs incurred by the AOA</td>
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<tr>
<td><strong>Research</strong></td>
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<tr>
<td>• Continue to apply for external funding such as CORE*REMS, Conrad Hilton project, Alz program and PCORI grants.</td>
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<tr>
<td>• Revamp and remarket the Clinical Assessment Program to potentially generate the revenue OCCAP generates for the Family Medicine Board.</td>
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<tr>
<td>• Raise external funds to support research activities and lessen the dependence on funding from reserves.</td>
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</tbody>
</table>
ROOF TOP GOALS

100% increase in the awareness of Osteopathic medicine
50% increase with engagement of DOs
100% increase in international awareness of DOs

PHASE II: Strategic Priority Window: Member Model, Value & Relevance

Goal
Strengthen and build the AOA value proposition so that membership is attractive, can stand on its own, and leads to growth in number of members.

Operational Metrics: 2017-2019

<table>
<thead>
<tr>
<th>Description: ESTABLISH NEW METRIC DASHBOARDS FOR 2017-2019!</th>
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<tbody>
<tr>
<td>• Assess competitive costs and affordability of membership.</td>
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<tr>
<td>• Develop new, non-dues revenue sources.</td>
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<tr>
<td>• Assess the impact of removing the requirement for AOA membership to maintain board certification.</td>
</tr>
<tr>
<td>• Potential removal of the CME requirement to maintain AOA membership.</td>
</tr>
<tr>
<td>• Create improvements to the real and perceived value of membership through modification of existing programs and services.</td>
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<thead>
<tr>
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<tbody>
<tr>
<td>Affiliate Affairs</td>
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<td>Affiliate Alignment Task Force Membership</td>
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<tr>
<td>• Determine the viability of included state/specialty dues as options within the dues renewal process.</td>
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<tr>
<td>• Collaborate with AOIA in the development of revenue sharing models for identified and appropriate non-dues revenue sources.</td>
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<tr>
<td>AOIA/Legal</td>
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<td>AOIA Membership Committee</td>
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<tr>
<td>• Refine AOA and AOIA product inventory to better align with member wants and needs, including all affinity programs.</td>
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<tr>
<td>• Consolidate, develop, expand and relaunch affinity program to increase non-dues revenue</td>
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<tr>
<td>• Continue advocacy on behalf of members with respect to osteopathic issues with insurers, hospitals and work with Communications team to better promote advocacy services as part of the member value.</td>
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<tr>
<td>Certifying Board Services</td>
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<td>BOS</td>
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<tr>
<td>• Assist with coordination of messaging and message channels on enhancement of AOA Cert Requirements</td>
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<tr>
<td>Communications</td>
<td></td>
<td>Membership Comm</td>
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<tr>
<td>• Execute phase 2 of the Brand Awareness Campaign in digital and social media channels, paid search, and regional out-of-home, Find Your DO</td>
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<tr>
<td>FY 2018 Key Work Plan Activities:</td>
<td>% Completed by Year End FY2018</td>
<td>Notes</td>
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<tr>
<td>• Apply market segmentation strategy to engage DOs and students with targeted AOA messages,</td>
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<td>BEL</td>
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<td>dedicated programming (OMED, online CME, member programs &amp; services)</td>
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<tr>
<td>• Execute member recruitment marketing campaign (direct mail, email, digital/social and print ads) to DOs and MDs</td>
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<td>• Initiate 2nd first stage of rebuild of osteopathic.org</td>
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<tr>
<td>• Recruit and train new DO spokespeople to support earned media; elevate in-person media interactions</td>
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<tr>
<td>Education</td>
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<td>COCA</td>
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<tr>
<td>• Monitor and review receptiveness of electronic accreditation systems for functionality, efficiency, and data collection.</td>
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<td>COCA</td>
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<tr>
<td>• Education will also continue to collect TIVRA (residency) data that can contribute to profession based research and board certification eligibility.</td>
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<td>Education</td>
</tr>
<tr>
<td>• Begin a conversation to redefine AOA role in CME (tracking for member value versus producing high quality distinctive programs).</td>
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<tr>
<td>• Continue TIPS program as an AOA offering</td>
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<tr>
<td>Finance/HR</td>
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<td>Finance</td>
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<tr>
<td>• Evaluate staffing of CME group and provide training and or transition of staff, where appropriate.</td>
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<tr>
<td>International</td>
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<td>BIOM</td>
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<tr>
<td>• Develop Assessment of Members International representation (FSMB/ AACOM data on DO international COM enrollees)</td>
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<tr>
<td>• Evaluate and propose options for member relevance marketing of DO Care to demographics of DO market (work with DO Care board to consider students; residents; new physicians; mid-career; near retirement)</td>
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<tr>
<td>Information Technology</td>
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<tr>
<td>• Continue the design and development of the &quot;TraCME&quot; platform for logging and reporting of CME and OCC</td>
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<tr>
<td>• Upgrade iMIS Membership System to version 20.</td>
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<tr>
<td>• Upgrade Single Sign-on (SSO) system for all Websites.</td>
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<tr>
<td>Membership</td>
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<td>Membership</td>
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<tr>
<td>• Complete work on Membership Alignment Recommendations through Committee…including fees, models of membership, communications enhancements, market targets.</td>
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<tr>
<td>• Create customer service benchmarks and metrics, leveraging current technologies, to establish standards for customer service excellence</td>
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<tr>
<td>• All CME data for 2016-2018 CME cycle will be in</td>
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<tr>
<td>FY 2018 Key Work Plan Activities:</td>
<td>% Completed by Year End FY2018</td>
<td>Notes</td>
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</table>
| TraCME by FY 2018. Amount of data entry by CRC staff will be reduced. Transfer OCC data in CE City dependent on development schedule of Physician Portal.  
- Review design of AOA membership invoice to enhance data collection efforts with dues payment.  
- Work with AOIA to enhance physician data with affinity program participation to further profile member interests and opportunities for future engagement – ongoing throughout the year.  
- Continue to enhance Osteopathic.org with information about AOA's policies and services.  
- Conduct email exit survey of dropped members to learn reasons for not renewing  
- Enhance promotion of DO Jobs, existing career development tools  
- Support Communications membership campaign.  
- Gift membership for the remainder of the year to OMED nonmember registrants – May-Sept 2017 deliver special email nurture and retention campaign – ongoing.  
- Prepare communication response plan to assist with anticipated questions and concerns from members and AOA Sponsors, on key issues– before HOD meeting in July 2017. | | | BEL  
Membership w/AOIA  
Membership w/communications |

**Public Policy**
- Identify member options on public policy as part of membership alignment options.  
- Consistently highlight state & federal public policy successes to the profession – especially those where impact can be immediately quantified for each member  
- Leverage MACRA changes to the practice of medicine so that DOs see the AOA as a needed resource and source of information and support

**Research**
- Centralize AOA facilitated online CME and establish a workgroup that assists with assessing and approving CME content offered by the AOA.
PHASE II: Strategic Priority Window: Board Certification Services

Goal
Invest resources to make AOA board certification more attractive and competitive.

Operational Metrics: 2017-2019

Description: ESTABLISH NEW METRIC DASHBOARDS FOR 2017-2019!

- Create ways to enhance and promote osteopathic certification training and programs to drive greater market visibility and adoption.
- Potential changes to the current OCC requirements with the objective of removing the most onerous components and issues without a reduction in quality.
- Create a world-class system that makes AOA board certification THE market leader.

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<thead>
<tr>
<th>FY 2018 Key Work Plan Activities:</th>
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<th>Notes</th>
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<tbody>
<tr>
<td><strong>Affiliate Affairs</strong></td>
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<tr>
<td>• Utilize state and specialty affiliated organizations to distribute informational materials on AOA board certification through educational programs, and student/resident outreach</td>
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<td>AOSED/ SOSE</td>
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<tr>
<td>• Conduct a call campaign to identify joint AOA/allopathic specialty programs providing data for CBS to utilize as determined.</td>
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<td>BOS</td>
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<tr>
<td><strong>AOIA/Legal</strong></td>
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<tr>
<td>• Advocacy to hospitals, insurers and third parties in support of recognition of AOA certification as equivalent to ABMS and coordinate with communications staff to promote successful outcomes</td>
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<tr>
<td><strong>Certifying Board Services</strong></td>
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<tr>
<td>• Continue management of all 18 in house Cert Boards.</td>
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<tr>
<td>• Recruit new VP Cert Board Services</td>
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<tr>
<td>• Continue alignment of certification and OCC work flow, to streamline support processes and meeting activity.</td>
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<tr>
<td>• Integrate the Board Certification Summit into OMEL annual meeting.</td>
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<tr>
<td>• Recruit a psychometrician to centralize routine psychometric responsibilities.</td>
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<tr>
<td>• Implement consistent AOA travel policies across all cert board activities.</td>
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<tr>
<td>FY 2018 Key Work Plan Activities:</td>
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<tr>
<td>• Enhance reporting of information to certifying board level through BOS Leadership meeting, and e-newsletter to all members, as well as other mechanisms.</td>
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<tr>
<td><strong>Communications</strong></td>
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<tr>
<td>• Execute marketing campaign to increase DO and MD awareness of AOA board certification and OCC (direct mail, email, digital/social and print ads, earned media)</td>
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<tr>
<td>• Support redesign of Certification Board websites</td>
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<tr>
<td>• Leverage earned media, when appropriate, to deliver AOA position on OCC</td>
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<tr>
<td><strong>Education</strong></td>
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<tr>
<td>• Complete the collection of TIVRA residency data to continue to feed board certification eligibility info.</td>
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<td>BOS</td>
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<tr>
<td>• Promote and discuss board certification while promoting SAS and Osteopathic Recognition</td>
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<td>PTRC</td>
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<tr>
<td>• Evaluate whether evidence demonstrates that continuous certification leads to improved care</td>
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<td>BOGMED</td>
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<tr>
<td>• AAP to reach out to select groups of program directors to encourage them to apply for osteopathic recognition and thereby generate potential demand for osteopathic certification.</td>
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<tr>
<td><strong>Finance/HR</strong></td>
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<td>FINANCE</td>
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<tr>
<td>• Assure funding for Certifying Board Summit</td>
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<tr>
<td>• CBMS Portal and CBS Item Bank</td>
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<tr>
<td>• Develop dashboard budget reports for BOS</td>
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<tr>
<td><strong>International</strong></td>
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<tr>
<td>• Educate on distinction and equity of AOA &amp; ABMS Board acceptance in US and internationally</td>
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<tr>
<td><strong>Information Technology</strong></td>
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<tr>
<td>• Continue the design and development of a “Certification Board Portal” to enhance and consolidate the online presence of all certification activities to make it easier for diplomates and to help the boards be more competitive.</td>
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<tr>
<td>• Continue the design and development of the consolidated Item Bank System</td>
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<tr>
<td>• Support development of Tablet based scoring Oral Exams</td>
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<tr>
<td>• Complete the transition of Certification Board websites to a unified platform.</td>
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<tr>
<td><strong>Member Services</strong></td>
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<tr>
<td>• New ways to market Board certification will be tested, such as: on-hold reminders, reminders on dues statements, etc.</td>
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<tr>
<td>• Ensure that the new CME report from traCME provides clear and accurate information about their CME requirements for board certification</td>
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<tr>
<td>• Provide membership perspective, and data support, in development of Physician Portal</td>
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<tr>
<td>• Integrate training for CRC to answer and support questions identified as level 1 regarding board certification alignment and evolution.</td>
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<tr>
<td>• Work with CBS to create an FAQ for AOA staff at OMED booth so they can assist with questions about AOA board certification. – September 2016</td>
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<tr>
<td>FY 2018 Key Work Plan Activities:</td>
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<tr>
<td><strong>Public Policy</strong></td>
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<td>BSFP</td>
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<tr>
<td>• Advocate for equivalent recognition of all AOA board certifications in proposed and existing state and federal laws/regulations</td>
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<tr>
<td>• Ensure OCC, when included in state or federal legislation, is appropriately explained/communicated to membership to avoid mischaracterizations (ie- licensure requirements; clinical quality improvement under MACRA)</td>
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<tr>
<td>• Monitor emerging issue of restricting OCC/MOC/MOL for licensure, payment and privileges and develop coordinated response with state and specialty affiliates to align with AOA position/priorities</td>
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<tr>
<td><strong>Research</strong></td>
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<tr>
<td>• Determine future of Clinical Assessment Program (CAP) coordinating with BOS on OCC activities.</td>
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<tr>
<td>• Conduct/support research that examines the outcomes of OCC to the profession that will assist in making evidence-based decisions.</td>
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</table>
PHASE II: Strategic Priority Window: Affiliate Alignment

Goal
Remain committed to sustainable alignment with AOA’s state and specialty affiliates to advance the osteopathic profession.

Operational Metrics: 2017-2019

<table>
<thead>
<tr>
<th>Description: ESTABLISH NEW METRIC DASHBOARDS FOR 2017-2019!</th>
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</thead>
<tbody>
<tr>
<td>• Potential for AOA to provide support and resources to state and specialty affiliates to identify sustainability models</td>
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<thead>
<tr>
<th>FY 2018 Key Work Plan Activities:</th>
<th>% Completed by Year End FY2018</th>
<th>Notes</th>
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<tbody>
<tr>
<td><strong>Affiliate Affairs</strong></td>
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<tr>
<td>• Continue work with consultant and Task Force on Affiliate Alignment models.</td>
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<tr>
<td>○ 3QTR – Reports and recommendations should be submitted to BOT at Mid-Year</td>
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<tr>
<td>• Engage the leadership of AOSED and SOSE regularly (at least 6) over the year. Each meeting will be focused on one to two issues of relevance facing the AOA/Affiliated organizations.</td>
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<tr>
<td>• Utilize existing meetings/programs to include face to face meetings (AOA Annual Meeting, AHP/OMEL, OMED, Cluster meetings)</td>
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<tr>
<td>• Assess effectiveness of Affiliate Friday Folder</td>
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<tr>
<td>• Expand audience to include nonpractice affiliate organizational staff</td>
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<tr>
<td>• Collaborate with other departments on communication outreach to affiliated organizations</td>
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<tr>
<td>• Improve relationships with specialty affiliates participating in OMED</td>
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<tr>
<td>○ Enhance point of contact relationship with specialty affiliate executive directors</td>
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<tr>
<td>○ Engage in outreach to specialties not currently participating in OMED</td>
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<tr>
<td>• Assess the ongoing viability of Regional Osteopathic Medical Education (ROME) programs</td>
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<tr>
<td>• Support 2-3 SOMA initiatives that meet AOA strategic goals to build student engagement opportunities with AOA; outline future opportunities that would build more long-term engagement.</td>
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## FY 2018 Key Work Plan Activities:

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<th>AOIA/Legal</th>
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<tbody>
<tr>
<td>Work with Affiliate Task Force and CAGOS governance consultant to structure organization so that AOA is better aligned with its members’ needs and to identify appropriate opportunities for affiliate engagement in governance.</td>
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<thead>
<tr>
<th>Certifying Board Services</th>
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<tbody>
<tr>
<td>[See Certification Board Enhancement activities for Affiliates]</td>
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<tr>
<th>Communications</th>
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<tbody>
<tr>
<td>Deliver message and media training to state &amp; specialty societies</td>
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<tr>
<td>Strengthen content partnerships with specialty colleges and COMs</td>
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<tr>
<td>Collaborate on earned media strategy and execution (research, CME content, opportunistic media)</td>
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<tr>
<td>Expand marketing and distribution of CME and enduring materials through video, audio and live conferences</td>
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<thead>
<tr>
<th>Education/Accreditation</th>
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<tbody>
<tr>
<td>OMEL in association with AHP offers continued opportunity for education to work with affiliates</td>
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<tr>
<td>Collaborate with specialty colleges for the Application Assistance Program and to have ACGME EDs at all conferences</td>
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<tr>
<th>Finance/HR</th>
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<tbody>
<tr>
<td>Establish effective financial arrangement w/ affiliates for CME revenue share options</td>
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<tr>
<th>International</th>
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<tbody>
<tr>
<td>Enhance DO Care infrastructure- complete assessment and plan re: IT, Marketing, risk management, travel/logistics</td>
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<tr>
<td>Work with AOF to do Development plan for DOCARE</td>
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<tr>
<td>Establish 3-year budget for DO CARE</td>
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<tr>
<td>OIA- Enhance affiliate support with communications, marketing, meeting planning and board affairs support</td>
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<tr>
<td>Evaluate international affiliate opportunities and existing relations. Propose recommendations to BIOM on new affiliate relations, and propose representation plan.</td>
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<tr>
<th>Information Technology</th>
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<tr>
<td>Promote and support the sharing of the Minerva online learning platform as a shared resource for AOA affiliate CME sponsors</td>
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<tr>
<th>Member Services</th>
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<tr>
<td>Create an intro/welcome FAQ for new affiliate leadership about Client &amp; Member Services that highlights how AOA supports/partners with its affiliates.</td>
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<tr>
<th>Public Policy</th>
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<tr>
<td>Enhance legislative tracking support, strategy, and collaboration to demonstrate value to existing and potential members and increase visibility within their market</td>
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<tr>
<th>% Completed by Year End FY2018</th>
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<td>CAGOS</td>
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<td>OMEL PTRC BOGMED</td>
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<td>BIOM</td>
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<tr>
<td>Affiliate Alignment Task Force</td>
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<tr>
<td>FY 2018 Key Work Plan Activities:</td>
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<tr>
<td>• Explore the benefits and resources necessary to develop a state or regional AOA Public Policy staff contact program to support work of State Government Affairs</td>
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<td>• Integrate affiliates more intentionally into AHP, Health Policy Forum, DO Day, and Town Hall events</td>
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<tr>
<td>• Support and educate affiliates in HOD resolution development process</td>
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<tr>
<td>o Demonstrate how AOA utilizes approved policies in State &amp; Federal public policy advocacy efforts</td>
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<tr>
<td>Research</td>
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<td>BSAPH &amp; BOCER</td>
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<tr>
<td>• Continue to provide grant-related CME programs that include stipends for the affiliate and provide education to their constituents during their respective annual meetings (e.g., CORE*REMS, Conrad Hilton project, Alz program).</td>
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<tr>
<td>• Partner with affiliates for OMED to integrate the Public Health Seminar and Sponsorship of Research Speakers</td>
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ROOF TOP GOALS
100% increase in the awareness of Osteopathic medicine
50% increase with engagement of DOs
100% increase in international awareness of DOs

PHASE II: Strategic Priority Window: International Impact

Goal
Leverage the opportunity to enhance global visibility and the impact of opportunity to enhance global visibility and the impact of osteopathic medicine.

Operational Metrics: 2017-2019

Description: ESTABLISH NEW METRIC DASHBOARDS FOR 2017-2019!

- Research and develop approaches to better integrate and coordinate existing international engagement opportunities.
- Approach, plan and invest to advance visibility and impact through global clinical care mission work, affiliate representation, research, education, licensure and other regulatory issues, and/or accreditation opportunities.

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<tr>
<td>Affiliate Affair</td>
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<tr>
<td>AOIA/Legal</td>
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<tr>
<td>• Review international volunteer activities currently available through DO Care and other organizations</td>
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<tr>
<td>• Provide guidance in international involvement and opportunities to secure recognition of US model osteopathic medical care</td>
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<tr>
<td>Certifying Board Services</td>
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<tr>
<td>Communications</td>
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<tr>
<td>• Leverage digital/social channels and earned media to build awareness of DO CARE missions, and DO/student opportunities for international engagement</td>
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<tr>
<td>• Support efforts to engage with and elevate OIA, including promoting international program at OMED</td>
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<tr>
<td>• Provide communications counsel and support on international licensure and other regulatory issues</td>
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<tr>
<td>Education/Accreditation</td>
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<tr>
<td>• Through COCA, complete efforts to acquire recognition as an accrediting agency through the WFME. This will assist the COCA in serving as a recognized accrediting agency for osteopathic medical schools outside the United States.</td>
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<td>COCA</td>
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<tr>
<td>• Prepare education exchange for Korean Delegation Partnership meeting.</td>
<td></td>
<td>BOE</td>
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<tr>
<td>Finance/HR</td>
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<tr>
<td>FY 2018 Key Work Plan Activities:</td>
<td>% Completed by Year End FY2018</td>
<td>Notes</td>
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<tr>
<td><strong>International</strong></td>
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<tr>
<td>• Focus on Practice Rights to achieve progress in Africa (AMCOA-South Africa), South America, Korea, and India.</td>
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<td>BIOM</td>
</tr>
<tr>
<td>• Follow up on current requests for COM Accreditation. Begin assessment on COM potential for COCA expansion Internationally</td>
<td></td>
<td></td>
<td>DO CARE</td>
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<tr>
<td>• Establish policy for sustainability platforms for international mission outreach support</td>
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<td>BOCER</td>
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<tr>
<td>• Develop DOCARE fund development plan, for sustainability of strategic, integrated and enhanced programs.</td>
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<tr>
<td>• Enhance international research collaborations w/ WHA (Geneva)</td>
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<tr>
<td>• Affiliate relations development w/ IAMRA and OIA (New Zealand)</td>
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<tr>
<td><strong>Information Technology</strong></td>
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<tr>
<td>• Provide technology support as needed to support international initiatives.</td>
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<tr>
<td><strong>Member Services</strong></td>
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<td>CCME</td>
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<tr>
<td>• Establish policy for awarding CME credits for mission work – AOA Category 1-B up to the maximum of 5-10 credits per CME cycle.</td>
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<tr>
<td><strong>Public Policy</strong></td>
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<tr>
<td>• Facilitate conversations and advocate to HHS for appointment to the US Delegation to the World Health Assembly</td>
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<tr>
<td>• Support additional coordination with IAMRA through the work of AAOE, develop strategy for how to increase recognition of US DO model internationally</td>
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<tr>
<td>• Develop proactive strategy to engage in emerging global health issues</td>
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<tr>
<td>• Leverage strategy to be an immediate key resource to federal and state agencies, and be an educational conduit to DOs</td>
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<tr>
<td>• Increase collaboration between AAOE and OIA to help educate on how government recognition and regulation of osteopathic practice can advance osteopathic medicine and US model of DO education/training internationally</td>
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<tr>
<td><strong>Research</strong></td>
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<td>BOCER</td>
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<tr>
<td>• Assist with identifying researchers to attend international meetings/panels to represent AOA and provide the US osteopathic medical perspective.</td>
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<tr>
<td>• Work with OIA to support its annual conference as it pertains to research.</td>
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<tr>
<td>• Host a research showcase in collaboration with OIA and highlight domestic and international researchers. May partner with Dept. of Education which has a similar activity but for educational purposes.</td>
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</tbody>
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### ROOF TOP GOALS

100% increase in the awareness of Osteopathic medicine  
50% increase with engagement of DOs  
100% increase in international awareness of DOs

## PHASE II: Strategic Priority Window: Governance Alignment

**Goal**  
Design a governance structure that best supports its mission, vision and strategy and business model in a sustainable way.

**Operational Metrics: 2017-2019**

<table>
<thead>
<tr>
<th>Description: ESTABLISH NEW METRIC DASHBOARDS FOR 2017-2019!</th>
</tr>
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<tbody>
<tr>
<td>• Establish recommendations for an incremental transformation of the AOA governance structure and processes.</td>
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<thead>
<tr>
<th>FY 2018 Key Work Plan Activities:</th>
<th>% Completed by Year End FY2018</th>
<th>Notes</th>
<th>B/C/C/T</th>
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<tbody>
<tr>
<td><strong>Affiliate</strong></td>
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<tr>
<td>• Educate affiliates in the AOA resolution and policy process</td>
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<tr>
<td>• Develop and provide flowcharts on the resolution and policy process at the AOA Board level</td>
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<tr>
<td>• Communicate BOT approved recommendations to affiliates</td>
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<tr>
<td><strong>AOIA/Legal</strong></td>
<td></td>
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<tr>
<td>• Present recommendations from Committee on AOA Governance and Organizational Structure to AOA Board of Trustees to (a) streamline AOA operations by eliminating duplicative efforts of bureaus, councils and bureaus, (b) develop a long-term plan to align Board structure with members, and (c) consider issue items for consideration regarding HOD</td>
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<tr>
<td><strong>Certifying Board Services</strong></td>
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<tr>
<td>• Review BOS policies and develop effective ways to enhance board certification processes and marketability.</td>
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<tr>
<td>• Implement process to certify non-AOA GME trained DOs; new ACGME SAS DOs, and MDs</td>
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<tr>
<td><strong>Communications</strong></td>
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<tr>
<td>• Leverage member communications channels and events to increase understanding of need and opportunity for governance re-alignment; and any new approved changes</td>
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<th>Notes</th>
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<td>Consultant</td>
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<td>AOSED</td>
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<td>CAGOS</td>
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<tr>
<td>BOS</td>
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<td>BOT BEL</td>
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<td>FY 2018 Key Work Plan Activities:</td>
<td>% Completed by Year End FY2018</td>
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<tr>
<td><strong>Education/Accreditation</strong></td>
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<tr>
<td>• Complete and implement new COCA Policies and Procedures</td>
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<tr>
<td>• Realign BOGMED to be staffed by Postdoctoral staff</td>
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<tr>
<td>• Begin to phase out COPT.</td>
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<tr>
<td>• Move CCME accreditation to the Department of Accreditation.</td>
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<tr>
<td><strong>Finance/HR</strong></td>
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<tr>
<td>• Evaluate financial implications of any recommended changes</td>
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<tr>
<td><strong>International</strong></td>
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<tr>
<td>• Establish annual goals for BIOM, and identify where other potential B/C/Cs may want to expand their scope further to include International initiatives.</td>
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<tr>
<td><strong>Information Technology</strong></td>
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<tr>
<td><strong>Member Services</strong></td>
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</tr>
<tr>
<td>• Promote member opportunities, as defined through task force to support international activities</td>
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<tr>
<td>• Evaluate membership options to market broader in international environments for members.</td>
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<tr>
<td><strong>Public Policy</strong></td>
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<tr>
<td>• Create an exception mechanism to fast track and approve new AOA policy when needed on emerging and urgent issues</td>
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<tr>
<td>• Develop process for regular review of existing AOA policy to determine how similar policies can be combined to streamline compendium</td>
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<tr>
<td><strong>Research</strong></td>
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<tr>
<td>• Streamline Bureau membership to ensure all members are active participants.</td>
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<tr>
<td>• Implement conflict of interest policies on grant reviewers and recipients</td>
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FY 2017-2018 Proposed AOA Budget
2016-17 Finance Committee

John W. Becher, DO, Chair
Boyd R. Buser, DO, Vice Chair
Mark A. Baker, DO
Ronald R. Burns, DO
Joseph A. Giaimo, DO
Mark S. Cantieri, DO
Ira P. Monka, DO
William J. Burke, DO
Geraldine T. O’Shea, DO
Joseph M. Yasso, DO
Robert S. Juhasz, DO

Adrienne E. White-Faines, MPA, Advisor, Chief Executive Officer

Frank W. Bedford, CPA, Secretary & Advisor, Chief Financial Officer

Finance Department

Michael J. Schultz, Assistant Controller
   Monica Flores, Executive Assistant
Gina M. Fieramosca, CPA, Senior Accountant
   Nissa A. Harvey, CPA, Senior Accountant
Josephine A. Scumaci, General Accountant Specialist
   Theresa Smith, AP Specialist
   Randy Weaver, AR Specialist
   Angela M. Wilkins, Accountant
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American Osteopathic Association
FY 2018 Budget Narratives
July 2017

REVENUES

Operating Budget:

Total operating revenues for FY 2018 are budgeted at $44.7 million, a reduction of $800K from FY 2017, representing an overall decrease of 1.8%.

Key Assumptions:
- Potential changes in membership as AOA continues to strengthen member value proposition in accordance with the strategic plan.
- Continued reductions in OGME accreditation revenue during transition to single accreditation system in ACGME.
- Primary increases in Board Certification and COCA revenues.

Accordingly, projected revenue reductions were made to the operating budgets in the following areas:
- Membership: ($935K)
- OGME/CME: ($142K)
- Publications: ($381K)

Similarly, projected revenue increases are anticipated as new business operations are expanded to support these assumptions:
- COCA Fees: $288K
- Certifying Board Fees: $104K
- AOIA: $413K

Non-Operating Budget:

Conservative increases in total non-operating revenue are projected in two areas leading to a net gain of $125K:
- Lease income 142 E. Ontario: $81K
- Investment income: $44K

EXPENSES:

Operating Budget:

To accommodate reductions in revenue and ensure a balanced budget for FY 2018, equivalent expense reductions of approximately 1.7% from FY2017 expense budget overall have been planned. Total operating expenses for FY 2018 are budgeted at $44.7 million, which is a reduction of $777K.
Although these reductions touch every area of AOA business operations, careful attention was afforded to ensure sustainability of critical operations and continued robust support for strategic improvement efforts.

Key Assumptions:
- Expense budget reductions are in alignment with diminishing service lines, such as staffing and operational expenses associated with the OGME transition to SAS.
- Reductions in IT recognize completed infrastructure over prior years, and increased use of consultants going forward.

DEPARTMENTAL BUDGET HIGHLIGHTS
Activities to optimize FY 2018 revenue and expense management across the Association are shown below:

**Accreditation**
- No substantive reductions have been made to COCA operational budget. Strategic improvement plans are moving forward.
- COCA continues to maintain budget for 25 surveys.
- Accreditation fee increase after 10 years

**Affiliate Affairs**
- Revenues and expenses reflect termination of contract management services for AODME on Sept. 30, as the organization becomes part of AACOM.
- Travel and consultant expenses have been adjusted to support the Affiliate Alignment strategy.

**Certifying Board Services**
- All 18 boards are now managed centrally. Cash and investments have been consolidated into the AOA General Fund.
- Alignment of certification and OCC workflows continues, as well as streamlining of meeting planning and support processes.
- Recruitment of a staff psychometrician to centralize routine psychometric responsibilities, along with re-contracting of consultant psychometricians to support high-level subject matter expertise, is planned for FY 2018, eventually allowing annual savings of $1 million.
- All Certifying Board members and examiners are now complying with AOA travel policies.
- Under CBTF2 assumptions, Honoraria for Board Members and Examiners will be moved toward central standard in FY 2018.

**Communications**
- The AOA will increase marketing efforts and outreach to members in FY18, focusing on additional recruitment of members and promotion of AOA board certification.
Brand Campaign
- AOA has budgeted $2.5M for investment to continue the brand awareness campaign which will include digital and social advertising, national print and paid search. Existing campaign assets will be refreshed with new headlines, copy and a few new faces. The budget also includes funding for marketing research with consumers and DOs to test the impact of the campaign at the three year milestone.
- Includes $75,000 to extend AOA’s partnership with Aspen Institute and The Atlantic as a sponsor at the 2017 Aspen Spotlight Health conference, which is attended by renowned thought leaders in health policy, public health, industry and academia. AOA is a joint sponsor with the American Hospital Association at the $150,000 level.

Publications: JAOA
- Online display advertising revenue for the *JAOA* increased by $30,000 as a result of revised ad spots on JAOA.org and a closer partnership with Association Revenue Partners.
- The *JAOA* has reduced its print circulation by no longer sending new primary care residents the print *JAOA*. In FY18, this reduction amounts to 3,000 fewer print recipients, resulting in a savings of $9,550 in printing, paper, postage, and mail handling.
- The *JAOA* continues to investigate new revenue opportunities by soliciting institutional subscriptions from international osteopathy schools, chiropractic schools, and other medical libraries. Advertising outreach, article packaging, and more are also being considered.

Special Projects
- Special Projects anticipates 8 CME activities for FY18, including a mix of online webcasts, live webcasts, *JAOA* monographs and supplements, and *AOA Health Watch* issues. In addition, we continue to seek grants that include OMED symposia, OMED sponsorships and ROME meetings. We continue to collaborate with other specialty colleges and external groups on these CME ventures.
- All CME activities produced by the Department of Communications generate a profit for the AOA. This will continue to keep online posting fees within the AOA.

Meetings & OMED
- OMED continues to be a flagship event for the organization as it shows unification of the profession. This year ACOG and ACOOG will be joining us at the conference. Increased outreach to prospective exhibitors and sponsors will be more focused and aligned.
- Expenses for OMED will be higher with the overall cost of all items increasing as Philadelphia is a union city with many strict labor regulations.

Education
- The Education Bureaus and Councils continue to work on program accreditation and training approval. Efforts to improve efficiency and cost-effectiveness of meeting time are also planned for all.
- Demand for the Application Assistance Program (AAP) is increasing with a growing number of requests for independent reviews of applications before they are submitted. The AOA is establishing a cadre of peer reviewers to accommodate that need. A total of $300,000 has
been requested from reserves to reimburse the cost of reviewers and provide resources for in-person consultations, if necessary.

- Postdoctoral COM inspections and the demand for unscheduled inspections continues, although the number of new program inspections has fallen by approximately 30%. The AOA accreditation team staffing will be adjusted accordingly.

**Executive:**
- Recruitment of key Senior Leadership Team (SLT) positions is planned in FY 2018, including:
  - Vice President, Certifying Board Services
  - Senior Vice President, Public Policy
  - Vice President, Human Resources
  - Vice President, Accreditation
  - Vice President, Affiliate Affairs

**Membership Services:**
- CME operations in the amount of $712K were transferred to the OGME/CME Department.
- The following activities were transferred to Affiliate Affairs:
  - Division of Students/Interns/Residents $308K
  - SOMA Membership Incentive $150K
  - Bureau of Emerging Leaders $23K

**Public Policy (Government Relations & State Government Affairs)**
- Public Policy Engagement
  - Committee Member travel budget will again be utilized for DOs brought to Washington for events, Capitol Hill testimony, and meetings of federal panels. As well, the budget continues to be utilized to advance key nominations to federal panels and committees, such as MedPAC.
  - For the first time, we plan to solicit sponsorships for DO Day in Spring 2018 to offset expenses.
  - We plan to add a Fall “mini” DO Day advocacy day for 2017, that will be focused on DOs and the more specific advocacy message they can convey by drawing on their experience as practicing physicians.
  - We are further integrating OMEL and the Advocacy for Healthy Partnerships (AHP) meetings into one meeting, “LEADS: Leadership, Education, Advocacy and Development” to provide an enhanced leadership and advocacy educational experience for affiliate leaders, medical educators, and students and residents, and examining additional mechanisms to offset expenses.
- Public Policy Strategy
  - Lobbying consulting services of $315,000 will continue for Dentons, that covers both federal and state needs, as well as additional specialized consulting as needed (such as Red Rock Strategies).
• Public Policy Bureaus
  o The Bureau of State Government Affairs (BSGA), the Bureau of Federal Health Programs (BFHP), and the Bureau of Socioeconomic Affairs (BSA) continue to all be housed under public policy.
• Public Policy Development
  o The work of the AOA’s physician representatives to the CPT and RUC continues to be supported by the department to align with the policy function and work with CMS. Collaboration will continue with AOIA Physician Services in this effort.

Information Technology
• Continue the development of enhancements to TraCME, the new CME and OCC tracking system that was launched in FY16.
• Complete the upgrade of the AOA’s membership system, iMIS, to version 20.
• Collaborate closely with the Communications Department on the re-development of osteopathic.org.
• Technology support for Certification Boards.
• Support and enhancements to the online eLearning platform, for online delivery of category 1A CME and platform sharing with affiliate CME sponsors.
• Upgrade the single sign-on (SSO) system for all websites to a standards based solution.
• Implement upgrades to the AOA telephone system.
• Infrastructure upgrades to replace outdated server equipment and improve the reliability of the data center power systems at 142 Ontario.

International Affairs
• Focus remains on practice rights expansion and sustainability of mission initiatives.
• Budget includes delegation visits to OIA (New Zealand), Kora Partnership, AMCOA trip South Africa (w/FSMB), and WHA, Geneva.

Research and Development
• Research and development grants continue at the FY 2017 level.
• New grants at $75,000 is budgeted for AACOM partnership and $100,000 for a substance abuse grant.
Budgeted Revenues as a Percentage of Total Budgeted Revenues

- Research
- Publications
- Postdoctoral Accred.
- Membership Dues
- COCA
- Convention
- Certified Boards
- Certification
- All Other

FY 2017
FY 2018
Budgeted Expense Categories as a Percentage of Total Expense Budget

- Salaries
- Benefits
- All Other
- Cert. Board
- Travel
- Prof. Serv.
- Depreciation
- Convention
- Inspections
- Occupancy
- Mailing
- Printing

FY 2017
FY 2018
American Osteopathic Association  
Pro Forma Statements of Financial Position  
May 31

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<td>Actual 2016</td>
<td>Estimated 2017</td>
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<td>5/31/2018</td>
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**ASSETS**

100 CURRENT ASSETS:

101 Cash and Investments (At Market Value)  
  102 34,803,166  
  103 51,671,962  
  104 41,098,560  

105 Certifying Boards  
  106 16,170,141  
  107 -  
  108 -  

109 Osteopathic Research Development Fund  
  110 5,408,964  
  111 5,677,216  
  112 5,120,300  

113 Dale Dodson Educational Fund  
  114 2,297,953  
  115 2,679,433  
  116 2,567,883  

117 NOAC Capital Improvement Fund  
  118 378,951  
  119 378,951  
  120 378,951  

121 Total unrestricted cash and cash equivalents  
  122 59,059,175  
  123 60,407,562  
  124 48,165,694  

125 Accounts receivable:  
  126  
  127 Affiliated organizations  
  128 471,795  
  129 258,082  
  130 265,824  

131 Education  
  132 56,582  
  133 150,880  
  134 155,406  

135 Other  
  136 2,388,136  
  137 2,265,988  
  138 2,333,968  

139 Total accounts receivable  
  140 2,916,513  
  141 2,674,950  
  142 2,755,199  

143 Interest Receivable:  
  144  
  145 Operating  
  146 99,450  
  147 93,272  
  148 95,137  

149 ORDF  
  150 22,304  
  151 21,978  
  152 20,879  

153 Total interest receivable  
  154 121,754  
  155 115,250  
  156 116,017  

157 Prepaid expenses  
  158 1,403,082  
  159 1,294,120  
  160 1,332,944  

161 Deposits  
  162 47,601  
  163 40,144  
  164 41,348  

165 Total current assets  
  166 63,548,125  
  167 64,532,026  
  168 53,411,201  

169 Property and Equipment  
  170 27,209,564  
  171 28,079,498  
  172 31,776,874  

173 Less Depreciation  
  174 (18,040,833)  
  175 (19,226,874)  
  176 (20,611,626)  

177 Property and equipment-net  
  178 9,168,731  
  179 8,852,624  
  180 11,165,248  

181 Deferred rent receivable  
  182 720,703  
  183 777,806  
  184 801,140  

185 Other  
  186 27,000  
  187 10,000  
  188 10,200  

189 Total other assets  
  190 9,916,434  
  191 9,640,430  
  192 11,976,588  

193 TOTAL ASSETS  
  194 73,464,559  
  195 74,172,456  
  196 65,387,789  

Page 8
American Osteopathic Association  
Pro Forma Statements of Financial Position  
May 31  

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### LIABILITIES AND NET ASSETS

#### CURRENT LIABILITIES:

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<tr>
<td>Accounts payable</td>
<td>1,328,283</td>
<td>1,341,529</td>
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<td>Accrued expenses</td>
<td>1,694,074</td>
<td>1,495,689</td>
</tr>
<tr>
<td>Accrued salaries and benefits</td>
<td>1,763,521</td>
<td>1,945,271</td>
</tr>
<tr>
<td>Accrued property taxes</td>
<td>489,359</td>
<td>523,710</td>
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<tr>
<td>Deferred revenue</td>
<td>20,676,633</td>
<td>20,196,705</td>
</tr>
<tr>
<td>Other Liabilities</td>
<td>760,800</td>
<td>509,597</td>
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#### TOTAL LIABILITIES:

<table>
<thead>
<tr>
<th>A</th>
<th>B</th>
<th>C</th>
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<tbody>
<tr>
<td>26,712,670</td>
<td>26,012,501</td>
<td>21,356,345</td>
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#### NET ASSETS:

#### Unrestricted:

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<th>A</th>
<th>B</th>
<th>C</th>
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<tr>
<td>Osteopathic Research Development Fund</td>
<td>5,180,435</td>
<td>5,291,449</td>
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<tr>
<td>Dale Dodson Educational Fund</td>
<td>2,297,953</td>
<td>2,629,433</td>
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<tr>
<td>Bridge Contribution Fund</td>
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#### Reserve Fund:

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<td>Beginning Balance</td>
<td>38,723,535</td>
<td>36,864,601</td>
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<tr>
<td>Increase (Decrease) in Reserve Fund</td>
<td>(1,858,866)</td>
<td>1,258,989</td>
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<tr>
<td>Ending Balance</td>
<td>36,864,601</td>
<td>38,123,590</td>
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#### Total net assets - unrestricted:

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<th>B</th>
<th>C</th>
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<td>46,133,519</td>
<td>47,835,002</td>
<td>43,994,170</td>
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#### Temporarily Restricted:

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<td>618,370</td>
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<td>37,275</td>
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#### Total Net Assets:

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<th>B</th>
<th>C</th>
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<tbody>
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<td>46,751,889</td>
<td>48,159,955</td>
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#### TOTAL LIABILITIES AND NET ASSETS:

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<th>B</th>
<th>C</th>
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<td>73,464,559</td>
<td>74,172,456</td>
<td>65,387,789</td>
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### American Osteopathic Association

**Statement of Activities**

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<tr>
<th></th>
<th>A FY2016</th>
<th>B FY 2017</th>
<th>C FY 2017</th>
<th>D FY 2018</th>
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<tbody>
<tr>
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<td>PROJECTED</td>
<td>ACTUAL</td>
<td>ACTUAL</td>
<td>BUDGET</td>
</tr>
<tr>
<td><strong>Operating revenues:</strong></td>
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<tr>
<td>Publications:</td>
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<td>Revenue</td>
<td>1,143,197</td>
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<td>(2,036,746)</td>
<td>(1,858,821)</td>
<td>(2,119,222)</td>
<td>(1,759,965)</td>
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<td>Surplus/(Loss) on Publications</td>
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<td>(836,176)</td>
<td>(689,222)</td>
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<td>Membership Dues</td>
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<td>21,056,100</td>
<td>20,245,000</td>
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<td>703,000</td>
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<td>485,683</td>
<td>578,554</td>
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<td>277,808</td>
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<td><strong>Other Operating Revenues:</strong></td>
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<td>Certifying Boards-net</td>
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<td>Miscellaneous</td>
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<td>349,214</td>
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<td>Total Other Operating Revenues</td>
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## Operating expenses:

### Central Office

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<tr>
<th>Item</th>
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<th>FY 2017</th>
<th>FY 2017</th>
<th>FY 2018</th>
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<tbody>
<tr>
<td></td>
<td>PROJECTED</td>
<td>ACTUAL</td>
<td>BUDGET</td>
<td>BUDGET</td>
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<tr>
<td></td>
<td>235</td>
<td>236</td>
<td>237</td>
<td>238</td>
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<tr>
<td>Meetings/Administration</td>
<td>632,612</td>
<td>913,540</td>
<td>809,901</td>
<td>826,910</td>
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<td>Human Resources</td>
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<td>1,177,378</td>
<td>1,145,369</td>
<td>1,341,335</td>
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<td>Member Services</td>
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<td>OGME/CME</td>
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<td>Executive</td>
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<td>3,360,401</td>
<td>3,129,172</td>
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<td>Finance</td>
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<td>COCA</td>
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<td>992,336</td>
<td>989,754</td>
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<td>Affiliate Affairs</td>
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<td>International Affairs</td>
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<td>Certifying Board Services</td>
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<td>government Relations</td>
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<td>28,214,256</td>
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### Committee expenses:

<table>
<thead>
<tr>
<th>Item</th>
<th>FY2016</th>
<th>FY 2017</th>
<th>FY 2017</th>
<th>FY 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PROJECTED</td>
<td>ACTUAL</td>
<td>BUDGET</td>
<td>BUDGET</td>
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<tr>
<td></td>
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<td>256</td>
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<td>258</td>
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<td>Educational Affairs</td>
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<td>Professional Affairs</td>
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<td>Public Affairs</td>
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<td>105,121</td>
<td>140,911</td>
<td>168,511</td>
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<td>Business Affairs</td>
<td>19,492</td>
<td>16,805</td>
<td>35,910</td>
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<td>Government Affairs</td>
<td>115,523</td>
<td>112,571</td>
<td>289,018</td>
<td>207,560</td>
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<td>Elected Officers</td>
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<td>2,432,576</td>
<td>2,709,046</td>
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<td>Other Committees</td>
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<td>17,923</td>
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<td>15,700</td>
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<td>4,288,351</td>
<td>4,399,228</td>
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### Excess of Operating Revenues

<table>
<thead>
<tr>
<th>Item</th>
<th>FY2016</th>
<th>FY 2017</th>
<th>FY 2017</th>
<th>FY 2018</th>
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<tbody>
<tr>
<td></td>
<td>PROJECTED</td>
<td>ACTUAL</td>
<td>BUDGET</td>
<td>BUDGET</td>
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<tr>
<td></td>
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<td>276</td>
<td>277</td>
<td>278</td>
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<tr>
<td>Operating Expense</td>
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<td>Over Expenses before Transfer</td>
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<td>1,507,053</td>
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### American Osteopathic Association

**Statement of Activities**

<table>
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<tr>
<th></th>
<th>A FY2016</th>
<th>B FY 2017 Actual</th>
<th>C FY 2017 Budget</th>
<th>D FY 2018 Budget</th>
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<tbody>
<tr>
<td><strong>Nonoperating Activities:</strong></td>
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<td>142 East Ontario</td>
<td>430,203</td>
<td>315,543</td>
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<td>Investment income</td>
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<td>Total nonoperating revenues</td>
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<td>282</td>
<td>Change in Operations and nonoperating activities</td>
<td>2,271,803</td>
<td>4,697,536</td>
<td>831,931</td>
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<tr>
<td>283</td>
<td>Reserve Uses:</td>
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<tr>
<td>284</td>
<td>Brand Awareness Campaign</td>
<td>(3,509,634)</td>
<td>(2,359,660)</td>
<td>(2,400,000)</td>
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<tr>
<td>285</td>
<td>Member Value Initiative</td>
<td>(94,093)</td>
<td>(95,820)</td>
<td>(350,000)</td>
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<td>286</td>
<td>Postdoctoral Application Assistance</td>
<td>-</td>
<td>(119,353)</td>
<td>(110,000)</td>
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<td>287</td>
<td>Postdoctoral Inspection Catch Up</td>
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<td>(56,568)</td>
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<td>Governance Alignment</td>
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<td>289</td>
<td>Research</td>
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<td>International Alignment</td>
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<td>(100,000)</td>
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<td>291</td>
<td>Affiliate Alignment</td>
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<td>(110,000)</td>
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<td>292</td>
<td>COCA Initiatives</td>
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<td>-</td>
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<td>293</td>
<td>Certifying Board Summit</td>
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<td>(167,233)</td>
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<td>294</td>
<td>Total Reserve Uses</td>
<td>(4,130,669)</td>
<td>(3,438,547)</td>
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<tr>
<td>295</td>
<td>Increase (Decrease) in Reserve Fund</td>
<td>(1,858,866)</td>
<td>1,258,989</td>
<td>(3,085,119)</td>
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<tr>
<td>296</td>
<td>Temporarily Restricted Contributions</td>
<td>(45,936)</td>
<td>(293,417)</td>
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<td>297</td>
<td>Bridge Contribution Fund</td>
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<td>298</td>
<td>ORDF</td>
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<td>Dale Dodson Education Fund</td>
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<td>300</td>
<td>Total Increase/(Decrease) in net assets</td>
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</tr>
<tr>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
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<td>PROPOSED</td>
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<td>FY 2018</td>
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<td><strong>INFORMATION TECHNOLOGY:</strong></td>
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<td>314</td>
<td>315</td>
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<td>Applications:</td>
<td>iMIS 15 upgrade</td>
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<td>Conference Room Audio Upgrades</td>
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<td>318</td>
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<td>Rewire Server Room</td>
<td>eLearning Platform Development</td>
<td>TraCME Platform Development</td>
<td>CBS Portal Development</td>
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<td>322</td>
<td>323</td>
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<tr>
<td>rePhysicianPortal</td>
<td>CBDB-Cert Brd Database System</td>
<td>Awareness Campaign Microsite</td>
<td>Blade Servers/SAN Disk Storage</td>
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<td>326</td>
<td>327</td>
<td>328</td>
<td>329</td>
<td></td>
</tr>
<tr>
<td>UPS System</td>
<td>Portable A/C Unit</td>
<td>CBS Item Bank</td>
<td>Windows Server &amp; SQL Server Licenses for IMS Upgrade</td>
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<tr>
<td>330</td>
<td>331</td>
<td>332</td>
<td>333</td>
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<tr>
<td>Sharepoint Upgrade</td>
<td>Osteopathic.org Overhaul</td>
<td>Case Kbox for Desktop Upgrades</td>
<td>SSO Software</td>
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<td>334</td>
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<tr>
<td>Cert Brd - 3 Websites</td>
<td>Cert Brd - Contingency</td>
<td>ABOA Oral Exam Scoring Tablets</td>
<td>COCA E-Accreditation</td>
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<td>ColdFusion 2016</td>
<td>Copy Machine Partial Replacement</td>
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<td>342</td>
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<tr>
<td><strong>AOA TENTATIVE IMPROVEMENTS/FURNITURE AND EQUIPMENT:</strong></td>
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<td>Subtotal - Furniture and Equipment</td>
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<td><strong>142 EAST ONTARIO:</strong></td>
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<td>374</td>
<td>375</td>
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<td>398</td>
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<tr>
<td>Subtotal - (NOAC) DC Lease</td>
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American Osteopathic Association  
Pro Forma Statement of Operating Cash Flow  
For the Fiscal Years June 1, 2016 Through May 31, 2018

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<th>B</th>
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<td>402 Cash Flow Effects of Changes in Current Assets and Liabilities 16,590,727 (3,559,513)</td>
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<tr>
<td>404 Information Services (807,617) (1,040,500)</td>
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<tr>
<td>405 Furniture and Equipment (161,809) (150,000)</td>
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<td>406 EAST ONTARIO</td>
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<tr>
<td>407 Capital Expenditures</td>
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<td>408 Building Improvements (15,240) (1,256,208)</td>
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<tr>
<td>409 Tenant Improvements (10,555) (1,036,005)</td>
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<tr>
<td>410 Lease Commissions (6,809) (214,663)</td>
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<tr>
<td>411 Sub Total (11,494) (2,506,876)</td>
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<tr>
<td>414 CASH AND INVESTMENTS AT END OF PERIOD 51,671,962 41,098,560</td>
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<tr>
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<td>Actual</td>
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<tr>
<td>----------------------</td>
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<tr>
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<td>Actual</td>
</tr>
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<td>Information Technology</td>
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<td>Total Net Expense</td>
<td>$ -</td>
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## American Osteopathic Association
### Proposed Expense Budget
#### For the Fiscal Years Ending May 31

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<tr>
<th>Item</th>
<th>FY 2016</th>
<th>FY 2017</th>
<th>FY 2017</th>
<th>FY 2018</th>
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<td>Actual</td>
<td>Estimated</td>
<td>Actual</td>
<td>Actual</td>
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<td>$4,880,701</td>
<td>$4,294,461</td>
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</table>

| **Info Tech Redistributed**               | (4,085,298) | (4,880,701) | (4,294,461) | (4,387,471) |

| **Total**                                 | $ -         | $ -         | $ -         | $ -         |
### AMERICAN OSTEOPATHIC ASSOCIATION

**PROPOSED EXPENSE BUDGET**

**MEMBER SERVICES**

FOR THE FISCAL YEARS ENDING MAY 31

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<th>FY 2017 Budget</th>
<th>FY 2018 Budget</th>
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<td>FY 2017 Budget</td>
<td>FY 2018 Budget</td>
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AMERICAN OSTEOPATHIC ASSOCIATION  
PROPOSED EXPENSE BUDGET  
FOR THE FISCAL YEARS ENDING MAY 31  

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<th>FY 2017 Actual</th>
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## Proposed Expense Budget

**For the Fiscal Years Ending May 31**

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## American Osteopathic Association

### Proposed Expense Budget

For the Fiscal Years Ending May 31

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### AMERICAN OSTEOPATHIC ASSOCIATION

**PROPOSED EXPENSE BUDGET**

**FOR THE FISCAL YEARS ENDING MAY 31**

**PCORI Grant/Conrad Health Project**

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### AMERICAN OSTEOPATHIC ASSOCIATION
### PROPOSED EXPENSE BUDGET
### FOR THE FISCAL YEARS ENDING MAY 31

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## AMERICAN OSTEOPATHIC ASSOCIATION
PROPOSED EXPENSE BUDGET
FOR THE FISCAL YEARS ENDING MAY 31

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## American Osteopathic Association
### 142 East Ontario Building
### Statement of Revenues and Expenses

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## American Osteopathic Association
### 142 East Ontario Building
### Statement of Revenues and Expenses

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<th>A FY 2016 Actual</th>
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| **AMERICAN OSTEOPATHIC ASSOCIATION**
| **PROPOSED EXPENSE BUDGET**
| **FOR THE FISCAL YEARS ENDING MAY 31**

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American Osteopathic Association

House of Delegates

Report of the Committee on Resolutions

William Ashley Hood, DO, Chair
Douglas Rosendale, DO, Vice Chair
July 23, 2017
A/2017

Mr. Speaker and members of the AOA House of Delegates:

Your Reference Committee on Resolutions presents the following summation of our meeting of the 97th AOA House of Delegates, and the Committee recommends that it be approved.

WHEREAS, the July 2017 Annual Meeting of the American Osteopathic Association’s House of Delegates in Chicago, Illinois, at the Marriott Magnificent Mile is concluding its session of policy actions setting the future direction of the osteopathic medical profession; and

WHEREAS, this body now represents more than 130,000 osteopathic physicians and osteopathic medical students in this United States and abroad; now therefore be it

RESOLVED, that we acknowledge the leadership offered by Boyd R. Buser, DO, the American Osteopathic Association’s 2016-17 President for Leading the Change in the single accreditation system and further enhancing value of the American Osteopathic Association membership and board certification for DO and MD US trained physicians, and also encouraging us “to bring out the DO in all of us”; and be it further

RESOLVED, that this AOA House of Delegates extend to Mark A. Baker, DO, the full support of this assembly as he begins his year as AOA President focusing on improving communications and relationships with affiliates, engaging the youth of our osteopathic profession and promoting unity
within our osteopathic profession. This AOA House of Delegates joins him in embracing our osteopathic roots, by “dancing with the one who brung ya”; and be it further

RESOLVED, that this AOA House of Delegates recognizes the ongoing involvement, effort, and service provided by the AOA Past Presidents and AOA Board of Trustees over these days and all House of Delegates and alternates who have taken the time away from their practices and families to be here; and be it further

RESOLVED, that this AOA House of Delegates recognizes the collective efforts and great success in building the five Phase 1 pillars of the AOA strategic plan

- Expense Control and Revenue Enhancement
- Increasing the Impact of Osteopathic Medical Research
- Expansion of OGME and Quality Enhancement
- Enhancing the impact of our Public Policy work, and
- The AOA Brand Visibility Campaign

And be it further;

RESOLVED, that the following individuals and organizations be given the gratitude of the profession for their efforts in supporting this AOA House of Delegates to discharge its duty in the policy process:

- Melanie R. Jessen, DO, president of the Illinois Osteopathic Medical Society for her enthusiastic and warm welcome, and excellent reviews and options for finding Chicago’s deep dish pizza;
- David Broder, DO Vice Speaker in his absence, sending well wishes and prayers for the health of his family, as he was indeed missed;
- Ray L. Morrison, DO, forever known at this House as the $150 man did Yeoman’s work to lead this House of Delegates through some difficult deliberations. Our specific gratitude and great thanks for his efficient execution of duties;
- Our osteopathic residents, interns and medical students who value involvement with their state, specialty and national organization, and especially to those serving as delegates and alternates during this House of Delegates;
Our House of Delegates’ Pages for their help and assistance in helping you get to where you
needed to go, and assisting the ACGME panel by forwarding delegate questions from the
floor of the HOD, to the Panel during the discussion; and

COSGP and SOMA for the AOA mentor café for students, calling attention to physician
and student wellness and burn-out with the “save 400” campaign; and

Guy A. DeFeo, DO aka “Rocky” extending the very warm invitation for the House of
Delegates to register for OMED 2017 being held in Philadelphia, October 7-10, including
a special shout out to our very own “Adrienne”; and be it further

RESOLVED; that this AOA House of Delegates show its appreciation for the ACGME Panel;
Boyd R. Buser, DO, Karen J. Nichols, DO, and Thomas Nasca, MD, for their continued efforts in
advancing the single accreditation system, including special acknowledgement of ACGME programs
which have achieved osteopathic recognition. In closing their discussion, Dr. Nichols offered the
inspirational quote “no one is lesser, no one is greater, together we are better”; and be it therefore

RESOLVED; that this AOA House of Delegates recognize JAOA Editor in Chief Robert
Orenstein, DO for increasing the readership of the JAOA more than 30% and would like to join
him in acknowledging Michael Patterson, PhD in completing 30 years of service to the JAOA; and
be it further

RESOLVED; that this AOA House of Delegates further acknowledges those individuals and
organizations receiving recognition including:

- American Osteopathic College of Radiology (AOCR), Oklahoma State University College of
  Osteopathic Medicine, Touro University College of Osteopathic Medicine, Missouri
  Association of Osteopathic Physicians and Surgeons, and the Museum of Osteopathic
  Medicine who received Strategic Team Award and Recognition Awards, (“STAR” Awards);
- The article, “Correlation Between Standardized Patients’ Perceptions of Osteopathic Medical
  Students’ Self-Rated Empathy”, received the George W. Northup, DO, Medical Writing
  Award
- Humayun (Hank) J. Chaudhry, DO, President and CEO, Federation of State Medical Boards
  of the United States and Chairman, International Association of Medical Regulatory
  Authorities, Sandra Featherman, PhD, and Stephen C. Shannon, DO, MPH, President and
CEO, American Association of Colleges of Osteopathic Medicine, who received Presidential Citations;

- Clinton Adams, DO, as the presenter of the A.T. Still Memorial Lecture, who inspired us to “continue to flaunt our DO pride” and to retain our AOA membership not because of board certification, but to retain our osteopathic identity; and be it further

RESOLVED, that this AOA House of Delegates recognizes Jon F. Wills for 42 years of service to the Ohio Osteopathic Association and the osteopathic profession as he transitions into retirement; and be it further

RESOLVED, that this AOA House of Delegates recognizes the consummate and ever charismatic leadership of William G. Anderson, DO who suggested to the HOD the need for a resolution that objects to the significantly increased costs of medicines, specifically the “life-saving” drug epinephrine. The increased cost prohibits access to epinephrine for many of those who have the greatest need, children and the elderly.

RESOLVED, that this AOA House of Delegates recognizes Adrienne White Faines, MPA, CEO, of the AOA for her remarkable accomplishments as she begins her fourth year representing our great osteopathic profession and our hopes for a few more days on the ground than in the air as the osteopathic profession embarks on a wonderful world of opportunities; and be it further

RESOLVED that this AOA House of Delegates recognizes and congratulates our favorite “southern gentleman” from the magnolia state of Mississippi, William S. Mayo, DO, President-elect, and offers him the full support of this body, and be it further

RESOLVED, the dedication and support of the AOA staff, who make this House of Delegates possible is recognized by those present; and be it further

RESOLVED, that this AOA House of Delegates agrees with AOA President Mark A. Baker, DO, that we need to embrace the opportunities before us as we ensure our prosperity, and also reminding us that our future is so bright, we have to wear shades.

Mr. Speaker, And I so move. APPROVED
Mr. Speaker, this concludes the Committee’s report. I would like to thank the following members of the Reference Committee for their collaboration and hard work.

**Committee Members**
1. William Ashley Hood, DO – **CHAIR** Mississippi
2. Douglas Rosendale, DO – **VICE CHAIR** AOAMI
3. Paula Grimaldi, DO Massachusetts
4. Anna Hayden, DO Florida
5. James Jempsa, DO Nevada
6. Luis Perez, DO Ohio
7. R. Taylor Scott, DO Michigan
8. Andrew Yuan, DO Connecticut

**Staff**
Yolanda Doss